SHE FRAMEWORK

Safety and Health Enhancement for Women Experiencing Abuse

Jill Cory and Lynda Dechief

A Toolkit For Health Care Providers and Planners


Women's
BC WOMEN'S HOSPITAL
& HEALTH CENTRE
An agency of the Provincial
Health Services Authority


IFV
BC Institute Against Family Violence

SHE FRAMEWORK

SAFETY AND HEALTH ENHANCEMENT FOR WOMEN EXPERIENCING ABUSE

A TOOLKIT FOR HEALTH CARE PROVIDERS AND PLANNERS

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Library and Archives Canada Cataloguing in Publication Data

Cory, Jill, 1957-

SHE framework : Safety & Health Enhancement for women experiencing abuse : a toolkit for providers and planners.

Available also on the Internet.

Funded by: Canadian Crime Prevention Centre.

The SHE Framework provides a critque of the practice of universal screening for violence in health care settings. BC Women's acknowledges the differing views on this practice.

ISBN 978-0-7726-5729-9

1. Abused women – Services for - British Columbia. 2. Abused women – Health and hygiene - British Columbia. 3. Women – Health and hygiene - British Columbia. 4. Women's health services - British Columbia. 5. Wife abuse. I. BC Women's Hospital and Health Centre. Woman Abuse Response Program. II. Title.

HV6626.23.C3C67 2007 362.82'9209711 C2007-970074-3

Contents

i. Authors

Jill Cory (1957 -) has twenty-three years of experience in the field of stopping violence against women, working in front-line, policy, training and research arenas. For the past 10 years, she has managed the Provincial Woman Abuse Response Program at BC Women's Hospital and Health Centre, developing policy, conducting research, establishing province-wide networks and providing curricula and training to support health regions to implement strategies and programs to reduce the health impacts of violence against women. She is the co-author of several publications, including "Reasonable Doubt: The Use of Health Records in Criminal and Civil Cases of Violence Against Women in Relationships (2004)" and "When Love Hurts, a woman's guide to understanding abuse in relationships" (2006, 6th printing). Recently, Jill has joined BC Women's Provincial Women's Health Team as the Senior Program Advisor, Provincial Women's Health and is responsible for establishing and supporting the Provincial Women's Health Network.

Lynda Dechief (1973 -) has provided research consulting for the Provincial Woman Abuse Response Program at BC Women's Hospital and Health Centre and the BC Centre of Excellence for Women's Health (BCCEWH) on a variety of projects involving woman abuse, child abuse, women's mental health and use of substances, and the use of women's health records in court cases involving abuse. In 2001, Lynda was awarded the Isabel Loucks Foster Public Health Scholarship for excellence and leadership in public health. Shortly after completing her M.Sc. in Health Care and Epidemiology in 2003 on the health care experiences of women in abusive intimate relationships, she was hired by Atira Women's Resource Society to establish the Maxxine Wright Place Project for pregnant and early parenting women impacted by abuse, substance use and mental health issues in Surrey, BC. During this time, Lynda created and delivered close to one hundred workshops and conference presentations. In 2005-2006, Lynda held an IMPART Community Research Fellowship, a mentorship and training program for professionals on gender, women and addictions, a strategic initiative of the Canadian Institutes for Health Research.

Jill Cory and Lynda Dechief met in 1998 at a Violence and Health Working group meeting hosted by the BC Centre of Excellence for Women's Health (BCCEWH) and they have worked together in various capacities ever since. In one partnership project between the Woman Abuse Response Program and Atira Women's Resource Society, Jill and Lynda created a web-based workshop for nurses wishing to enhance their understanding of the links between woman abuse, substance use, and pregnancy/early parenting.

It is our hope that, by understanding the complexities and barriers faced by women navigating health services, we can transform our health practices, settings, institutions, regions and systems to truly enhance the safety and health of women impacted by abuse and violence.

ii. Acknowledgments

We wish to thank a number of people who have been instrumental in the development and completion of the SHE Framework.

Louise Godard, co-coordinator of the Woman Abuse Response Program, BC Women's Hospital, for so readily and capably jumping into the completion of the SHE Framework from the minute she started working with Jill and Lynda. Her contribution to writing, editing and evaluating the Pilot project have truly enhanced the SHE Framework.

Marina Morrow and Morgan Baldwin for their thoughtful input into earlier drafts, guiding us to a more refined model that truly integrated the experiences of marginalized women.

Sherwin and Becky at Pink Sheep Media for their endless patience and intelligent approach to the design of the SHE Framework, ensuring that the readers would have the best roadmap possible to follow the complex model and evidence presented in the SHE Framework.

Penny Bain, former executive director of the BC Institute Against Family Violence, for her vision of the SHE Framework as a complementary document to the ASAP, a safety planning guide for anti-violence and justice sectors and Susanna Tam, for picking up where Penny left off to guide us to the completion of the project. Both have shown great insight and patience as we worked through the messages, medium and model for the SHE Framework

Gayla Reid, editor extraordinaire!

Vera Lagasse, Director for BC Region, and her colleagues at the National Crime Prevention Centre, for providing the funding, support and encouragement for this project and its sister project, ASAP.

Daphne Wilson and the other women from Powell River, BC mental health, addictions and anti-violence organizations who formed the SHE Team and committed themselves to be the pilot site for the SHE Framework. The insights we gained from working with the Powell River SHE Team have deepened our knowledge and greatly improved the SHE Framework.

And finally, all the women who shared their stories of abuse and violence and their experiences accessing health care in order to help improve the health system and better understand the needs of women impacted by abuse.

iii. Preface

We begin this document where all work around violence against women should begin – with a woman's experience of abuse[1]:

"The first time he hit me, I'll never forget. It was shortly after our son was born. I was shocked. I didn't expect it. But if I really think about it, there was a lot of control in how he stopped me from seeing my friends by being really rude to them and a lot of my friends didn't come around because they didn't like the way he was treating me. I'm a caregiver, I would give, give, give, do, do, do and it got to the point where it was expected, and the appreciation wasn't there, where nothing was done right and then the beatings came on.

I think putting me down was an excuse to make him feel better about himself. And then I'd feel sorry for him. There must be something wrong for him to be doing this. Maybe I can make it better. So, you keep trying and the harder you try, the worse it gets. But I was still having that dream of the white picket fence. Maybe I was staying for my son, maybe I was staying for him and also for the promises, that this is going to change, it's going to get better. He would say, 'as soon as I quit the drugs everything will be better, it's the drugs that are making me do this'

For me, the drug use was for coping with it, and because I actually used with him. I figured that it would keep him at home, and it would make him happy, and he wouldn't hurt me. But a lot of times after he came off of his high he wanted me to go out and get more for him. I would say, 'No. I've got to straighten out now because my son's going to come home tomorrow from his Grandma's, and I want to be able to care for him '. So, then it would all start again, the beatings.

I actually went to social services and told them that I needed help and they took it on themselves to take my son. So, when they finally had my son, and I was like 'Well, I still need help', they said 'You can't get help unless you go check yourself in for addiction'. Well, my addiction only got really bad after they took my son because it was like 'I've got nothing now. I'm still getting beaten up, you've got my son, what do I have left?' I can't stress what a horrible feeling it is - lonely, guilty, shameful, hateful, angry, everything intertwined. Mostly alone, you feel very alone. Nobody understands. My addiction got really bad.

In terms of health impact, mentally was the biggest thing, where you actually don't feel like doing anything any more, don't feel like taking care of yourself. I lost a lot of weight, I was real nervous, angry, negative all the time. I used to always be the positive one, saw the brighter side, but my life became chaos and I only understood chaos. And the beatings continued. I actually had guns held to my head, and knives, and choking.

What I didn't think was good about the hospital was how they kept pressuring me to give names, press charges. And when I didn't want to do it they looked at me like 'Well, then, you deserve it. You deserve getting hurt'. So, I felt more guilt and shame. But, if you give his name, he's going to come back for you. They were like, 'he's not allowed to do that'. Well, I know that. Nobody has the right to hit anybody. They would say, 'Well, put a restraining order on him', but what good's that going to do? They can't protect you 24 hours a day. When I finally did put one together, it was just as I said. They weren't able to protect me. He kept coming back and back and back.

One time he smashed the window, broke in and came in. There was blood everywhere, he was screaming and shouting at me. Six foot four, two hundred and forty pound Viking, just raging. I called

1 This story is an excerpt from one shared with Lynda Dechief, as part of her graduate research in Health Care & Epidemiology at the University of British Columbia.

911 and got put on hold. And then the police show up, and they're outside waiting. Waiting for what? Waiting for him to actually kill me? It was nuts. Eventually, you just don't bother with that. And the amount of red tape that you have to go through to even get a restraining order. So you just forget it and you keep taking it. Better to try to make him happy than to get him upset and have him on your back all the time.

People need to be educated about these issues instead of punishing you for it, and making you feel even worse. Because you're already feeling horrible, this man's making you feel horrible and stupid. And then you come out to try and get help and people are making you feel even stupider.

A lot of times, I think that people in the health system have mistaken me for being North American Indian and I do believe that played an important role. I hate to say it, but I think they're very prejudiced toward First Nations. They have this idea of the way they are supposed to be, 'they're all 'alkies' or addicts. They all get beaten up and deserve it'. I really didn't feel like anyone cared.

Making it even worse was them saying 'You're just a bag of nerves', and they give you pills, like Valium, to keep you calm. Well, you're going through an emotional feeling and that feeling should be okay. And all they try to do is keep you calm, so you basically become numb to everything instead of them actually trying to help you.

I remember one time saying 'The hell with this, I don't want X-rays. If you don't want to help me, I'm just leaving'. I really didn't think they were out to help me, they were out to get him. And to get him was just going to hurt me even more. And then it got to the point where you're scared to go to the hospital. I didn't want to go through that harassment. I remember getting broken ribs once and I just suffered it myself.

I think they were really judgmental, and I think that's sad because if they really got to know half the women out there, they're not stupid. It could happen to anybody. If people had wanted to help, they could have been asking me 'What can I do to help you?' At that time I don't know what they could have done, but just knowing that somebody cared enough to ask [what I needed] would have been really important.

When I did finally get out of the relationship, I didn't feel good about anything. I was a failure as a mother, I was a drug addict. I was in horrible shape. I'd lost so much weight. I was old and haggard looking. I'd lost all my friends. I was nothing. I didn't think I was going to make it. It's pretty tormenting. And to think that somebody can brainwash you to that extreme, or beat the hell out of you to that extreme. If it wasn't for my son constantly saying 'I love you Mommy. I need you, Mommy' I would have given up and just died.

I have my son back in my care now, which is wonderful. But there's just not enough support out there. I was talking to my doctor because I was really upset about having to make arrangements for my son to see his father. I don't want him coming to my home because I know that if he steps his foot in here, he'll keep pushing. But the system actually makes you have contact. You have to do this 'Parenting After Separation' program. A set up for failure as far as I see it.

Society keeps telling my ex that it's okay to be the man of your castle, and that you have every right to control. It's sad. Even my son, as little as he is, you can see this male thing in him already. The other day he said, 'All girls do is hee-hee-hee, giggle'. That's the female role already in his mind. I asked him, 'don't you giggle?', and I started tickling him, then he starts laughing.

I do feel a lot stronger now. I can actually see the rainbow, the pot of gold. I've put on a lot of weight. I was probably down to 100 pounds. I've put on 25 pounds since I left a year ago. People say I look a lot healthier, a lot better, a lot more alive. ”

- Woman abuse survivor

iv. Foreword

We live in a society which glamorizes violence against women. Daily, as we witness portrayals and images which link sex and violence, we become desensitized to what we see and are often unaware of the implications of continuously observing women being sexualized and assaulted by men. We live in a culture that not only glorifies woman abuse, it normalizes it.

We now know that violence against women is an important risk factor for women's ill health and can no longer be ignored or denied. Prevalence rates indicate that gender-based violence is a significant reality in the lives of women around the world. Health and gender inequality issues are closely linked; thus, the vital role the health sector can play in responding to woman abuse and in improving women's health and safety is becoming increasingly apparent.

The Safety and Health Enhancement (SHE) Framework challenges the health sector to take a proactive role in responding to violence against women. The SHE Framework provides health care providers, planners and policy makers with a practical approach to increasing the capacity of the health sector at all levels to respond to women impacted by abuse.

The feminization of the HIV/AIDS epidemic is a powerful example that illustrates the health sector's potential role in responding to women's health needs in the context of violence. We know that the highest rate of increase in new HIV infections around the world is among married women. This underscores the fact that the risks of violence and loss of power for women are often amplified within relationships where they are controlled by their male partners. In a context of gender inequality and sexual violence against women, women are too often unable to negotiate safe sex practices or to decline sex with husbands who are engaging in unprotected extra-marital sex and infecting their partners (wives) and other women.

Without considering the significant role that violence against women is playing in the growth in infection rates among women, we cannot combat the HIV/AIDS epidemic. However, by working together the global community, including the health sector, can transform its approach to the epidemic to one that considers the cultural and social context which fuels it. Strategies and preventive options, such as microbicides, give women the ability to protect themselves from infection without the cooperation, consent or even knowledge of their partner. Microbicides will not prevent a woman from being forced to have unprotected sex with her partner, but they will greatly empower women to have some control over their health and reduce their chances of infection.

The devastating example of the HIV/AIDS epidemic shows us how at every level of women's care it is integral to be attentive to gender and the context of women's lives. It also highlights the importance of multi-sectoral collaboration in effectively responding to violence against women and the resulting health impacts. If we translate this example to individual women's lives and the clinical encounter, health care providers can begin to conceive of women's health in the context of gender inequality and gender-based violence. By adopting this lens, health care providers can provide every woman with an experience that counters that which she may be experiencing at home - one where she receives the utmost respect for surviving in hostile social and intimate circumstances and where her voice leads the health care encounter. Health care leaders are challenged to make significant changes that go beyond clinical practices to recognize and participate in broader institutional and social change.

The SHE Framework will make a significant contribution to raising awareness among health policy-makers and care providers regarding the seriousness of violence against women and how it affects the health of women. In addition, the SHE Framework acknowledges that research is not enough and that action is required. The innovative *SHE Toolkit* provides the health sector with an opportunity to put research into practice and

engage in a comprehensive and transformative process of auditing health care settings to greatly improve the health and safety of the women they serve.

The health sector can not address the problem of violence against women alone, but by using the SHE Framework as a guide, the potential of the health sector to dramatically improve the health and safety of the women it serves will be realized.

- Louise Godard,
  Coordinator, Woman Abuse Response Program

v. Contact Information for the Woman Abuse Response Program

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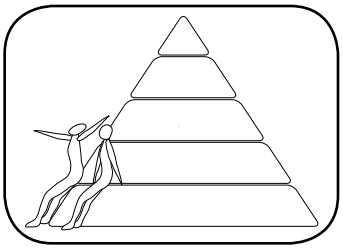
chapter one



I. Introduction to the Safety and Health Enhancement (SHE) Framework

An increasing number of health care providers, planners, policy makers, and researchers are working hard to make health care safer for women in order to reduce the risks and health impacts associated with violence against women.

In our work across the health sector, health care providers have described ways that they have tried to create safety for women during health care encounters. They also express the frustration of not knowing how to reduce or prevent risks women face. Many health care workers have tried using recommended screening questions and report that they did not address women's safety. Some health care providers tell us that the health system is not designed for safety.

In developing the SHE Framework, we have drawn on the creativity and commitment of health care providers to direct us to promising practices as well as to highlight flaws in the system that need amending. We also listened carefully to survivors of violence who told us about how the care they received from health care providers could either reinforce the abuse or offer a new vision of themselves and hope for safe lives in the future.

The vision of the SHE Framework is to provide guidance for health care providers, planners, policy makers, researchers, and community partners who are inspired to address women's safety by working in collaboration. The SHE Framework is designed to guide a multi-disciplinary team through a safety and health assessment process.

It is our hope that, by understanding the complexities and barriers faced by women navigating health services, we can transform our health practices, settings, institutions, regions and systems to truly enhance the safety and health of women impacted by abuse and violence.

A New Safety and Health Enhancement (SHE) Framework for Women Experiencing Abuse

A new health care model that can elaborate the complexities associated with woman abuse and advance the health care system's response to this pressing issue is required. The evidence presented in the SHE Framework, an innovative, comprehensive approach to the health sector's role in responding to violence against women, demonstrates that practitioners and researchers are beginning to distinguish between ineffective or unsafe health care practices and those that increase women's safety. Recognizing that women's experiences of abuse and their safety and health outcomes are shaped by interactions with the health care system, it is imperative that we understand more about how health care can contribute to improving women's overall health and safety while avoiding compounding the risks to women.

> "Many abused women who seek help from the health care system experience their contact with the "helping" professions and systems as another form of abuse. These women are doubly victimized, first by violent partners and then by practices and procedures that are insensitive to their needs" - Health Canada [1]

The evidence presented in the SHE Framework suggests that our focus must take us beyond an individual woman's experience in clinical encounters and look at solutions and opportunities from a broader institutional and social change perspective. This approach must include an integrated multi-sector approach to reduce and eventually eliminate violence against women and be guided by sound research and women's voices and experiences.

The SHE Framework aims to achieve this goal. It is guided by a women-centred care approach, a model of care that recognizes that trauma is a central aspect of many girls' and women's lives and focuses on empowering women impacted by abuse through respect and support of their decisions. A growing number of programs are moving towards providing women-centred care [2-9]. This approach ensures that women will not have their experiences of abuse echoed or compounded in their encounters with health care providers.

A. The Components of the SHE Framework

The Safety and Health Enhancement (SHE) Framework is comprised of three parts: two models, an evidence paper and a toolkit. The SHE Framework introduces two contrasting models, the *Compounding Harms* and the *Safety and Health Enhancement (SHE) Models*, which illustrate factors which contribute to a woman's experiences within the health care system. The models are supported by the *SHE Evidence Paper* which presents relevant research and women's narratives about their experiences of abuse and their contact with the health system. The accompanying *SHE Toolkit* guides health care practitioners, planners, and community partners to identify potential risks embedded within health care practices and policies for women impacted by abuse. The *Toolkit* enables users to build on strategies and promising practices for increasing safety and improving health and health care for all women.

1. Compounding Harms and Safety and Health Enhancement (SHE) Models

The contrasting models may provide new information or shed further light on the potential risks that women experience in health care encounters, as well as outline evidence-based strategies to reduce these risks.

Compounding Harms Model: The *Compounding Harms Model* describes the potential harms experienced by women within the context of health and health care, beginning with the abuse itself which is then intensified by interactions with the different levels of the health care system.

The *Compounding Harms Model* is depicted as an inverted triangle pressing against women who are impacted by abuse, with the additional burden of multiple tiers within the health sector compounding or echoing the dynamics of the abuse. All five tiers in the triangle threaten to topple onto the woman who is trying to negotiate the health system and advocate for her own safety and health.

Safety and Health Enhancement Model: The *Safety and Health Enhancement (SHE) Model* is a righted triangle and illustrates safety measures that reduce the harms and health impacts of the abuse for women. This model illustrates that, by addressing the systemic risks documented in the *Compounding Harms Models*, women can be shielded from further harm and their safety and health enhanced.

The *SHE Model* places equality-seeking policy and research at the base of the triangle as a stable foundation and depicts each ascending tier as a potential source of strength within health care that could mitigate the harms of abuse by a woman's partner. Rather than being weighed down by the tiers, the woman is now supported by them. Inverting the model can help conceptualize how health services can be reorganized to offer safety and health enhancing measures for women experiencing abuse.

There are five tiers in each model.

Tier One: ***Violence Against Women*** describes the dynamics of woman abuse and women's survival strategies.

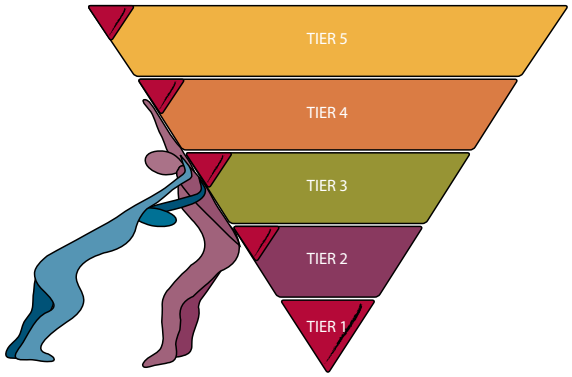
Tier Two: ***Health Impacts*** describes the impact of abuse on women's health.

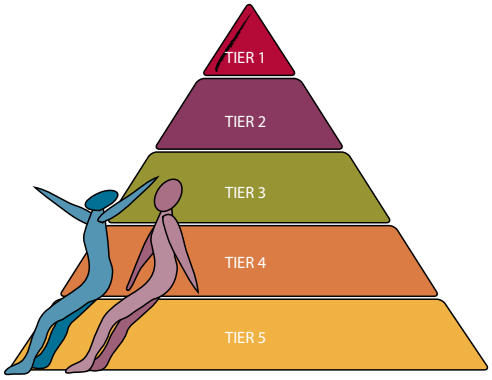
Tier Three: ***Access to Health*** outlines barriers to utilizing health care and practices that are designed to facilitate access.

Tier Four: ***Health Practices*** explores the institutional culture and routine practices that women experience in health care, and proposes more women-centred models of care.

Tier Five: ***Policy and Research*** reviews social and health policy and research that sets the direction for addressing woman abuse at international, national and local levels.

Compounding Harms Model





Safety and Health Enhancement Model

The colours representing each tier of the two models are used throughout this document to alert the reader to the tier being discussed. The same colour associated with each tier applies to the *Compounding Harms* and *Safety and Health Enhancement Models*.

The tiers of the model are elaborated upon at the end of this chapter.

2. SHE Evidence Paper

Combining evidence-based research with survivors' accounts of abuse and their experiences within the health care system, the *SHE Evidence Paper* provides insight into increasing women's safety based on current knowledge. Evidence is presented on each of the five tiers of the two models, illustrating in each tier both compounding harms and safety and health enhancement (SHE) measures within the context of health care for women impacted by abuse.

> "The degree to which women's strategies related to their safety and health are supported during their health care encounters can determine the degree to which women can begin to regain the health previously lost through experiencing abuse in their intimate relationships."
> – Lynda Dechief [10]

How to use the SHE Evidence Paper

The *SHE Evidence Paper* provides the foundation for a safety and risk assessment of any identified health setting by a Safety and Health Enhancement (SHE) Team. The team is comprised of colleagues in the health system and the anti-violence women's community. The *Evidence Paper* has been structured to enable the SHE Team to make extensive margin notes to link evidence with the health care setting's practices and policies as a first step in the risk/safety assessment process. This information is used as part of the *SHE Toolkit* to assist the SHE Team in the process of transforming their health setting to enhance women's health and safety.

3. SHE Toolkit

While the goal of the SHE Framework is to transform health settings, health care providers, policymakers and planners cannot do this alone, nor should they. The *SHE Toolkit* is a practical tool designed to guide a team of practitioners, planners, and community partners through a process of identifying compounding harms and safety and health enhancement measures in a particular area of health care. The area under review by this Safety and Health Enhancement (SHE) Team can be any health setting – a clinic, a unit of a hospital, an entire institution, a provincial program, even a health region.

This process is designed to enable the SHE Team to apply the models and accompanying *SHE Evidence Paper* to their health setting to evaluate practices and policies for their potential impact on women's safety and health.

How to use the SHE Toolkit

The steps of the SHE Process provide a mechanism for the SHE Team to weigh the risk/feasibility ratio of changing identified practices and policies that contribute to risks for women experiencing abuse based on evidence presented in the *Evidence Paper*. The *Evidence Paper* also provides ideas for implementing evidence-based changes to increase women's safety within health care environments. This is done by applying the SHE Action Plan to identify actions, leadership and a timeframe for implementing changes beginning with those identified by the team as high priority.

> "We need to develop a health care structure and a practice that starts from the premise that every woman could be experiencing abuse, but that not every woman is experiencing abuse. It is incumbent upon the system to uncover and reduce the potential risks women encounter in health systems and increase the protective measures to ensure women's safety to the greatest possible degree."
> – Jill Cory

The *Safety and Health Enhancement Toolkit* enables users to:

- Understand how health care practices, protocols, institutional culture and policies operate;
- Uncover potential sources of risk within each tier of the models;
- Identify and change potentially retraumatizing encounters or procedures;
- Support health care providers to understand the risks of disclosure;
- Review practice, policy and research through a women-centred lens;
- Point to safety and health enhancement measures based on evidence; and
- Work towards mitigating the harms of abuse inflicted by a woman's partner.

Using the *SHE Toolkit* will help you to:

- Create an accessible, safe environment during a woman's contact with health care services;
- Support a woman in her decisions about her safety and the safety of her children;
- Provide relevant health care to support and strengthen a woman so she is better able to survive in a relationship that is hostile towards her health and well-being;
- Reduce barriers to access, and create safety at all levels of health care organizations and across the health sector;
- Reduce the impact of gender and cultural biases; and
- Create gender equitable policies.

B. Who is this Framework for?

You are one of a growing number of health care providers, planners, policy makers, researchers and other health care leaders who are working hard to make health care safer for women in order to reduce the health and safety risks associated with violence against women.

In our work across the health sector, we have worked with nurses, physicians, midwives, doulahs, social workers, mental health and addictions counselors, unit clerks, physiotherapists, paramedics, aboriginal health advocates, policymakers and managers as partners who are committed to women's safety and equality.

Wherever we have the opportunity to work with health care providers, they describe ways that they have tried to create safety for women during health care encounters. They also describe the frustration of recognizing that a woman is not safe in her relationship and not knowing how to reduce or prevent these risks. Health care providers tell us that sometimes, in order to avoid the potential for increasing harms, they do nothing—not because they don't care, but because they cannot know if they are adding to the risks. Many health care providers tell us that health research and practice is not always designed for women's safety. We review many studies in the *SHE Evidence Paper* that echo this observation.

Health care workers who have tried using recommended screening questions about abuse in women's lives report that these questions did not address women's safety. For example, a screening program was implemented as part of a study at BC Women's Hospital and Health Centre. Following completion of the study, nurses were asked about their experiences of participating in the screening study. Their feedback included clinical observations that direct questioning can make women feel singled out and stigmatized; sharing information about abuse comes from a trusting relationship with a patient rather than from a question from a checklist; the presence of partners, and lack of translation, privacy and confidentiality all make screening inappropriate; there are risks to women in disclosing abuse; and that screening is not the same as good care [11].

Nurses also identified that woman abuse is "way too big an issue to get at from asking a few questions." [11] Based on this feedback, and emerging research calling into question the safety of screening, the Woman Abuse Response Program at BC Women's Hospital identified the need to expand the current role of the health sector in responding to woman abuse.

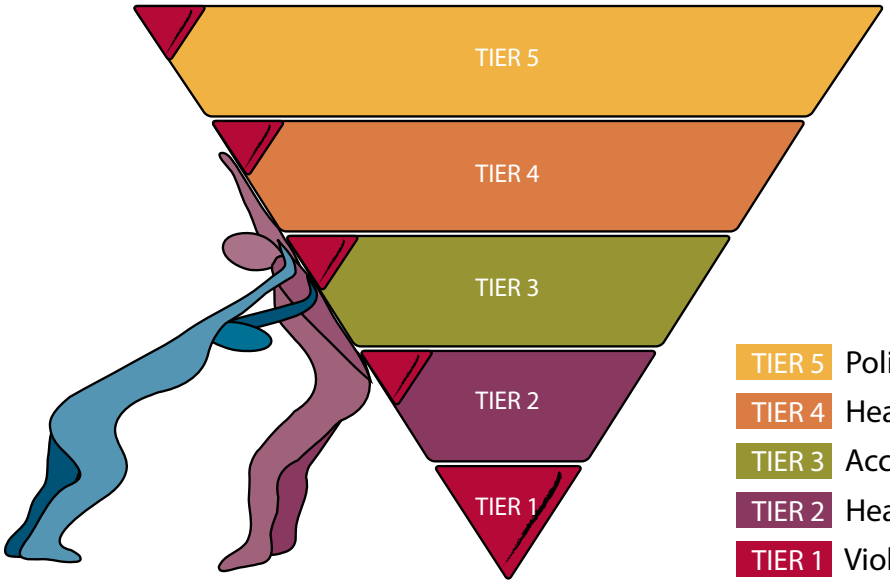
The vision of the SHE Framework is that health care providers will be inspired to address women's safety and health by working in collaboration to form a SHE Team. The *SHE Toolkit* will be used to guide the SHE Team of practitioners, planners, and community partners through a safety and health assessment process. Involving other sectors, particularly community-based anti-violence organizations, will be invaluable in developing relevant and meaningful responses and systems best suited to the health and safety needs of women impacted by abuse. Mutual respect and equal acknowledgment for each team members' unique contribution is vital to the success of the process, given the SHE Framework's mandate to redress imbalances of power within health care and between sectors.

Anti-violence advocates will also find this Framework useful. It is our hope that, by understanding the complexities and barriers faced by women navigating health services and by those working in the health sector, collaborative work will emerge that respects these challenges in the quest for safety for women experiencing abuse.

C. How Does the SHE Framework Apply to My Work Setting?

Violence against women has acute, chronic and life-threatening health impacts that cross all areas of health care and affect women across the life span. The challenge for health care providers is to make the links between a work setting or practice with particular populations of women and gender-based violence. We provide an overview of some of these links in the handout "How is SHE relevant to my practice?" ***(Appendix A)***, and expand upon the links in tier two of the model, health impacts of abuse. We encourage you to explore the relationship between your work setting and violence against women in more depth as part of the SHE Process.

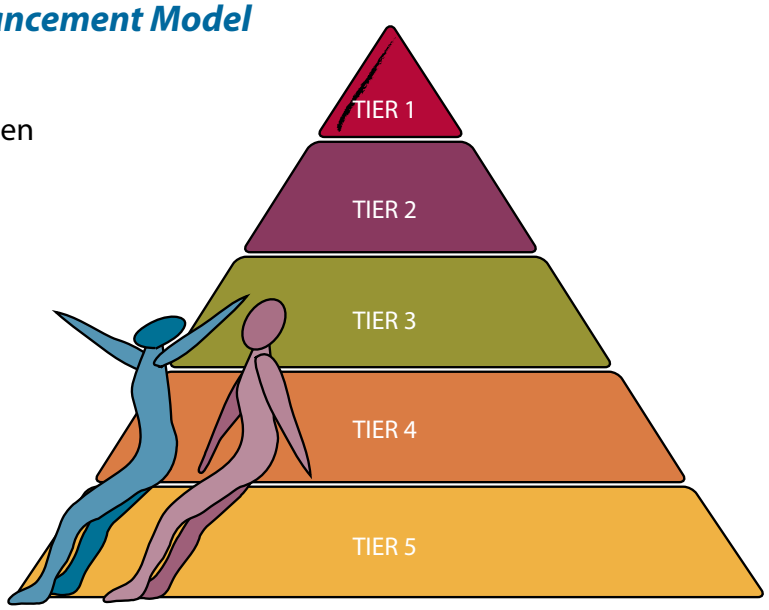
1. Compounding Harms Model



TIER 5 Policy and Research
TIER 4 Health Practices
TIER 3 Access to Health Care
TIER 2 Health Impacts
TIER 1 Violence Against Women

2. Safety and Health Enhancement Model

TIER 1 Violence Against Women
TIER 2 Health Impacts
TIER 3 Access to Health Care
TIER 4 Health Practices
TIER 5 Policy and Research



D. What are the Five Tiers of the Two Contrasting Models?

Below is a more detailed description of the two contrasting models:

1. ***Compounding Harms Model***
2. ***Safety and Health Enhancement (SHE) Model***

The two models provide the foundation for conceptualizing women's experiences in their abusive relationships and the impacts on their health, as well as how health practice, policy and research can shape their experiences.

Both models use the same five tiers to describe women's health care experiences within the context of abuse. The ***Compounding Harms Model*** begins with the harms that arise from ***violence against women (TIER ONE)***, such as isolation, degradation and loss of control. Arising from these experiences are the myriad ***health impacts (TIER TWO)*** of the abuse. Despite the burden on women's health, ***access to health care (TIER THREE)*** can be controlled by the abusive partner or diminished by factors within the health care system, creating additional harms.

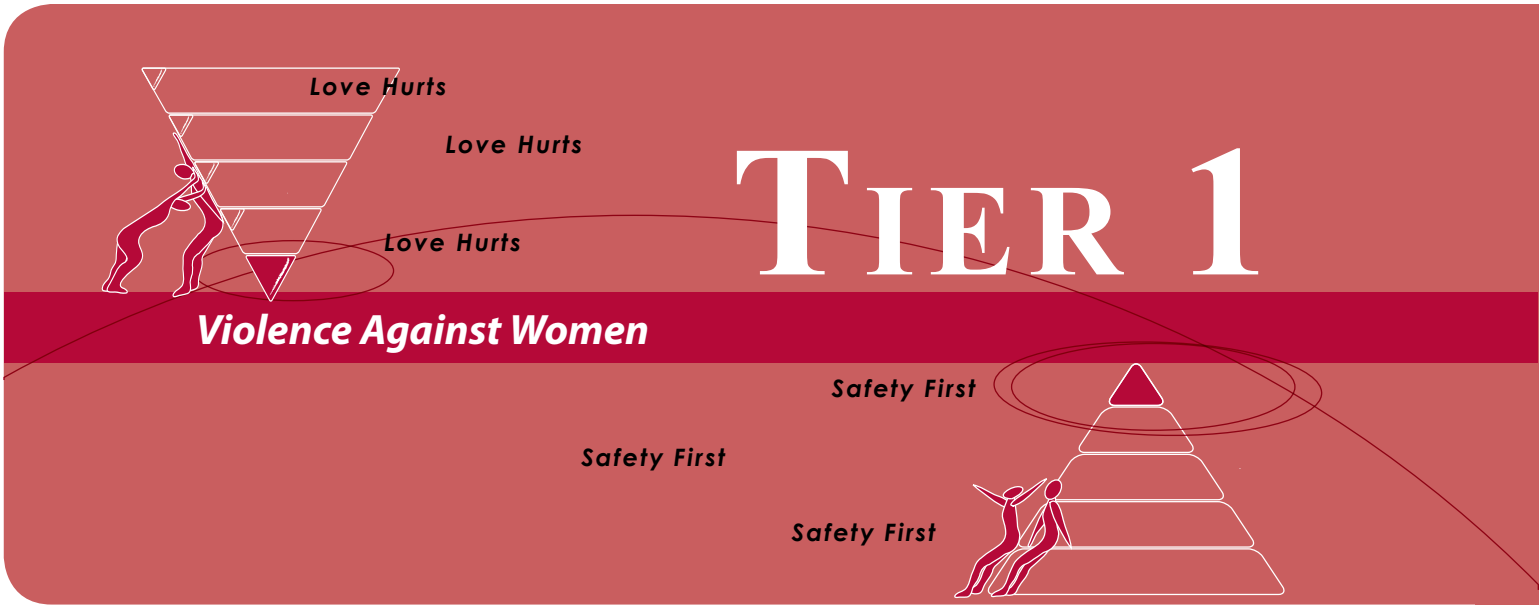
When women are able to access health care, routine and institutional ***health practices (TIER FOUR)*** can echo women's relationship dynamics of power and control, which can be retraumatizing for women impacted by abuse. Such practices are often the result of gender-blind or gender-biased health and social ***policy and research (TIER FIVE)*** that obscure the inequality of women, violence against women and its contributing social factors.

In contrast to the five tiers of compounding harms, the ***Safety and Health Enhancement (SHE) Model*** is a righted triangle, in which the five tiers provide a foundation to support women's health and safety.

This model places equality-based health and social ***policy and research (TIER FIVE)*** at the base of the triangle for stability. Each ascending tier is a potential source of protection within health care that could mitigate the harms of the abuse by a woman's partner. Such policy recognizes the health impacts of woman abuse and supports women-centred ***health practices (TIER FOUR)*** and principles that are in sharp contrast to the dynamics of abuse women face in their abusive relationships.

Such practices work to improve ***access to health care (TIER THREE)*** by taking into account the context of women's lives, especially those impacted by abuse or violence. Connections are made between women's experiences of abuse and the related ***health impacts (TIER TWO)***. This knowledge is incorporated into the care women receive.

By strengthening and supporting a woman's own safety strategies, a health care encounter can improve a woman's health and reduce the harms of ***violence against women (TIER ONE)***, whether or not a woman chooses to reveal her circumstances.



TIER ONE: Violence Against Women

COMPOUNDING HARMS: Love Hurts

> "What may seem to an outside observer to be a lack of positive response by the woman may in fact be a calculated assessment of what is needed to survive… and protect her children."
>
> – World Health Organization [12]

The model begins with a woman's experience of abuse in her relationship.

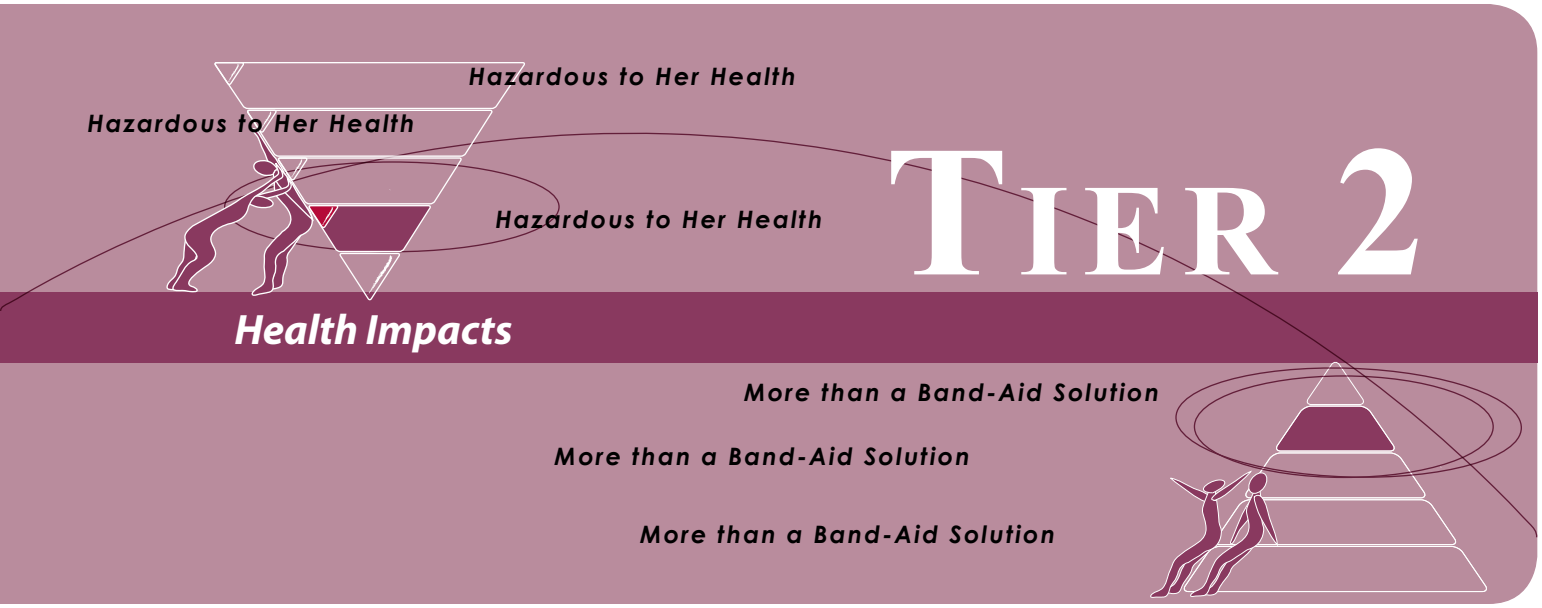
- Some women resist, others flee, while others determine that their safety is least compromised by remaining with their partner. While women try to navigate their relationships in order to mitigate the harms, regardless of what they do, women cannot control or prevent the abuse, nor are they responsible for the abuse.
- Statistics about woman abuse paint an incomplete picture; numbers cannot convey the experience of many women from diverse backgrounds who find themselves trapped in violent relationships by abusers who have employed intentional and methodical tactics to degrade, isolate, and terrorize them.
- Whether physical violence is a part of the pattern of abuse, women are traumatized by psychological terrorism, sexual violence and other forms of abuse.
- Statistics do show that, once a pattern of power and control is in place, women are right to fear the consequences of leaving. Women (and their children) are in gravest danger of injury or death when they leave the abuser—or even if they talk about leaving.
- Different inequalities, including gender, intersect in women's lives to create oppression and compound their experiences of violence.

SAFETY AND HEALTH ENHANCEMENT: Safety First

- Supporting women's strategies and understanding women's diverse experiences leads to relevant service design and delivery.
- Providing better support to individual women in abusive relationships would focus on women's safety rather than on changing herself or her circumstances; what may appear to be tolerance for violence may reflect deliberate, considered, life-preserving behaviour.
- Women's ability to negotiate their own safety is best supported by policies and institutions that understand the risks they face, value and support their health and safety, and recognize inequality as the basis of gender-based violence.
- Preventing violence against women can only come through change at all levels, rather than focusing only on individual women's relationships.

» *Critical Care Point*

Women experiencing abuse learn to weigh risk-benefit options, and make the relatively safest decisions. Pushing a woman to leave, or to talk about the abuse can increase her risk. Each woman is the only expert on her situation - her choices must be respected.



TIER TWO: Health Impacts

COMPOUNDING HARMS: Hazardous to Her Health

Violence and abuse affect all aspects of women's health.

- Beyond physical injuries, the health impacts of woman abuse can include: sleep deprivation, eating disorders, gastrointestinal illness, chronic headaches or back pain, hypertension, forced pregnancies and abortions, sexually transmitted diseases, cervical cancer rates, post-traumatic stress disorder, mental illness, substance use, and more.
- In most cases of mental illness and substance use among women, research indicates that violence and trauma precede these conditions.
- Health professionals in all areas of the health system provide care to women in abusive relationships daily, but many are unaware that the presenting health problems are the consequence of woman abuse.
- Too often, health care providers rely on the stereotypical signs of abuse, or on women to disclose abuse before considering their safety needs.
- Women are often pathologized and their health and safety issues are left unaddressed or misdiagnosed.

SAFETY AND HEALTH ENHANCEMENT: More than a Band-Aid Solution

- Although the abuse may remain under the surface throughout health interactions, evidence of abuse may be highly visible if providers are prepared to evaluate the health concerns and behaviour of women and their partners through a lens that recognizes the potential for women to be experiencing abuse.
- This approach would recognize the lifelong impact of abuse, and not limit its understanding of abuse to short-term, injury-based definitions of violence against women.
- Reducing these impacts requires a health care system that makes the connections between violence and health, and supports women in a manner counter to the dynamics of abuse – with mutuality and respect.

» Critical Care Point

The sequalae of health conditions that a woman experiences can compound the harms of the abuse perpetrated against her by her partner. These illnesses and conditions need to be recognized as some of the impacts of abuse, and the care women receive needs to change accordingly.

TIER THREE: Access to Health Care

COMPOUNDING HARMS: Between a Rock and a Hard Place

Women may be prevented from accessing health care and, paradoxically, when health care is accessed it may be to the further detriment of their health and safety. Abusers often:

- Prevent women from seeking care until they are very ill or pregnancy is advanced;
- Stay at a woman's side unceasingly during medical visits;
- Describe a woman as mentally ill, to minimize or discredit her concerns;
- Interfere with women's treatment regimens at home; and
- Manipulate providers by undermining her credibility.

In addition, care providers may unintentionally discourage a woman from returning to health care by:

- Admonishing her because she delayed seeking care, not recognizing that her partner is preventing her from using health services;
- Admiring her partner for never leaving her side, rather than recognizing the partner's motivation to control her health care encounter;
- Trying to move patients through quickly or keeping a woman waiting for hours in a busy emergency room;
- Trusting that a woman's partner will tend to her distress, rather than being the cause of the trauma;
- Offering information and resources about abuse in front of her partner and ignoring her need for safety and confidentiality; and
- Adopting assumptions and judgments that reinforce abusers' power and control and that alienate women from health care.

Interactions like these - usually considered conscientious and efficient - can unintentionally echo the dynamics of an abusive relationship. Opportunities to build trust may be missed, and women may not seek care again.

SAFETY AND HEALTH ENHANCEMENT: Making the Connections

In the *Safety and Health Enhancement Model*, women do not need to fear having the dynamics of their abusive relationship reiterated in health care encounters. Furthermore, the social context of women's lives is recognized as a key determinant of women's health and safety.

Aspects of health care encounters can mitigate the dynamics of abusive relationships and make women more likely to see health care as a safe place they can return to. This is done by ensuring that women:

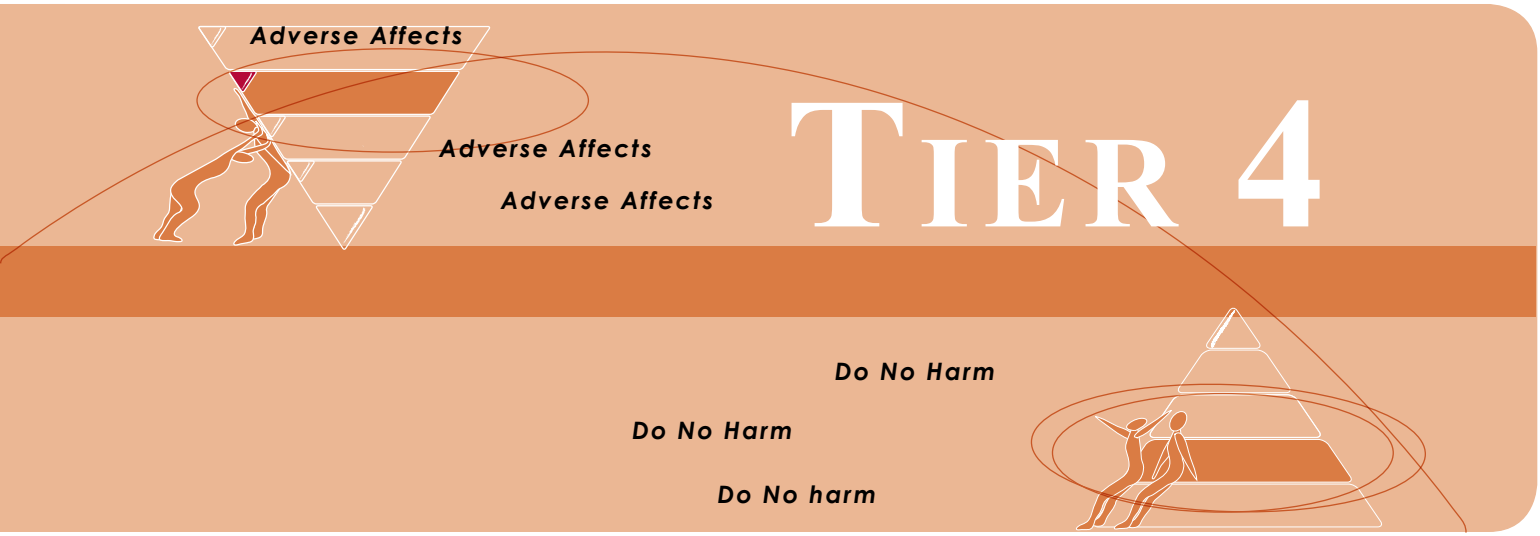
- Maintain control of decisions and information;
- Have full information prior to giving explicit consent for all procedures;
- Are not subject to treatments that are unnecessarily invasive or confining;
- Feel supported to over-ride the advice of providers;
- Feel that their safety is paramount;
- Make links between her health conditions, patterns of utilization and abuse; and
- Do not face logistical barriers to care, such as cost, hours of operation, and unilingual services.

In addition, health care providers can:

- Build trusting relationships with women;
- Create culturally safe and relevant practices; and
- Remove systemic barriers to care whenever possible.

» *Critical Care Point*

There is only one safe assumption: that any woman could be impacted by abuse. Interactions that begin there create a starting point for trust—a starting point for women to return in future and begin regaining control over their health, and their lives.



TIER FOUR: Health Practices

COMPOUNDING HARMS: Adverse Effects

Tier Four shifts the focus towards the system response, describing the routine practices and institutional culture in which health care is delivered. Traditionally, health services have been organized hierarchically and are based on principles of efficiency, control, and a focus on medical problems in isolation from the rest of a woman's body and her social circumstances.

- The medical model grants power to care providers, undermining women's expertise and pressuring providers to "fix" the problem, which can lead to misdiagnosis and mistreatment.
- The medical model routinely labels women "non-compliant" when their abusers prevent them from caring for their health and following recommended treatment regimes.
- Many routine procedures, from vaginal exams to ultrasounds, may deepen women's trauma.
- Research into screening for abuse has shown that, at best, this practice does not increase women's safety and, at worst, it can put women at further risk.
- The medical model can lead to interactions, practices and policies that minimize, trivialize, ignore, and control women experiencing abuse, thus echoing the dynamics of an abusive relationship.

SAFETY AND HEALTH ENHANCEMENT: Do No Harm

Women-centred care and trauma-informed service models begin with the premise that a high percentage of women have experienced trauma and that a system of care that is shaped by this knowledge will avoid alienating women who require health services.

These models help us to re-conceptualize a health care response that reflects the complexity of women's lives. They are organized around principles of "do no harm" and "understand and avoid retraumatization." They address women's health concerns and adapt treatment protocols to increase women's safety within the context of health services.

By applying these service models to the *Safety and Health Enhancement Model*:

- Women who are being abused will be recognized for their strength and expertise as they survive in a dangerous relationship;
- The focus on interventions will shift from changing women to changing the problem;
- The system would be organized on the tenets of women-centred care - that women are at the centre of care and decisions made about her health and all health treatments, advice, service options and care take place within the context of safety first;
- All health care would be provided in the context of a woman's life, with her safety and life circumstances at the forefront; and
- The role of the health sector in relation to woman abuse would then become "identifying the potential risks and opportunities for addressing woman abuse within the health sector with the goal to restrict possible harms and maximize possible benefits." [13]

» *Critical Care Point*

Shifting away from the medical model and toward women-centred care and trauma-informed models of care will support women in their quest for health care and safety without compounding their trauma or echoing the dynamics of abuse.

At best, health care encounters will support women in their efforts to regain control of their lives and health. At the very least, the interactions will reinforce that she is a capable individual deserving of respect, safety and good health.

TIER FIVE: Policy and Research

COMPOUNDING HARMS: Lip Service

Tier Five places all of these risks within the reality of gender and social inequality that reinforces discriminatory attitudes and social norms through mechanisms such as gender-neutral or gender-biased social policy and research. By ignoring that violence is rooted in gender inequality and oppression, "gender-blind" policies and research foster a social context in which violence against women is perpetuated nationally and globally. For example:

- Health care providers operate within the institutions that employ them, and institutions operate within a larger social context. Health and social policy and research are a reflection of and help to set this context;
- Much health research focuses on large-scale studies that lack crucial detail, and much health care policy ignores research that paints a bigger picture of women's lives and the effect that their social circumstances have on their health and safety; and
- The onus remains on women who are being victimized to achieve safety, usually without the support of, and often undermined by health, social, and justice institutions.

SAFETY AND HEALTH ENHANCEMENT: Seeing the Big Picture

There are bright spots on the horizon:

- International policy created by the World Health Organization (WHO), UNICEF and the United Nations (UN) identify gender-based policy analysis as a step toward ending woman abuse;
- Canada's Women's Health Strategy supports a population approach that transcends numbers and examines personal, social, and economic factors in women's health;
- Nations such as Spain have shown that collaboration between governmental and non-governmental organizations is the best way to reduce violence against women;
- Gender mainstreaming, gender analysis of all policies and research, attaching adequate funding to social policies that call for the reduction or elimination of violence against women, increasing legal sanctions against perpetrators and eliminating gender biases that privilege men's rights over women's safety would all decrease women's vulnerability; and
- Safety audits, which focus on institutional problems that fail to enhance women's health and safety, are showing much promise in other sectors.

» *Critical Care Point*

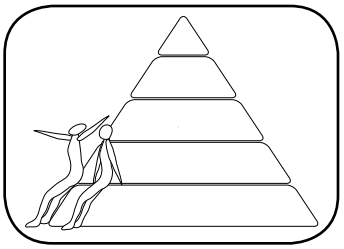
There is mounting evidence that women's health and security relies upon and improves with a coordinated approach that places women's safety as the primary goal. Perhaps most important to women's safety is the willingness of justice, health and human rights organizations to respond in a consistent and coordinated fashion to implement protective measures at a systemic level. In particular, any policies or actions developed within the health sector must respect and include the over-arching principles and practices that have been developed by anti-violence activists over the past thirty years.

E. Conclusion

Health care providers often feel that their efforts to help women who are experiencing abuse must result in immediate change. But the opposite is true. Woman abuse is a complicated problem that can only be resolved slowly, with respect, trust, and support from every level of the health care system and in collaboration with other sectors.

The two contrasting *SHE Models*, supported by the evidence from research and from women's experience, are elaborated upon in the next chapter to assist practitioners, planners, policy makers and researchers to assess health practices and policies to illuminate areas of compounding risks or enhancing women's health and safety. Using the *SHE Toolkit*, health care providers can work to reveal the sometimes hidden social context and institutional policies that unintentionally ignore and perpetuate woman abuse.

II chapter two



II. Background to the SHE Framework

The following sections define woman abuse and provide background to the very important roles that other sectors have played in addressing this issue. It includes a cautionary note about the health sector's attempt to address violence against women without the active involvement of other sectors, especially anti-violence women's advocates and organizations.

A. What Do We Mean by Woman Abuse?

Early definitions of abuse focused on those aspects of abuse that resulted in arrest, charge, or conviction but "a focus on acts only can also hide the atmosphere of terror that sometimes permeates violent relationships." [14]

The UN Declaration on the Elimination of Violence Against Women defines violence against women as "any act of gender-based violence that results in physical, sexual or psychological harm or suffering to women." [15]

Violence against women in relationships has also been defined by health researchers as:

> *A pattern of intentionally coercive and violent behavior toward an individual with whom there is or has been an intimate relationship. These behaviours can be used to establish control of an individual and can include physical and sexual abuse; psychological abuse with verbal intimidation, progressive social isolation, or deprivation; and economic control.[16]*

The pattern of abuse is an enduring, traumatic, and complex experience that isolates and controls women, whether or not it includes physical or sexual violence.

Human rights violations internationally are perpetrated differently against women, and women represent the overwhelming majority of survivors. The gendered element of woman abuse acknowledges the power inequalities and dynamics within gender relations and how abuse disproportionately affects women. The many manifestations of gender-based violence points to the significant role that social norms, gender roles and social and political institutions play in legitimizing and therefore perpetuating woman abuse, in addition to contributing to women's vulnerability to abuse. Thus, "violence against women is not only a manifestation of sex inequality, but also serves to maintain this unequal balance of power." [17]

Violence against women in relationships is viewed as one facet of a global picture of gender oppression that includes rape and sexual coercion, forced sexual initiation, sexual abuse of girls, trafficking, forced prostitution, exploitation of labour, debt bondage, violence against sex trade workers, rape in war, sex-selective abortion, female infanticide, deliberate neglect of girls, and female genital mutilation [18].

What's in a Name?

While many different labels are used to describe violence against women, they imply variations in meaning, specifically regarding the nature and cause of gender-based abuse [19, 20].

The use of the word "violence" highlights the serious, and often criminal, aspects of the experience, whereas

"abuse" suggests a broader spectrum of experiences, including emotional, verbal, financial, sexual, spiritual and mental aspects of abuse that are not currently considered a crime in most parts of the world .[2]

The words "partner", "spouse" and "family" capture that abuse is often experienced within the context of a relationship, but obscures the fact that it is women who are overwhelmingly the targets of the violence [22]. The term "intimate partner" wrongly suggests the relationship is grounded in intimacy rather than oppression. It also obscures the violence that women experience from other people in positions of power in their lives. For this reason, we avoid using the term 'intimate partner violence' in our analysis.

Throughout the SHE Framework, we use 'violence against women', 'woman abuse' and 'gender-based violence' interchangeably. To refer specifically to the women experiencing and impacted by this phenomenon, we use the terms 'women experiencing abuse', 'women in abusive relationships' and 'women impacted by abuse'. The first two terms take into account that many women are currently being abused or violated by their partners, and attention to their safety must direct everything we do. The latter term reminds us that it is difficult to clearly define when one is 'in' or 'out' of an abusive relationship; often the abuse and its impacts last far beyond when a woman and her partner are 'together'.

How Common is Woman Abuse?

Research on rates of violence against women has played a vital role in establishing the seriousness of the issue worldwide [23-29]. A recent study by WHO which collected and analysed data from ten countries indicates that lifetime prevalence rates of gender-based violence around the world vary, with rates ranging from 15% to 71%, with most countries falling between 29% and 62% [30]. While reviewing any prevalence rates it is important to take into consideration the underreporting of abuse, and understand that they can therefore be seen as representing only the minimum levels of abuse that occurs. Additionally, results show little of the complex nature of abuse and researchers recommend complementing quantitative studies with research that looks at the experiences of victims [31].

While definitively quantifying the rates of abuse has been hampered by differences in definition, definitions that compartmentalize different aspects of abuse, assume a "hierarchy of seriousness", and do not necessarily reflect the reality of women's experiences [32-34], we do know that, in Canada: :

- Approximately one in three women have experienced physical or sexual abuse at some point in their adult lives [35].
- One in ten women are experiencing abuse right now [36, 37].

That means that if 100 women come through a particular health setting in a given day, at least 30 have been impacted by abuse or violence as adults and 10 are currently in an abusive relationship.

The Myth of Mutual Battering

Research tells us that ninety to ninety-five percent of the victims of abuse are women [16, 20, 38]. According to 2005 justice statistics, the number of women who were injured or killed by their husbands or common-law partners was five times higher than the number of men who suffer physical injury or death at the hands of their female partners, and this statistic has remained constant since at least 1999 [39, 40].

How then, can battering be conceptualized as mutual? As detailed in the previous section, abuse is grounded in dynamics of power and control. Power and control, and the strategies employed to maintain power, are antithetical to the notion that the relationship is mutual. Despite this, the issue of men being abused by women continues to be raised in the literature, often suggesting that gender is not an important factor in abuse [41]. Survey tools such as the Conflicts Tactics Scale (CTS) contribute to the myth of mutual battering. The CTS is used to assess the type and frequency of physical tactics during "marital conflicts" where women and men both report the use of aggressive tactics. This has led some researchers to conclude that women are as abusive as men and that "mutual battering" or "reciprocal aggression" typify abusive relationships [42-44]. The CTS is considered by other researchers to be a blunt instrument that relies on the interview subject to identify 'acts' of violence, and has been criticized for not

2 Spain recently took the landmark step of designating psychological violence a crime [20].

taking into account the likelihood of distorted data as a result of interviews being monitored by abusive men, abused women's tendency to minimize the abuse and reliance on definitions of abuse that focus on physical assault and ignore the gendered, patterned and intentional use of power and control tactics.

The utility of such scales is also called into question because of the lack of attention to the intent behind, or impact of, violent behaviours [37, 44, 45]. When the context of abuse is included, it is evident that women rarely initiate violence against men, women's aggression is mostly retaliatory or self-defensive and that the violence experienced by women, as well as its impacts, is far more severe than that experienced by men [32, 37, 43-46]. One key example of the impact of abuse is women's loss of basic human rights and freedoms, which is surely the most poignant benchmark of the difference between violence against women in relationships and mutual battering.

Intersecting Oppressions

Many forms of inequality intersect with gender to shape the experiences of women in abusive relationships [47-50]. Researchers now insist that it is not enough to say that women of all backgrounds experience violence, or to attempt to identify "higher risk" groups of women; we must also understand the ways in which different inequalities intersect in women's lives to compound their experiences of violence [47, 49, 50]. For example:

- Women with physical disabilities may face greater risk of being abused because of their dependence on their partners and increased isolation [7, 39, 48, 51-54]. The rate of sexual abuse for girls with disabilities is quadruple that of the national average [55];
- Young women are at a higher risk of violence and of being killed [42, 56-58]. This may be due to the downplaying of the seriousness of abuse in relationships between younger women and their partners [59] when research reports that abuse can begin as early as in elementary school dating relationships [37];
- Women of all socio-economic strata are at risk of experiencing abuse in their relationships but poverty can increase difficulties escaping the abuse [34, 48, 60-62];
- First Nations and Inuit women experience violence at rates higher than the Canadian average [53]. Relationship abuse may be exacerbated for these women by economic factors, a history of colonization, and a cultural legacy of mistreatment and abuses that arose in past decades through educational practices [63];
- Immigrant and refugee women may face greater barriers to escaping abuse due to isolation on the basis of language or culture, and to their dependent status on their partners as a result of immigration legislation and their marginalised place in the workforce [61, 64-67];
- Women who live in rural communities also face similar effects due to isolation and increased community pressure to not speak out about abuse [32, 68, 69];
- Lifetime prevalence rates for abuse in same-sex relationships are between 25% and 35%, comparable to heterosexual populations [70]. However, lesbians, bisexual, queer, transsexual and transgendered women can face increased difficulties obtaining support in the social context of homophobia and heterosexism [48, 70-72]; and
- Almost all women who work in the sex trade have experienced abuse or violence, with most being victimized more than once [73]. The marginalization and stigma associated with the survival sex trade and the normalizing of violence towards this population of women contributes to the barriers women face when trying to access health care and supports.

B. Collaboration: What is the Role of the Health Sector in Addressing Woman Abuse?

> "Violence against women continues because globally there has been inadequate attention on changing the underlying social, economic and political inequalities that support violence against women." – World Health Organization [12]

Efforts to address violence against women initially focused on providing shelter for women and imposing criminal sanctions against abusers. Responses within the health care system emerged as it became increasingly apparent that woman abuse can have significant impacts on women's health, and that women with experiences of abuse comprise a significant percentage of patients in every health setting [74].

It is now well recognized that responses to violence against women must include a commitment from all social institutions if we are to remedy violations in women's human and legal rights. From this perspective, any discussion of violence against women must be approached using an integrated, multi-sectoral human rights, legal and health approach.

Below we summarize feminist and legal contributions to the advancement of safety for women and explore the current and future role of the health sector.

Contribution of Feminist and Human Rights Advocates

Gender-based violence has existed in Western societies for centuries, perhaps even millennia, and has come under public scrutiny at other times in history [20, 75]. However, the issue was largely invisible in public discourse throughout much of the twentieth century, however, until feminist activists began to "name it" in the 1960s [37, 76].

Identifying the public nature of woman abuse became possible because of the courage of survivors who began to speak out, seek support and critique services that were not addressing what was considered to be a "private" issue.

It is now well accepted that violence against women has its roots in social inequality. Woman abuse is perpetuated by the unequal distribution of social and economic capital and political power along gender lines [77].

The expertise of anti-violence advocates who work in transition houses, community-based victim support services and other community-based organizations have made an enormous contribution to the discourse about violence against women. They have dispelled myths such as "woman abuse is a private matter", "woman abuse results from personal dysfunctions" or "violence against women is one form of interpersonal conflict".

> "A catalyst for taking woman abuse seriously occurred when Member of Parliament Margaret Mitchell (Vancouver East) stood in the House of Commons in 1982 and cited recent estimates that 1 in every 10 women experiences violence in her relationship each year, and suggested that her colleagues might want to do something about it. The ranks of her elected counterparts erupted with laughter and derision [37]. Now, finally, twenty-five years later, violence against women is generally viewed by government officials as a serious issue worthy of public attention and funding."
>
> - Lynda Dechief [10]

This perspective also provides an analysis of why violence against women cannot be described as mutual battering, citing the fact that gender-based violence occurs in a social context of an unequal distribution of power and resources.

Activists work at multiple levels to promote safety for women, starting with individual women and their children to provide sanctuary and support, to working at a systemic level to challenge social norms that protect men's rights over women.

Due largely to the work of survivors, anti-violence advocates and researchers world-wide, violence against women has now become an issue of international concern [77].

Woman Abuse and Legal Perspectives

Early labels and definitions, such as "wife battering" and "wife beating", focused on severe acts of physical violence that could be considered criminal behaviour inside legally recognized relationships. Due in part to the galvanizing of public censure, it became possible in 1968 to get a divorce on the basis of physical cruelty [37].

These early definitions did not capture the reality or entirety of women's experiences however, so definitions expanded to also include psychological abuse and acts of coercive sex [32, 76]. In 1983, it became possible for a husband to be charged in Canadian courts with sexually assaulting his wife [37]. Definitions also were expanded to include abuse in common-law and dating relationships.

While the legal system has made some progress toward recognizing the criminal nature of violence against women, there are many examples within the legal realm where the rights of men override the human rights of women who are being abused by a partner.

The legal system is steeped in traditional ideas about men's rights over women and children and has avoided applying appropriate sanctions to perpetrators of gender/power-based crimes. Ironically, one result of gender-biased legislation in Canada is that the very impacts of woman abuse – mental health issues, substance use, poverty, poor health – are more often than not used in court against women with experiences of abuse. This is evident in cases of child custody and access, where despite a male partner's violent behaviour towards his partner, this seems not to influence the court's decision to uphold men's right to have access to their children [78, 79].

Despite slow change, legal and police institutions' response to woman abuse is being advanced through policies on violence against women in relationships, coordination of services between local responders, "domestic violence units" consisting of police working with advocates to provide a team of supports to women, and the creation in some provinces of courts dedicated to hearing cases of violence against women.

Many abusive men's treatment programs, both court-mandated and voluntary, are being developed that focus on men's responsibility and accountability for their violence. To date, not enough is known about the effectiveness of men's treatment with respect to women's safety, but more evaluations are being conducted from this perspective.

Health Sector Involvement in Addressing Woman Abuse

Formal calls for action in health care have come in response to evidence that revealed that many abused women were not being adequately cared for in the health care system, and that some women were experiencing further harmful effects as a result of their health care encounters [80-85]. In response, programs to address woman abuse are now proliferating throughout health care systems across the industrialized world.

Early pioneers in the health field relied on the expertise of anti-violence advocates and researchers to develop advocacy or empowerment models within the health sector to respond to woman abuse. Challenges to implementing such an approach within institutions and professional associations that did not see violence against women as a health issue limited the success of these early attempts.

As well, pressure to conform to standardized approaches to health issues brought these advocacy models more in line with the bio-medical model. The result, screening for woman abuse (identification of violence through direct questioning), was introduced as an effective and efficient method for identifying "intimate partner violence".

What About Universal Screening?

While the focus on implementing screening raised some awareness regarding the need to develop a response in health settings to woman abuse, there is no evidence that screening has increased women's safety within health care settings or in their relationships [85, 86].

Once the complexities associated with the dynamics and context of woman abuse are understood, reliance on the usual medical approach of problem identification and treatment appear to not be a tool that can capture women's experiences and safety needs. Furthermore, service providers can never assume that they know the full extent of violence that is occurring simply because they have inquired about abuse [87]. Consequently, screening is now viewed by many health researchers, practitioners and activists as oversimplifying women's experiences and a practice that may, in fact, inadvertently retraumatize women.

As concerns related to screening for abuse are raised, health practitioners and researchers are now asking "is there any harm in asking a question?" A review of the literature suggests the answer is 'yes'.

- Standardized questions focus on physical abuse and threats of abuse. This reflects a problematic underlying assumption - that abuse against women can be characterized by discrete acts of physical violence and that these occur in recognizable forms for women to identify and describe [33]. Thus, screening questions do not capture the full extent of woman abuse.
- Women with abusive partners may assume responsibility for the abuse, blame themselves for causing it, reject stigmatizing labels and may name experiences as abusive only in retrospect and therefore not identify with standardized screening questions [76].
- Women may not disclose abuse - even though they know they are in an abusive relationship and that they are not to blame - because they worry about further consequences from their partner [88-91].
- Women have been asked screening questions in front of their partners or others, or at other inappropriate times during their visit [92].
- When women do disclose, their safety has been jeopardized by well-meaning providers having a "talking to" with the abusive partner [92].
- Poor women, women of colour and aboriginal women are much more likely to be asked screening questions, further perpetuating stereotypes of abuse, and minimizing the abusive experiences of middle class and/or white women [49, 93-97].
- Evidence shows that when women are identified as abused, health care providers often downplay or dismiss the abuse and its impacts, or re-create dynamics of the abusive relationship in their desire to "rescue" women or "fix" the problem [93, 98].
- Women who use drugs or alcohol have been treated worse when identified as experiencing abuse, despite their substance use being related to the violence [97, 99].
- Women may face judgment or blame when they disclose abuse, or be pushed into courses of action (such as going to a transition house) that may not be appropriate, given their situation [100].
- Health care generally does not change to incorporate an understanding of how the abuse is affecting a woman's health, access to health care, or ability to follow prescribed treatments [62].

Given the potential risks in screening for woman abuse, it has become evident that being identified as a woman experiencing abuse was not necessarily improving the health or safety of women. On the contrary, women's health or safety was often lost amidst the goals of achieving disclosure from women regarding violent incidents in their relationships, and "preventing" further abuse [85, 86].

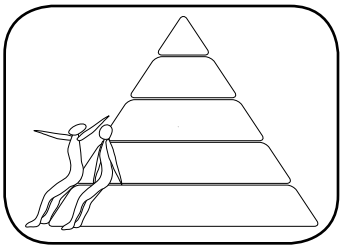
C. Conclusion

The authors conclude, after carefully reviewing the literature, listening to women and talking with health care providers and anti-violence experts, that changes are required in many areas and at many levels, rather than simply inserting an "add-on" to current practice.

The health system must work closely with community activists and the legal system to ameliorate the impact of woman abuse and eventually reduce the prevalence and acceptance of gender-based violence. All responders must have access to mechanisms of coordination, including internal coordination across health disciplines, and external coordination with other systems such as legal and social services. To be most effective and relevant, the development of policies, practices and protocols must be done in consultation with community-based organizations because of their expertise and experience in working with women experiencing abuse [77].

By engaging in the SHE Process and working with the *Evidence Paper* and the *Toolkit*, you can be part of a transformative process which will truly enhance the health and safety of women impacted by abuse.

III chapter three



III. SHE Evidence Paper

> "The problem of violence against women is enormous and troubling. There are no easy answers. The health sector cannot solve it alone. Still, with sensitivity and commitment, it can begin to make a difference."
>
> - World Health Organization [81]

This evidence paper outlines the evidence illustrating both compounding harms and safety and health enhancement (SHE) measures within health care for women impacted by abuse. Evidence includes three complementary and legitimate forms of knowledge: research reported in the academic literature; accounts from women who have experienced abuse or violence in their intimate relationships; and promising practices, programs and policy.[3]

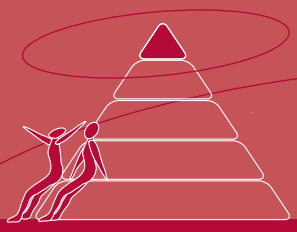
The two contrasting models emerged from the observations and analyses that there are multi-tiered barriers that interfere with women accessing and receiving safe, supportive health care. The models reflect our effort to create a visual understanding of the contrasting realities of harm and safety within health care. But to truly have validity, the models needed to be grounded in research evidence, practitioners' perspectives and survivors' experiences. This is the goal of the *SHE Evidence Paper* – to present a wide range of evidence to enable users of the SHE Framework to have confidence in the models and their application. This chapter is dedicated to presenting the evidence as it relates to both compounding harms and women's safety and health enhancement. The research also adds to the discussion about the role of universal screening and routine inquiry in women's health and safety.

The paper reviews the evidence as it relates to each of the five tiers. After a brief introduction, each tier is divided into two subsections: 1) the *Compounding Harms Model*; and 2) the *Safety and Health Enhancement Model*.

The five tiers, and the responses associated with each, correspond to the *Safety and Health Enhancement Toolkit* in the following chapter. This chapter can be read on its own or used as the workbook for the *toolkit*. Space to write notes about how different compounding harms or safety and health enhancement measures relate to your own health setting is provided down the side of each page.

> "The tendency to undervalue women's safety has resulted in the woman becoming more at risk by the very act of approaching the system…. This heightened risk is unrecognized within the system. In human terms, each person within an agency will want to believe that what they do is helpful or neutral…. Because of our good intentions we strongly resist the possibility that what we are doing may increase the risk to the woman. What all the research indicates is that women are most at risk when they a) make contact with the system or b) when they begin the process of separation." – Don Hennessy [101]

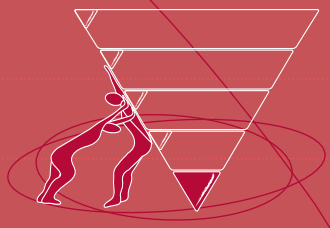
3 A number of the practices, programs and policies outlined in this chapter are reported in the academic literature. Others have come to our attention in our work, mainly throughout the province of British Columbia. We use these as examples but do not suggest they are an exhaustive list. There will undoubtedly be many other promising examples which you will be familiar with, will guide your work, and that we hope you will bring to our attention.



Safety First

Violence Against Women

TIER 1



Tier one: this tier documents the harms women are subjected to by abusive partners. While statistics can describe the reported rates of

violence against women, to understand the experience of abuse, we turn to research that includes the perspectives of women [31]. While we work closely with anti-violence women's advocates because of their expertise in this area, it is incumbent upon health care providers to also understand women's experiences of abuse.

The dynamics of power and control women experience in their abusive relationships are also central to their experience at every level in the health system. This knowledge allows each of us to be able to analyze the health system from a perspective of the risks embedded throughout for women impacted by abuse. To fully apply the *SHE Toolkit*, this understanding must inform our analysis through each of the five tiers.

The following statements summarize the parameters of violence against women.

- Violence against women is a gender-based legal, social and human rights violation that employs strategies of terrorism to reduce women's rights and freedoms.
- Other forms of inequality intersect with gender to shape the experiences of women in abusive relationships.
- Abuse is a pattern of power and control. It can include physical, psychological, sexual, emotional, spiritual, cultural and financial forms of abuse as well as other threatening, coercive and degrading acts intended to gain and maintain control, including the use of children.
- The impact is significant - isolation, degradation, fear, and loss of autonomy - which further entrap women in the relationship.
- The greatest danger women face is when they try to leave, or otherwise challenge their partners' authority.

Tier One also describes what we know about how women's safety and health can be enhanced when:

- Supportive others (including health

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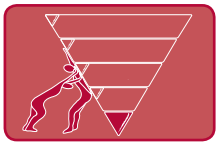
care providers) understand the dynamics and impacts of abuse, and work with women to help them to understand their experience; and
- Women are recognized for having agency and are supported in the steps they are taking to keep themselves and their children safe within the context of their abusive relationship, a difficult "balancing act" that may compromise long-term health in favour of immediate safety and survival.

The evidence for each of the tiers demonstrates that when women are supported in safety strategies — by individuals, institutions and the larger social context — they are more able to escape and heal from the harms associated with woman abuse.

Tier One: COMPOUNDING HARMS: Love Hurts



Violence is a pattern of power and control

Abuse against women in relationships is patterned, intentional, and takes many forms that result in women being degraded, controlled and isolated. Women in one study described an overarching pattern of control within which physical abuse was not generally considered the entirety or even the worst aspect of the abuse, but was perceived as simply another means for authority to be exerted over them [10].

In a large-scale survey of 12,300 Canadian women over the age of 18, four behaviours were identified as being used to control a woman within her relationship: jealousy of social contact with other men; limited contact with family and friends; whereabouts monitored; and access to finances limited [35, 45].

> "Before he ever abused me he would terrorize me by throwing things around, and I think that he got the results he wanted which were basically that I stopped saying what I believed in or I would [agree with] whatever it was that he wanted. So it was a thing of control. And then it did escalate to physical violence… and over the years it became more frequent. But in the times in between those physical assaults when he raged, that was even more terrifying… stressful and distressing."
> - Woman abuse survivor [4]

Abused women are often very isolated. Some women sever relationships with friends, family, or professionals because they have been given unsafe advice, been judged or blamed for the abuse [10].

Abusive partners may move their families frequently whenever detection becomes likely, while other families may live in the same neighbourhood for years, with no one in the community noticing or taking action to assist the victims [102].

> "[There was] a lot of control in how he stopped me from seeing my friends by being really rude to them, and a lot of my friends didn't come around because they didn't like the way he was treating me."
> - Woman abuse survivor

An abuser may use children as "pawns" in

4 Unless otherwise specified, the quotes contained within this document from woman abuse survivors are taken from Care, Control & Connection: Health-care experiences of Women in Abusive Intimate Relationships [10].

the relationship, and may use the threat of violence against the children to terrorize the mother into staying in the home [103, 104]. Violence against children may escalate when the woman is leaving [105].

Child custody and access procedures also provide abusive men opportunities to continue to harass, monitor and intimidate women who have left them [78, 106, 107].

Greatest danger is when leaving

The risk of violence appears to be highest when there is a change in the dynamics of power and control. For example: (a) the abuser is living with his partner, but she wants to end the relationship; (b) the abuser is separated from his partner, but he wants to renew the relationship; (c) there has been a sudden and/or recent separation [108-112].

> "I always knew that if I ever left him it would be ugly. There was just going to be no nice, easy, friendly way to do this … I understood that some things would definitely put him over the top."
> - Woman abuse survivor

Abusers who have used a weapon are at increased risk to commit repeat violence and spousal homicide [108, 113].

There are serious limitations to how much women can protect themselves even if they manage to leave their partner. The risk of injury and death rises dramatically once a woman tries to end her relationship with her abuser [20, 35, 114-117].

Violence is gender based

Violence against women in relationships is now generally attributed in the health care literature to the lesser status and subordinate position of women in society in relation to men [34, 44, 53, 80, 118-124].

Structural inequalities between men and women, rigid gender roles, and notions of manhood linked to dominance, male honour and aggression all serve to increase the risk of woman abuse [125]. Yet, violence directed against women is often concealed by the use of terms such as "domestic violence", "family violence" or "intimate partner violence" [10].

By focusing on "acts" rather than patterns of abuse, measures such as the CTS and many "screening" questions fail to account for the exercise of gender-based power [44, 45].

The *impact* of abuse is a more accurate indicator of the presence of abuse than identification of certain acts as violence [31].

When the impact of abuse is taken into account, research shows that ninety to ninety-five percent of the victims of abuse are women [16, 20, 38].

Women who are abused are subject to social expectations and norms about appropriate roles for women that make it difficult for women to recognize and get free from abuse [34].

Women are held responsible for fixing relationships and keeping families together and, at the same time, for keeping themselves and their children safe [78].

In treatment groups for abusive men, men report that they consider themselves central, superior and deserving in their intimate relationships, and thus their partners as peripheral, inferior and subservient [107, 126].

> "I would give, give, give, do, do, do and it got to the point where it was expected, and the appreciation wasn't there, where nothing was done right and then the beatings came on. It was just endless."
> - Woman abuse survivor

Social stereotypes excuse male abusive behaviour while holding women responsible for much more than they are able to control. When a woman seeks support and safety, our social institutions provide little support for her and minimal sanctions for her abuser [34].

While gender is one dimension of who has power in our society, there are other "social determinants" of health which can increase women's risk of being impacted by abuse [48].

Gender intersects with other social determinants of health

It is not enough to say that women of all backgrounds experience violence, or to attempt to identify "higher risk" groups of women; we must also understand the ways in which different inequalities intersect in women's lives to compound their experiences of violence [48].

Mental and physical ability

Women with physical disabilities, approximately 15% of the women in Canada [127], may face greater risk of being abused because of their dependence on their partners and increased isolation [7, 39, 48, 51-54].

A diagnosis of mental health problems may affect the woman's credibility and therefore the responsiveness of health and community agencies (e.g., she may be denied services or custody of her children) [79, 128-131]. Justice system personnel may see her as "less deserving" of an optimal response [126].

Substance use

Substance use also has implications for system and community responsiveness to women experiencing abuse. Specifically, drug and alcohol use has potential implications for child custody that may prevent the woman from seeking safety by leaving or alerting authorities [79, 131].

Women are doubly penalized by professionals for being abused and substance using. The medical model, with a focus on "problems" is more likely to focus on substance use and discount or ignore its complex relationship with violence, which almost always predates the substance use [132].

Age

Young women are at a higher risk of violence and of being killed [42, 56-58]. This may be due to the downplaying of the seriousness of abuse in relationships between younger women and their partners [59, 133] when research reports that abuse can begin as early as in elementary school dating relationships [37].

Lack of access to resources may increase a woman's dependence on the abuser for her needs. Women who are elderly may be particularly vulnerable to insufficient access to resources and increased reliance on an abuser, which may include her adult children [104, 134].

Socio-economic status

There has been much debate over whether poverty increases a woman's risk of being abused [16]. While being poor has been found to be positively correlated with the likelihood of being in an abusive relationship [135], lifetime prevalence rates of women of different socio-economic status are similar [60].

This has been interpreted to mean that women of all socio-economic strata are at risk of experiencing abuse in their

relationships, while poverty can increase difficulties escaping the abuse [34, 48, 60-62].

> "I ended up going back [to him] after a while… mostly for financial reasons. I wasn't able to get welfare. I wasn't able to sustain a living here in the city even though I had been looking for work and it was one of those practical decisions of women going back into a situation they don't even want to go into but there were no other choices."
> - Woman abuse survivor

Lack of independent access to resources has implications for women's health and safety [103, 129, 136-148].

On the other end of the spectrum, a woman with higher socio-economic status may not have access to family finances, may fear not being believed if she speaks out about the abuse due to her partner's social or financial status, and may fear ostracism from her community [149].

Race, culture and ethnicity

Rates of violence in the relationships of First Nations and Inuit women have been found to be higher than the Canadian average [53].

Relationship abuse may be exacerbated for indigenous women by economic factors, a history of colonization, and a cultural legacy of mistreatment and abuses that arose in past decades through educational practices [63].

Women of colour, First Nations women and poor women who are victims of relationship abuse face an increased likelihood of having their children apprehended by provincial authorities [9, 150].

Abuse for all "racialized"[5] women can be compounded when disclosure may bring on assumptions that "certain cultures are more inherently violent", stigmatization of interracial relationships, culturally inappropriate responses, or additional discrimination or violence against racialised communities [20, 48, 50, 62-69, 151-153].

Immigrant and refugee women may face greater barriers to escaping abuse due to isolation on the basis of language or culture, and to their dependent status on their partners as a result of immigration legislation and their marginalized place in the workforce [61, 64-67].

> "Most women, especially women of colour who don't speak English, they don't demand, they don't know their rights."
> - Woman abuse survivor

There can be negative consequences for a woman by reporting the violence if her immigration status is dependent on her partner [49, 133].

Geography

Women who live in rural communities also face similar effects due to isolation and increased community pressure to not speak out about abuse [32, 68, 69]. In addition, rural areas often lack support services such as women's shelters [103, 133, 154].

Women who live in urban centres may be increasingly isolated due to the anonymity of cities, decreased contact with one's neighbours and the separation of "home" and "work", public and private spheres [155].

5 'Racialization' is the phenomenon in which the term 'race' is used to refer generally only to people who are not white. While the experiences of 'racialized' women are clearly varied and unique, it is asserted that what they do share is the experience of assumptions being made about them on the basis of their skin colour, hair colour and texture, and facial features [48, 63,150].

Sexual orientation

Women in same-sex relationships experience abuse at the hands of their partners at similar rates as women in relationships with men [72, 152, 153], which provides support for the theory that abuse stems from power and control, and not simply gender [156]. Lesbians, bisexual, queer, transsexual and transgendered women can face increased difficulties obtaining support in the social context of homophobia and heterosexism [48, 70-72].

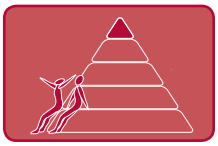
Sex work

Almost all women who work in the sex trade have experienced abuse or violence, with most being victimized more than once. In one British Columbian study, 99% of women working in the sex trade reported that they had been the victims of some form of abuse, with 97% reporting multiple victimization, and 73% having been sexually abused as children [73]. The marginalization and stigma associated with the survival sex trade and the normalizing of violence towards this population of women contributes to the barriers women face when trying to access health care and supports.

> "People of colour, marginalized people in general… you feel you're not wanted, you're not welcome… not just in the health care system, everywhere you go you feel that attitude [but] obviously you can't prove it."
> - Woman abuse survivor

All of these factors may affect how women are perceived and treated in the health system.

Tier One: SAFETY AND HEALTH ENHANCEMENT: Safety First



> "Women who are abused experience a lengthy process of losing (or never having) a sense of self-worth and then regaining a sense of power and control in their relationships. This process can take years – if not an entire lifetime. Health care… may well accelerate her process towards change and safety… [and] ultimately lead to prevention of more serious injuries and medical symptoms, [and] prevention of mental health and psychiatric symptoms…. The most difficult lesson learned over the years has been the recognition… that it is essential to respect her process, her timetable, and her decisions."
> – WomanKind [157]

Research and women's stories reveal that women in abusive relationships are actively engaged in strategies to mitigate the negative aspects of their circumstances, challenging the myth of women as helpless or deficient. Their ability to stay safe and begin to heal from the impacts of abuse is largely determined by the support women receive in re-building their sense of self, regaining control over their lives and making connections to a network of support.

Women's information needs

Women in abusive relationships employ particular adaptive survival strategies [158]. A woman's ability to keep herself safe is related to the amount of information and knowledge she has [126].

It is important that women are able to identify the dimensions of the abuser's violence and the implications for safety planning [159-161].

> "[I now] realize that the abuse is entirely his fault…. [It] has been three years, but [the health care provider] helped plant the seeds of that…. It just takes awhile to digest a few things."
> - Woman abuse survivor

Negotiating safety

Women's strategies generally lessen the immediate harm done to them while they work at rebuilding their self-worth, reclaiming control over their lives, and reaching out for social support [10].

Researchers have also reported on the ways in which women make and constantly revise risk-benefit calculations about leaving their abusive relationship [162]. Additional research clarifies that what appears to be tolerance of violence in their lives may actually reflect deliberately considered life-preserving behaviour [163].

> "It had gotten to a point where I was just living [in the abusive relationship], but what really kept me sane was knowing that there were people out there who cared. My doctor cared, though she didn't even know who I was. These strangers showed empathy, they listened, I think they understood, they tried to be helpful."
> - Woman abuse survivor

Women have been also described as surviving the abuse while getting ready to break free [158], and their decisions to stay or leave as highly rational choices [164].

Negotiating the dangers of leaving

While getting safely out of an abusive relationship may ultimately be the way to regain their health and safety, women in abusive relationships understand that leaving their abuser could potentially further jeopardize their health [10].

Thus, strategies for staying safe can include staying in a relationship and acquiescing to a partner's control, while amassing the resources necessary to get safely away [10].

How this is achieved can vary greatly, and women recognize that they cannot always address long-term health issues while making decisions to protect their health and safety in the short-term [10].

Leaving an abusive relationship is a process [98, 158], and can be conceptualized as a spiral of escape out of a web of entrapment [165].

> "Everyday feels better because of [the counselling], even the rough spots…. It helps a lot, and gives you that much more energy because somebody else is able to care for you or watch out for you, or just give you that kind word to carry you on to your next step."
> - Woman abuse survivor

According to a grounded theory study in which a researcher interviewed 13 abused women in-depth, the ability ultimately to leave comes from a shift in power within the relationship [158].

Supporting women's strategies

The fortifying of women's strengths, by any of the people in their lives, can help them to break free of abuse [158]. This also has been demonstrated in studies within the justice system [166].

> "It was amazing because I hadn't felt that good in a long time. And then going back home… just feeling so caged again… but I had this sense of relief that I was getting help. Somebody out there was helping me."
> - Woman abuse survivor.

In order for their safety strategies to be effective, women need to be perceived as experts in their circumstances [163, 167].

Women impacted by abuse want to have their wisdom and experiences listened to [168], and to have responses tailored to their unique situations and needs [162].

The key to survivors' empowerment is shared control in their interactions with health care providers that recognize that women are in charge of their healing and do not expect to be rescued [169].

Women's sense of agency must be facilitated and their personal strengths supported [124, 170]. To be relevant, all health service and education protocols, on behalf of woman abuse survivors, must be grounded in the realities and complexities of the abuse experience [171].

While some health care providers may view a successful intervention as one in which the woman leaves her abuser, training must emphasize the constraints she feels in leaving an abusive partner and the increased risks to her safety [172].

Women must always be treated as the expert in decisions about leaving an abusive relationship. Any attempt to coerce or threaten her to leave could put her at further risk and alienate her from future contact with the system. Respecting a woman's decision to remain with or return to her partner supports her safety and demonstrates that the health care provider recognizes the complexity of her situation and the limits to her ability to make choices.

> "Tell [a woman in an abusive relationship] all the options she has and let her know [you're] not going to tell her [she has] to go to the shelter…. You just have to let [women] know what's going on, not tell them, 'Don't do this anymore', or 'Let's do this"…. You can let her know what things are available that you can help her with… [and let her know], 'You don't have to do anything at this moment'."
> - Woman abuse survivor.

The conceptual shift from rescuing women impacted by abuse, to aiding in their empowerment has implications for health care practice [22].

> "We must be willing to accept that battered women are not so different from other women, that battering relationships may not be so different from 'normal' relationships. Perhaps battering is simply an extreme manifestation of characteristics of most sexual relationships. Perhaps battering is simply a caricature of our ideal of romantic love with its emphasis on intensity, isolation and total mental and physical possession and obsession."
> – Linda MacLeod [32]

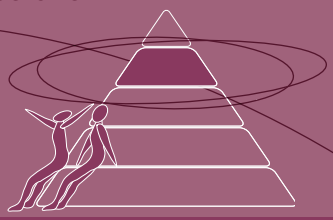
Dr. Marylou Nancy Yam suggests that practitioners need to view a woman experiencing abuse as an individual

who can make decisions and collaborate with others to change her situation. Health care practitioners can begin to make this shift by examining their own attitudes regarding women, and asking themselves, "Do I blame the woman for her predicament? Do I see the abused woman as a powerless victim? Do I think the abused woman is able to participate in freeing herself from the controlling relationship?" [22]

> "In contrast to dominant views of battered women as helpless victims or as provocative women who ask for the abuse, [we must] approach battered women as survivors of harrowing, life-threatening experiences, who have many adaptive capacities and strengths."
> – Michelle Bograd [173]

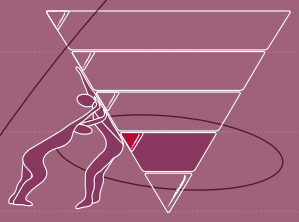
By understanding women's experiences in abusive relationships, and with accessing health services, we can begin to develop an integrated intervention model which places women's safety and health at the centre of our response.

More than a Band-Aid Solution



TIER 2

Health Impacts



Tier two: the physical and emotional harms associated with abuse may result in health impacts or exacerbate pre-existing health problems. This tier

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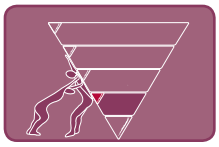
outlines the research documenting what we know about how the patterns of mental and physical intimidation and abuse have significant and lasting impacts on women's health, with disability and death on the extreme end of the continuum of physical impacts. We know that:

- Abuse affects all aspects of a woman's health, including physical injuries and disability, mental health, use of substances, sexual and reproductive health, and general health conditions;
- The health impacts of abuse may continue long after a woman has left the abuser; and
- Because abuse can affect every aspect of women's health, there is no specific "presentation" of symptoms.

We also know that incorporating an accurate view of the health impact of abuse, including how the dynamics of abuse impact a woman's ability to care for herself, will lead to more appropriate health care responses. In this tier's safety and health enhancing measures, we will outline some proven and promising models of care for addressing health issues in the context of women's lives, such as:

- Programs which provide training on the links between violence/abuse and women's health; and
- Programs and models based on an understanding of the links between woman abuse and other health and social issues, including mental health issues, substance use, race/ethnicity, poverty, HIV/AIDS, age, sexual orientation, and disability.

"A history of battering has proven important as a backdrop to many vexing issues in women's health." - Dr. Anne Flitcraft [174]



Tier Two: COMPOUNDING HARMS: Hazardous to Her Health

> "Ignoring violence as a factor in women's health and well-being not only leads to misdiagnosis and inadequate treatment, it also disregards the full extent of the personal/social consequences of violence."
> – Health Canada [1]

We present the health impacts of abuse under separate headings. In reality, these conditions and symptoms do not occur separately or in isolation from each other. For example, a woman can be injured as a result of an assault and may also have chronic gastro-intestinal problems, bladder infections, migraines and problems sleeping. It is essential to recognize the possible concurrent nature of acute, chronic and long-term physical and mental health consequences of woman abuse.

General health conditions

Living in terror can manifest in women's bodies as problems sleeping, including insomnia, nightmares or repetitive dreams [26, 36, 175].

> "It has affected my health in ways that I don't even know, but the obvious one for me was that I wasn't getting sleep and I was tired.... When you're in a really stressful situation, you start exhibiting weird symptoms and your body reacts in certain ways... eczema or I'll get heat rashes or other bizarre things that just show up where there's no real cause.... It's much more subtle. And you deal with all your health problems longer."
> - Woman abuse survivor

Women experiencing abuse can also develop disorders related to eating and digestion, including loss of appetite, anorexia, bulimia, nausea, vomiting, diarrhea, constipation, irritable bowel syndrome, gastrointestinal illness and spastic colon [175-180].

> "An indicator is my waist. If I got really stressed and I had no way to talk about it, my feelings mostly got stuffed down and I had to do it with food and so my weight went up and down and all over the place."
> - Woman abuse survivor

Women who experience abuse can also have chronic and recurring symptoms including fainting, seizures, chest pain, hypertension, muscle tension, headaches, backaches, palpitations, and hyperventilation [43, 175, 177, 181].

> "I was convinced that I was going to die if I didn't get [my abusive partner] out of my life. I was convinced he was going to kill me, but that worried me less than dying from exhaustion and stress."
> - Woman abuse survivor

Mental health impacts

Significant rates of mental health problems are consistently found among abused women. Women who have endured violent relationships are four to five times more likely to require psychiatric treatment [182]. Mood (e.g., depression, suicidality), anxiety (e.g., post traumatic stress disorder), and somatic disorders occur at high rates for women experiencing abuse [43, 87, 139, 142, 183-191].

Psychological impact is not determined by the severity or frequency of physical assault [192, 193]; rather, exposure to dominance is the strongest determinant of psychopathology, as well as threats of harm, sexual abuse, and emotional abuse [45].

> "It wasn't just depression, it was literal body exhaustion from that level of fear that I was in."
> - Woman abuse survivor

Coercive control by the abuser can have a significant impact on the psychological resources of the woman (e.g., decreased sense of agency, loss of identity, feelings of hopelessness, helplessness, guilt, and shame) [129, 141, 142, 160, 194-199].

In some cases, the psychological impact of being abused can lead to the development of significant mental health problems that may interfere with an abused woman's decision-making ability and ability to protect herself [103].

> "[t]he body mends soon enough… but the wounds inflicted upon the soul take much longer to heal."
> - Women abuse survivor [200]

There is evidence that many of these health problems post-date the battering [43, 189]. Thus, some clinicians believe that mental health problems should be treated as symptoms of abuse and not as mental health disorders per se [130, 189].

However, pre-existing mental health problems (including those resulting from childhood abuse or sexual assault) may also be exacerbated by woman abuse as a result of increased stress or being prevented from obtaining treatment [201].

Physical injury and disability

Violence against women in relationships has been found to be the single most common cause of injury to women [190].

Physical violence can result in bruises, lacerations, abrasions, burns, sprains, fractured bones, broken teeth, choking, head injuries, and internal abdominal injuries [43, 147, 175, 177, 202].

Injuries can range from minor to life threatening and may include injuries from firearms or other weapons.

> "I actually had guns held to my head, and knives held to me, and choking."
> - Woman abuse survivor

Injuries sustained through abuse are more likely to be to the chest, neck and facial areas compared with injuries unrelated to abuse [181].

Chronic pain at the site of previous injuries is common for women who have experienced abuse [177, 203]. Long-term or permanent disability, such as hearing loss, visual impairment, disfigurement, brain damage, or paralysis can result from injury [26, 175].

Women may die as a result of acute physical trauma; 40% to 60% percent of murders of North American women are perpetrated by their intimate partners [204, 205]. According to police reports for 1999, 523 women in Canada died at the hands of their husbands or common-law partners [56].

Substance use

Women in abusive relationships are at increased risk for use of substances, including illicit drugs, alcohol, tobacco and prescription medication [26, 45, 187, 206].

> "When my anxiety levels get too bad because of my relationship, I take one [Valium]…. Trauma, the battering experience, the anxiety of the relationship problems have caused me to take a medication I wouldn't take otherwise."
> - Woman abuse survivor

Substance use may represent a woman's strategy for coping with distress or it may reflect pressure from the abuser to consume these substances with him [129, 130, 206].

> "He wouldn't let me not drink, he would bring alcohol over, or you had to drink just to be near him. He would put a glass under my face, he knew I didn't want to drink."
> - Woman abuse survivor

Substance use has many implications for women's safety. When intoxicated, a woman may not be able to make decisions that might protect her from the abuser. A woman may also be reluctant to leave an abusive relationship because of her dependence on the abuser for access to drugs [131].

Despite the increased risk, women in abusive relationships are more likely to be inappropriately prescribed medication than women not experiencing abuse [45, 207]. Women express fears of addiction to prescription medication or a loss of alertness increasing their risk for more abuse [208].

"When [a woman whose husband beat her] visited her physician complaining of weight loss, sleep problems, loss of energy, being unable to concentrate, and having lost pleasure in her everyday activities, her physician prescribed a tranquilizer." [34]

> "Talking about my depression symptoms with my family doctor…. She [didn't] even try to talk to me [or ask me] what was bothering me [or how] I feel…. Just a prescription."
> - Woman abuse survivor

One researcher points out that the "most damaging side effect [of inappropriate medication] is not a directly physical one, but the impact their use has on patients' abilities to think or feel their own way out of a situation." [209]

One women who was given anti-depressants after visiting her physician for injuries from her partner said that "[t]he medication made me feel numb. It was hard to respond normally." It was only during a brief interval when she was "noncompliant" and stopped taking the medication that she was able to escape her abusive partner [210].

Reproductive and sexual health complications

Because the terms of sexual relations can be dangerous to negotiate by women in abusive relationships, and many women are sexually assaulted by their abusive partners, they face an increased risk of contracting sexually transmitted infections, including HIV/AIDS, and of having unwanted pregnancies [26, 175, 177, 192, 211, 212].

> "I don't use the birth control pill because my family has a strong history of breast cancer. I had always used condoms, but he said he didn't like to…. Then I became pregnant."
> - Woman abuse survivor

Other gynaecological symptoms of abuse include chronic pelvic, abdominal or vaginal pain, vaginal bleeding or infection, fibroids, pain with intercourse, urinary tract infections, pre-menstrual syndrome, and dysmenorrhoea [175, 177, 178, 213].

Violence against women in relationships has been reported in an exploratory study

to increase a woman's risk of pre-invasive and invasive cervical cancer [214]. The mechanism through which this happens is unknown, but the stress of being in an abusive relationship and the transmission of human papillomavirus through sexual assault are offered as possible factors [214].

Perinatal effects

There is some debate over whether pregnancy is a time of increased risk for abuse. What is clear, however, is that women are more vulnerable, less able to assert their independence, and less likely to leave during pregnancy [45, 215, 216]. Women experiencing abuse may also be more likely to require and seek health care during pregnancy than at other times during their lives [42].

Women in abusive relationships are also more likely to have an unhealthy diet during pregnancy, poor fetal weight gain, blunt injury to the abdomen, fetal injury and death, miscarriage, pre-term birth, and decreased or low birth weight babies [57, 175, 217, 218].

The use of tobacco, alcohol and other substances can have an impact on the pre-natal development of infants whose mothers are experiencing abuse [219, 220].

Other health impacts

Despite what is known about the far-reaching physical and mental health impacts of woman abuse, the negative societal beliefs and stereotypes that exist about women who are being abused can influence the way health care providers evaluate women and their health concerns.

Connections between abuse and health are generally concealed through prevailing methods of diagnosis [162].

Health care providers can and have compounded the problems of women experiencing violence by "negatively labeling them as hysterical or with borderline personality disorders." [221] When women have been labeled as having a mental illness, they are often disbelieved when they do speak out about the violence they or their children are experiencing [79].

A health care encounter shaped by these beliefs can result in a negative experience for a woman experiencing abuse. Women who use drugs or alcohol or who have mental health problems are already marginalized in society and are often more harshly judged and blamed for the abuse. The routine and institutional practices which play a role in this are explored more in Tier Four.

> "The doctor was extremely rude to me. I told him I might be emotional around the surgery [to repair the scar from a knife wound] because of the connections with the abuse. He said, "don't you come up to my office being emotional. You get some Valium or something and get under control."
> - Woman abuse survivor [79]

The health costs of violence against women

In addition to the costs to individual women's health, at the societal level it is the health sector that carries the major burden of care arising from the consequences of violence [12].

The total measurable costs of woman abuse in Canada each year relating to health and well-being is estimated to be $1,539,650,387 [222].

In conclusion, an understanding of the dynamics and impacts of abuse can help to reframe negative judgments into recognition of women's strengths and safety strategies which will help to support women in addressing the enormous health burden of abuse.

Tier Two: SAFETY AND HEALTH ENHANCEMENT: More than a Band-Aid Solution

All of the health impacts outlined above have established treatments. However, the root cause of the impact and what women are able to do to care for their health in the context of their relationships and their social location must be incorporated into any treatment plan or approach.

While health care providers cannot prevent abuse or related health impacts, they can, first, do no harm, and second, work with women to improve their health. By connecting health issues with their underlying social causes, health care providers can help women to also make these links between their experiences of abuse and a myriad of physical and mental health impacts.

Rather than trying to identify abused women, the high prevalence and incidence of woman abuse in our society allows us to link the issue of violence with health impacts based on the findings that many female patients are experiencing or have experienced abuse. A health and safety enhancement approach recognizes that women will volunteer information about abuse if it is relevant and safe, and if they have had the necessary support to identify their experiences as abuse.

Linking violence and health

WomanKind, an innovative health care program in Minnesota, points out that, "health professionals must address not only the presenting problem but also the underlying cause of the medical and/or mental health problem. The ultimate goal for health care providers is to integrate issues of domestic abuse into the total health care of each patient… Health professionals must make the connnection between a patient's health problems and the abuse and violence in her life." [157]

Empowering health care providers through training and program development is an important way to learn how to support the knowledge and strengths of abused patients and make links to women's health issues [223].

One cannot dictate to health care providers to share control with their patients in health care interactions [84, 223]. Rather, educators must model non-abusive ways of interacting [224]. One way to achieve this is to involve staff in the planning of programs. Initiatives that respect staff input empower them in developing programs that may also help to create a culture of non-violence [225].

Empowering methods of educating about violence against women can model how providers can interact effectively and supportively with their patients. Health care providers are more likely to exhibit supportive principles of caring, sharing control and connecting in their own practice if they experience those same principles at work. This includes having personal and professional experiences of abuse validated and addressed in the health care system [172].

One example of empowerment training is found in British Columbia. This hospital-based program for woman abuse that educates health care providers about women-centred care, and addresses structures of power within the health care system has spearheaded an initiative to support the creation of similar programs province-wide [171].

The Woman Abuse Response Program at British Columbia's Women's Hospital is educating health professionals to shift practice rather than place the responsibility on women to disclose abuse. The guiding principles are adapted from the anti-violence field, acknowledging the centrality of women's safety and the need to mitigate the intersecting discriminations of gender-based violence, social circumstance and culture and race [171].

The program recognizes that staff may bring their own experiences of abuse to their work, and that this experience can be helpful in creating strategies for responding appropriately to abuse in the lives of their patients based on the clinical area, focus of care and workload [226].

At the same time health care providers are understanding how similar women's experiences of abuse can be, they must also become aware of the particular ways religion, culture, race, language and immigration status affect a given woman's perceptions of abuse, her access to services, her response to interventions and the impact of abuse in her life.

This program also works at a systemic level, advocating for changes in policy that discriminate against women, or policies that disregard violence in the lives of women, ignore the gendered reality of violence or assume the safety and autonomy of all women [226].

Linking race, ethnicity and woman abuse

To provide effective services to women who are targets of abuse, social institutions need to have adequate knowledge and awareness of violence against women in relationships, have appropriate attitudes towards violence against women in relationships, and be responsive to the woman's individual needs (i.e., language, culture, ability sexual orientation, age, or lifestyle) [104, 141, 153, 227].

Changes in the ways that the health care system treats issues of race, both within the workplace and in regards to patients, can help provide better care for women in abusive relationships. Rather than being interpreted within the ideological framework of multiculturalism, culture should be addressed in terms of the political status and historical experiences of the social group for whom one is caring [48, 150, 228-230].

> "The issue isn't one of cultural sensitivity, it's one of respect…. Talking culture doesn't make sense here, but understanding the impact of migration, of gendered relations, does… and treating women as whole beings is an absolute necessity."
> – Dr. Yasmin Jiwani [150].

A broader model of "cultural safety" has been proposed that argues for health care providers to take into consideration the socio-political reality of their patients, not simply culture in isolation [48, 150, 228-230].

A culturally-competent intervention respects a woman's right to dictate the course of her actions and recognizes that she will accept an option only if it makes sense from her frame of reference [231].

This model "asserts that in order to be effective, medical practice must recognize the centrality of the patient's perspective and social environment in defining and explaining his or her condition and in designing and implementing medical response." [232]

> "Cross-cultural challenges in providing appropriate health care to women in abusive relationships include:
>
> • Countering stereotypes about violence and specific groups;
>
> • Providing interpretation services that allow safe disclosure (i.e. that are not based on informal volunteers from one's community or family);
>
> • Providing services that are not based solely on Euro-Canadian values;
>
> • Providing services that are accessible from the perspective of women; and
>
> • Supporting "solutions" that respect and account for women's cultural and religious values."
>
> - Dr. Marina Morrow and Dr. Colleen Varcoe [7]

Shifting health care based on white, hetero-sexual, able-bodied, middle-class, middle-age norms to a health care system which recognizes the diverse social locations of its patients and works to redress and address the social determinants of health is an important part of treating the health implications of woman abuse.

Linking substance use and woman abuse

According to Dr. Norma Finkelstein, a well-respected researcher in women's health, "trauma is central and pervasive to the development of addiction and mental health problems in women." [233]

> "To substantially reduce the incidence of alcoholism and drug abuse in women of childbearing age… social changes are needed in areas of financial supports, housing, health care, employment, child care, children's services, family supports, legal rights, and sexual division of labour in the family."
>
> – Dr. Norma Finklestein [233]

In the provision of health care services, an integration of harm reduction and women-centred care – both models based in the reality of individual lives in a social context of disempowerment and stigma – are promising directions for supporting women impacted by substance use and violence [132].

The Maxxine Wright Community Health Centre, located in Surrey, British Columbia, is an example of health services based on an integrated women-centred harm reduction model. Its development is based on an understanding of the complex links between women's experiences of violence/abuse and substance use, and a sequelae of other medical and social conditions. A partnership between the local health authority and an anti-violence women's organization provides a range of health and social services under one roof by a well-trained, multi-disciplinary team committed to women-centred care [234] .

In the United Kingdom, the Stella Project has been actively working towards bringing service providers from both the anti-violence and substance use fields together to develop better practice [235]. Initiated in 2002, it aims to support both sectors through training, events and consultancy to assist in the development of good practice, procedures and policies [236].

Linking mental health and woman abuse

Mental health issues are often the missing link between substance use and woman abuse, with women self-medicating or being prescribed medications to address the mental health impacts of experiencing abuse and violence [132, 233].

Understanding that more than 70% of those with Post-Traumatic Stress Disorder are women [237], and that violence and abuse precedes mental health issues for the vast majority of women [238] can shape the provision of more appropriate mental health care for women.

Women-centred mental health projects piloted around British Columbia, which take into account women's experiences of violence and unique social context, have been demonstrated to improve women's health and well-being [6].

As well, designing "trauma-informed" health care services—based on the understanding that more than half of the women who walk through their doors will have experienced trauma at some point in their child or adult lives—can help to avoid retraumatization in health care settings [239].

In October 1999, the BC Association of Specialized Victim Assistance and Counseling Programs and the BC/Yukon Society of Transition Houses offered a three-day professional development symposium, *Connecting: Mental Health and Violence Against Women*, designed to create an opportunity for dialogue and relationship building between mental health workers and women working in the community on issues of violence against women [7].

More recently in British Columbia, a process called *Building Bridges: Linking Woman Abuse, Substance Use and Mental Health* began with a roundtable forum in December 2006. This ongoing initiative is bringing practitioners from the anti-violence, substance use and mental health fields together in order to learn from each other how to better incorporate the links between the three issues into their work through dialogue and development of best practice guidelines [240].

Linking pregnancy and woman abuse

Using the knowledge and experience developed through working with pregnant and early parenting women impacted by abuse, substance use and mental health issues at the Maxxine Wright Community Health Centre, Atira Women's Resource Society and the Woman Abuse Response Program, in partnership with Fraser Health and Kwantlen College Nursing, developed on-line training modules for nurses on the links between these issues.[6]

Linking HIV/AIDS and woman abuse

It has been argued that addressing gender inequality and woman abuse as one of its symptoms, is critical in addressing the spread of HIV/AIDS among women [241].

According to the World Health Organization, women are often unable to negotiate safe sex practices with their partners, abusive partners may engage in extra-marital sex,

6 This web-based workshop can be accessed at: <www.atira.bc.ca/AdvancingHealthCareWorkshop>.

and sexual assault can result in tearing of sensitive tissues and an increase risk of contracting the virus [242].

Thus, WHO has recognized that looking at sex-desegregated data is necessary to reflect progress in addressing gender issues in HIV/AIDS is important for equity as well as effectiveness [242].

> "The struggle for gender equality is the toughest struggle of all, and never have I felt it more keenly than in the battle against HIV/AIDS .... I cannot emphasize strongly enough that the inertia and sexism which plague our response are incredibly, almost indelibly engrained, and in this desperate race against time we will continue to lose vast numbers of women. That is not to suggest for a moment that we shouldn't make every conceivable effort to turn the tide; it is only to acknowledge the terrible reality of what we're up against."
>
> - Stephen Lewis [241]

An example of health care programs taking into consideration the links between abuse and HIV/AIDS are those developing processes for disclosure of HIV status to current and prior sexual partners that work to recognize and minimize adverse consequences for HIV-positive women from abusive partners [242].

Linking age, violence and health

Taking into account the different ways that abuse affects women and girls across their lifespan is important in addressing woman abuse and its health effects.

For young women and girls, taking seriously the power and control experienced in their dating relationships, giving them girl-only space to talk about issues of violence, racism, and self-esteem, and supporting their independence through physical activity and community action are all part of POWER Camp National, based in Ottawa [243].

POWER Camp for Girls Vancouver arose out of a meeting of health researchers and young women at an Adolescent Health Working Group hosted by the BC Centre of Excellence for Women's Health in 2001. Evaluation of their two-week summer daycamp and after-school program shows that it is effective in improving girls' self-esteem, safety, body image and health [244].

In White Rock, British Columbia, the first senior women's transition house in Canada was recently established. Taking into account the very different ways that abuse affects women over 55, Ama House supports women in regaining their safety and health [245].

Working with programs that provide education on violence against women, osteoporosis clinics are beginning to recognize that abuse may play a role in a significant percentage of the fractures they see in older women [171].

Linking sexual orientation and violence

Violence in same-sex relationships can be even less visible to others than abuse in heterosexual relationships. Training and resources are provided to social service and health care providers to improve their knowledge and skills in the are of same-sex relationship abuse by Safe Choices, a Vancouver-based program. Safe Choices focuses on improving the health and safety of women who are currently or have been in abusive lesbian relationships by empowering women and strengthening communities to respond to the issue [246].

Linking disability and violence

The DisAbled Women's Network (DAWN) Canada has been making the links between women's physical and mental ability and violence/abuse for several decades. Their work includes supporting and participating in research regarding the links, and addressing issues such as poverty, employment equity, violence, mothering, sexuality, health, isolation, access to services and New Reproductive Technologies (NRTs) [247, 248].

Linking poverty and woman abuse

Women, especially single parents, make up the vast majority of people living in poverty. Poverty is a significant barrier to leaving an abusive relationship, and the high levels of abuse that homeless and poor women experience lead to a myriad of health problems [249].

Working to address this "feminization of poverty", while building services on the understanding that transportation, childcare and the inability to purchase prescribed medications and other health-related items are significant barriers to addressing health issues can create more appropriate services for women marginalized by abuse and poverty [249].

Because women and their children living in poverty often seek shelter services because they have difficulty finding affordable housing [249], it is especially important for health care providers to be knowledgeable about community resources, and to work with community agencies to provide a continuum of care [10].

This continuum of care, along with empathic and caring health care providers who worked to establish trust and rapport with women, has been reported to facilitate health promotion behaviours, such as better attention to prevention and women's increased ability to advocate for themselves [249].

Making links to break isolation

Research suggests that when health impacts are dealt with in the context of women's lives, and women feel cared for, that they have some control over their health care encounter, and they feel connected to a health setting or community resources they are referred to, their health can improve [10].

> "That's when I started getting better, when I started saying, 'This is what I need. This is what I need you to do. And this is what I'm going to do.'"
> - Woman abuse survivor

Experiences in health care and other resources which counter the effects of disempowerment, isolation and degradation can improve women's health and well-being [10].

> "Now things are better and so I sleep better. I feel more comfortable and each day [I'm] taking more control back of my life and what I'm doing."
> - Woman abuse survivor

Interaction with supportive others has also been found to be part of the healing process [250].

> "Little by little I became fine and my sleep habits became regular."
> - Woman abuse survivor

With improved health, women are more able to deal with the abuse in their lives and ultimately regain their safety and health [10].

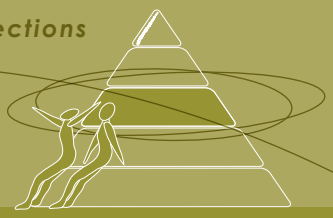
> "Vitality and fitness-wise, I've got a lot more energy to do things and to be with people and have more fun. I don't usually get sick very often… so I think I'm getting it together."
> - Woman abuse survivor

Healing after departure from an abusive relationship is not solely about physical separation from the abuser, but includes women realizing their own potential [158, 250].

> "I do feel a lot stronger now. I can actually see the rainbow, the pot of gold…. I've put on a lot of weight. People actually say I look a lot healthier, a lot better, a lot more alive. I was probably down to 100 pounds. I've put on 25 pounds since I left."
> - Woman abuse survivor

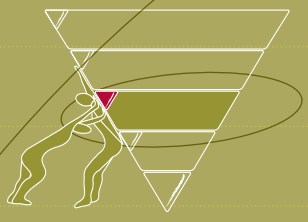
In the next tier, women's access to health care settings, and how this can be hindered or facilitated, is discussed.

Making the connections



TIER 3

Access to Health Care



Tier three: Given the enormous burden that abuse puts on women's health, it is not surprising that many studies show that women in abusive

NOTES

relationships are more likely to require health care than women not experiencing abuse, in a range of health settings. Paradoxically, women experiencing abuse also describe relationship and systemic barriers that interfere with them receiving much-needed care, including:

- Being prevented from accessing health care by their abusive partner;
- Having abusive partners dominate or control the health care encounters; leaving women without the care they need; and
- Women delaying or avoiding health care due to previous negative encounters with either individual health care providers or systemic barriers.

These encounters can "echo" the abuse women are subject to in their relationship and make them less likely to seek health care in the future [10].

> "It got to the point where [I was] scared to go to the hospital, even. A lot of times I remember just trying to take care of myself. I didn't want to go to the hospital. I didn't want to go through that harassment. Because I knew what was going to happen, knew that they were going to try to get me to give them his name and all this stuff. So, I'd sooner suffer at home."
> - Woman abuse survivor

While these barriers can intensify women's isolation and leave the health impacts of the abuse untreated, creating safe access to appropriate health services can work to mitigate the impacts of abuse by improving health and decreasing isolation.

This can be achieved by:

- Health care providers understanding and accounting for the dynamics of power and control that women may be experiencing by their partner;
- Health care providers working to provide care that is counter to the dynamics of abuse women are experiencing;
- Removing systemic barriers to care wherever possible; and
- Designing services based on the needs of women, such as support groups, rather than being limited to traditional medical services.

Tier Three: COMPOUNDING HARMS: Between a Rock and a Hard Place

Access to health care is complex for women experiencing abuse. They are caught between poor health, a controlling partner and a system that is unprepared to adequately respond to their health and safety needs. Some key factors that limit women's access to health care and increase risks to her safety and health are described below.

Access to health care is controlled by abusive partners

An abusive partner may interfere with a woman's ability to care for herself, seek health care, or adhere to proposed treatment regimens. Abusive partners may make it difficult for women to care for chronic medical conditions such as diabetes, asthma, angina, and pain [190].

Power and control in relationships may manifest as an abusive partner preventing a woman from seeking health care until she is very ill [93] or from seeking prenatal care before the third trimester, remaining by her side unceasingly during her hospital stay, or exerting control over medical decisions [251].

In addition to preventing the woman from gaining access to other basic resources she needs, an abuser may control women's access to health care and other services by preventing, accompanying, undermining, controlling or monitoring health care contact and decisions, and insisting on premature release from hospital [190, 208].

An abusive partner may also describe a woman as mentally ill and a danger to herself as a strategy to maintain control over her [130].

Having needs ignored or devalued in her relationship may make a woman either delay seeking, or not seek health care [10, 252].

Negative health care encounters also affect women's decision to utilize health services.

Access is determined by health care providers

Women impacted by abuse report that they were more reluctant to access health care if, in previous health care experiences, they felt health practitioners did not care about them, gave them little say in treatment decisions, pressured them into certain courses of action, shared their personal information without permission, or made them feel guilt or shame. This was true whether or not health care providers knew about the abuse [10].

Newman found that women in transition shelters specifically named the lack of concern in the health care system as a barrier to getting help in leaving their abusive relationships [253].

> "I don't go [to health care] unless there's something dreadfully wrong with me. You just don't want to be treated like you're wasting other people's time or you're wasting your time."
> - Woman abuse survivor

Plichta and colleagues found that a significant proportion of the 1,082 women they surveyed (7% of whom reported being

in abusive relationships) reported having health concerns minimized and being told "it's all in your head." [27]

In another study, 50% of abused women reported negative experiences in health care and 63% did not go to hospital emergency immediately after being attacked by their partners. Part of the negative experience was that health care providers focused only on the physical injuries [93].

Feeling that the knowledge they had about their health or relationships was not respected or included in health care decisions also made these women less likely to seek health care in the future. Not receiving support after disclosing abuse had a similar effect [10].

> "That [kind of treatment] doesn't make it easier to take yourself to the hospital, [knowing] that you're going to be left feeling terrible and upset [when you're] needing to have some support."
> - Woman abuse survivor

Many women describe a "no-win" paradox when seeking health care, where they are either made to feel they are being overly sensitive and have accessed health care over "nothing", or else they have waited far too long and have put their health in jeopardy [10, 63].

> "[When I described the health impacts of the abuse my doctor said] 'Nothing is wrong with you. Just relax. Go on a vacation'."
> - Woman abuse survivor

An attitude of superiority among health care professionals can be frustrating for women, often to the point of not wanting to visit a doctor [9].

Women in abusive relationships fear being put in danger through health care providers speaking to their partner, documenting the abuse, or involving police or other authorities without their consent [90]. They also fear having their children apprehended [90].

Prejudicial attitudes (eg. class elitism, racism, sexism, ageism, and homophobia) towards both the survivors and the perpetrators of violence can play a role in women's experiences in health care and their likelihood of accessing care in the future [63, 64, 94, 97, 254].

> "People who are on welfare [may have] already been put down by welfare people [making them feel] that 'You're dirt, you're a bum, you're not working, you're using our system'. And then they have this in their mind that everybody's putting them down, so they go to hospital, and they get the worst treatment [because they do not speak up]. They go to medical labs, and they get no treatment. They go to their doctor, and hear 'Oh, you're fine.' They get no treatment. They're the ones who really suffer."
> - Woman abuse survivor.

Physicians often attribute violence to cultural groups on the assumption that these communities are inherently violent [64].

First Nations women describe avoiding health care if, during their encounters, they felt invalidated, diminished, not listened to, negatively stereotyped, or their personal circumstances disregarded [63].

> "A young, First Nations woman was sexually assaulted. She went to hospital, the doctor refused to do a physical exam because she had tracks on her arms. She begged him for drugs for STDs and the morning-after pill. He refused."
> - Women's advocate [79]

Women who use drugs or alcohol are often discredited and not given appropriate treatment, making them less likely to return [99].

> "A lot of times, I think that people have mistaken me for being North American Indian and I do believe that it did play an important role. I hate to say it, but I think they're very prejudiced toward First Nations. And they have this idea of the way they are supposed to be, 'they're all "alkies" or addicts. They all get beaten up and they deserve it'. I really didn't feel like anyone cared."
> - Woman abuse survivor

Women who use drugs or alcohol are even more unlikely to seek health care during pregnancy for fear of providers' judgement and involvement of child welfare authorities [255].

Linkages between violence and mental health are rarely explored, making women in abusive relationships fear being labeled "crazy", rather than being seen as someone experiencing the impacts of abuse [64, 256, 257].

A review of mental health services across the province of BC found that "crisis responses are poor and inadequate in some regions and are experienced by some women as further traumatizing. In some rural communities it was almost routine for individuals experiencing an acute psychiatric crisis to be jailed until other supports could be found. In general, psychiatric hospitals' crisis responses were experienced by women… as punitive rather than helpful and supportive." [258]

Systemic responses discourage access

While it may be difficult to draw a clear line between attitudes of health care providers and systemic level barriers, it is also important to recognize that despite the best intentions of individuals within it, aspects of the health system can discourage access for abused women [141, 148].

When health care institutions do not make the link between violence against women and health or address the concomitant health issues, a woman experiencing abuse is less likely to make those links, or see the health care system as a place where her health concerns will be taken seriously.

No longer seeing the health care system as an avenue of support means that women can become even more isolated [10].

A lack of understanding of the links between women's safety and women's empowerment may result in disempowering behaviour on the part of service providers, which can prevent women from seeking help [126].

The emergency room, where acute injuries present the most obvious links between abuse and health, is a setting that is least likely to have the elements in place to support women experiencing abuse – including sufficient time, a relationship with the health care providers, and privacy [162].

Paradoxically for health care institutions beginning to make those links and instituting a screening program, knowing that she may be asked about the abuse as part of routine assessment and/or that her abusive relationship may be documented in health records may also prevent a woman from seeking health care [79].

The routine involvement of hospital social workers or child protection workers when woman abuse is suspected may place women at risk, or in future, she may delay or avoid seeking health care [79].

> "I remember getting broken ribs once and I didn't even go in. I just suffered it myself. I knew they had to be broken because it was so painful, but I didn't even want to go in and check… because… I really didn't think they were out to help me, they were out to get him. And to get him was just going to hurt me even more."
> - Woman abuse survivor

Limited hours of operation, lack of services, or distance to services make women unable to access needed health care. In particular, women who live in rural and remote areas frequently do not have adequate access to acute care, family practitioners or specialists and many women fear that their privacy will not be maintained if they seek help from a professional [48, 63, 64].

Signage used in medical facilities may also deter women from accessing services. For example, services which clearly identify themselves as providing abortion services, drug and alcohol treatment, mental health services, sexually transmitted infection testing or treatment, may be accessed but at a cost to a woman's dignity or privacy. Though health care providers may be accustomed to talking about health issues openly and objectively, if the social meanings that words are imbued with are not recognized, it can create barriers to accessing services.

The medical system's requirement to produce identification may also be a barrier for women whose identification is controlled by an abusive partner [234].

Some supports may be available but may not be accessible to the woman due to cost, transportation, hours of operation, language, disability-related issues, etc. [259].

> "When you first come in, they ask you what you're there for and I said… 'I've been hit by my partner, I need to be seen by a doctor…. The nurse… she just had me fill out some papers and then go and sit in the waiting room. I was left sitting in the waiting room a long time just bawling my eyes out… I couldn't stop crying… I just could have used a little support."
> - Woman abuse survivor

Knowing they may have to wait for long periods of time can make women in abusive relationships less likely to seek health care [10].

"Efficient processing" of patients or the "ten-minute factor" effectively limits the potential of developing trust and communicates to women that their health concerns are not important, making women less likely to seek health care [10, 64, 90, 97].

Health care providers trained to identify and "fix" problems may make women who have been prescribed solutions in the past – such as involving the police – to avoid health care [10, 254, 260].

Diversity of the patient population is often not reflected in the staff, making women of colour and aboriginal women less likely to believe they will receive culturally safe care [231].

According to one study, language barriers often force women to turn to physicians who share the same cultural and racial background. Women experiencing abuse fear that their confidence may be breached resulting in ostracization and exclusion from their community [64].

Recognizing that abusive partners will prevent and control access to health care, the health care system can work to provide services that women can and will access.

Tier Three: SAFETY AND HEALTH ENHANCEMENT: Making the Connections

Evidence suggests that there is a great deal that concerned health care providers can do in their individual practice to facilitate access to care for abused women [10]. Health systems can also shift to facilitate access to care for women experiencing the health impacts of abuse.

Recognizing partner's control over access

Not assuming that a woman's partner has her best interests at heart can be an important first step. Nurses at one maternity hospital describe how they came to realize that the partners who are always at a woman's side may not be the caring, supportive people they appear to be [226].

Providing some services to women in a private setting, away from her partner, may provide women with an opportunity to express their needs. However, health care providers must understand that she may fear expressing wishes that are different from her partner's, for fear of later retaliation [226].

Missing or being late for appointments can be important clues to a woman's situation. Rather than a punitive approach such as charging fees, insisting on rescheduling or refusing services, health settings that are flexible and can offer drop-in services can provide more accessibility to women experiencing abuse [261].

Strategies such as asking women what is possible for them in terms of booking appointments, and ensuring it is safe to phone her home with reminders of appointments, can help address accessibility issues [171, 234].

Health care providers can achieve caring health care encounters by considering women's feelings and needs, expressing concern about those needs, and taking women and their concerns seriously [10].

Providing care to counter the dynamics of abuse

If women in abusive relationships feel cared for and included in decisions in a health care setting, they are much more likely to view the health care system as a place where they can find care and support and seek assistance in the future [10].

> "If you get the help that you need, you're more open or willing or more optimistic to go and seek help again."
> - Woman abuse survivor

Active and non-judgmental listening and accepting and supporting women in their choices are essential aspects of a caring health care encounter. Caring approaches help ensure that women feel comfortable returning to the health care setting for additional support as they work at regaining their health and escaping their abusive relationships [10].

Some First Nations women report being much more likely to seek health care if they have had affirming encounters [63]. The features of these encounters include: feeling genuinely cared for; sharing knowledge and having power over health care decisions; being encouraged to ask questions; having providers be unconcerned about time constraints; being helped to become more in control over health; and being able to develop a long-term relationship with their provider [63].

Building trusting relationships

In research interviews, family doctors describe seeing women fail to return to their practice after being asked screening questions about physical abuse in their relationships. They instead began to focus on building trusting relationships with their patients in the hopes that they would share personal information when they felt it safe to do so [262].

One example of a community-based health care setting with the explicit service philosophy of engaging women in as welcoming a way as possible is the Sheway project which provides a comprehensive array of health and social supports to pregnant women in Vancouver who use substances [261].

Sheway's goal is to reduce the isolation of women by "providing a positive experience with a community service which may serve as a basis for further connection." [261] This is done by focusing on building trusting relationships with women who access services. Sheway recognizes that having staff from differing visible minorities can serve to help women feel safer when first accessing services.

As well, taking into account the conditions of women's lives, Sheway staff work to actively and effectively address surmountable barriers by providing outreach, being accepting of where women are at, and not dictating care to women [261].

> "With this kind of client, it is the only way you can get an effective relationship. If you become more directive they are not going to come back. It's about empowering people and giving them a sense of self."
> - Key informant – Sheway [261]

In Powell River, the mental health team learned from anti-violence women's advocates that many women impacted by abuse wanted to access a particular support group at mental health services but were reluctant to go through the intake and assessment process or be seen to be accessing mental health services. They teamed up, then, to offer the support group at the women's centre, thus reducing this barrier to women accessing health services and supports. This also allowed women to get to know and trust the mental health care providers, thus providing a bridge into those services for women impacted by abuse.

Harm reduction

Women using substances are likely to be experiencing abuse or still dealing with its impacts. Thus, supporting women where they are "at" with their use of substances, with dignity, choice and support is more apt to make women in abusive relationships return to health settings [234, 255, 261].

Harm reduction is a public health philosophy which neither condemns nor condones the use of substances. It focuses attention on the consequences of substance use, not the use itself and recognizes that some users cannot or will not stop use in the short-term. In harm reduction, behaviour change is viewed as an incremental process [263, 264].

In the case of women experiencing abuse, it also recognizes that the root cause of the problem, the violence, may need to be dealt with first before the symptom or coping mechanism – the use of substances – can be addressed [132].

Harm reduction also takes a broader view in recognizing that harms related to substance use are not caused by user behaviour in isolation, but are influenced by distinct social and environmental factors. For example, misinformed or ineffective interventions or policy can be as important

as user behaviour and the contexts of use as the source of substance-related harms, and therefore must also be targeted for "harm reduction" interventions [263, 264].

Fir Square, the maternity unit at BC Women's Hospital specifically designed for women struggling with their use of substances, has developed harm reduction strategies to improve women's access to care. For example, rather than giving up a woman's bed if she leaves the hospital, Fir Square allows a woman to return up to 24 hours later and still have her place without going through a re-admission process. Rather than punishing women for having fears or anxiety about being in health care or the realities of living a street-entrenched life, this policy works to ensure that women face few barriers to accessing the health services they need.

Cultural safety

Culturally competent health systems focus on accessibility, accountability, sustained partnership (care is based on trusting, continuing, respectful and responsible relationships between patient and clinician), and the context of family and community [230].

Addressing cultural safety more appropriately within its structures may mean that the health care system needs to hire and promote more people to management who represent the patient population being served [150, 231].

Without assuming that women will automatically be better treated by health professionals of their own ethnic or religious background, it has been argued that representation within the health care system of the diversity of the population can only help to better reflect the needs of all patients [1, 231].

Having health care providers that reflect patients' diversity also does not mean that there are resident "cultural experts." Rather each staff person needs to make the investment of time and resources to become culturally competent [231]. This involves a commitment to:

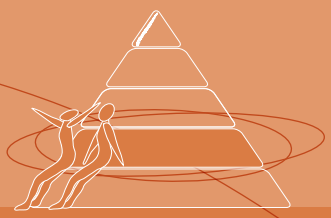
- Self-evaluation and critique;
- Working to make patient-provider relationships more equal; and
- Developing mutually beneficial and respectful partnerships with community agencies [265].

Removing structural barriers

Additionally, striving to remove barriers by providing transportation, increased hours of operation, services in several languages, privacy, services to those without health coverage or identification, etc., can assist women in abusive relationships in accessing the care they need [234].

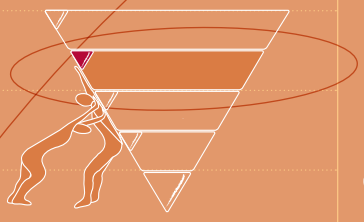
In addition to Fir Square, which has limited beds, BC Women's also provides health services on an outpatient basis to pregnant, substance-using women. The clinic recognizes that women living in poverty or with violence may not have a Personal Health Number, identification or a phone number, so not having these is not a barrier to receiving care at the clinic.

In order to recognize and remove barriers, the World Health Organization recommends a "situational analysis" describing available services, how they are organized and how accessible they are. They suggest that it is crucial to consider financial, transportation, time, cultural and other barriers, as well as geographical distribution when judging the accessibility of services [12].



Do No Harm

TIER 4 Health Practices



Tier four explores the ways in which both what is done and how things are done in health care can influence not just accessibility but also the

NOTES

safety and health of women impacted by abuse. As reported in Tier Three, women in abusive relationships observe that the traditional system of care can re-create dynamics of abusive relationships in which women lose control over decisions, and do not feel cared for or respected.

> "When an act of violence cannot be prevented, high quality service can minimize all forms of harm caused to the victim… harm will be minimized when the individual's medical, psychological, social and legal needs are all met."
> - World Health Organization [12]

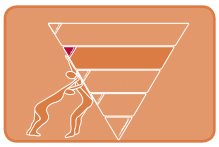
The *Compounding Harms Model* illustrates what may be less visible in the broader institutional culture of health care, including:

- The medical model, which does not view a woman as a whole being or in light of her social context and, by relying on gender stereotypes about the nature of women, can thus ignore or minimize the underlying causes of women's health concerns;
- The power and expertise afforded doctors and other health care providers to prescribe solutions;
- Lack of consent or control in procedures that can retraumatize women;
- Labeling women as the problem when they are not able to 'comply', thus limiting solutions to those aimed at her changing her circumstances, rather than adopting a social change approach that addresses the circumstances that sanction inequality and violence; and
- Attempting to identify women as abused within health care structures that may result in further negative experiences.

> "One of the things my partner really reinforced, because that was one of my worst fears, was that I was a hypochondriac… and it [was] the same going to see the physician. [Being made to feel,] 'Oh you're just exaggerating things again' or 'You're being too sensitive about this or that'. And that's part of the problem is that you have somebody else messing with your mind now… I think I was ill a lot longer because of it."
> - Woman abuse survivor

This tier also reviews promising practices and models within the health sector that offer potential to mitigate the harmful effects of woman abuse, and provide high quality health care. These models begin with the premise of recognizing that routine and institutional practice may be harming women, and work to avoid retraumatization. Essential to these practices include that they:

- Are not "add-ons" but fundamental shifts in the way health services are organized and delivered;
- Aspire to counter the dynamics and impacts of abuse in health care practices;
- Understand that one in three women experience abuse or violence in an adult relationship, and base services on this knowledge, rather than promoting an identification/disclosure approach;
- Strive towards safety, equality, respect, collaboration, and the inclusion of social determinants of health to increase women's health and safety;
- Understand that health care providers must experience these conditions in their work and educational settings in order to demonstrate them with patients;
- Recognize that individual health care providers can do a great deal, but many changes require institutional-level support for change;
- Create institutional practices based on the needs and realities of women impacted by abuse, including women-centred care, trauma-informed treatment, harm reduction, and cultural safety; and
- Work in partnership with anti-violence women's organizations.



Tier Four: COMPOUNDING HARMS: Adverse Affects

> "It is important to recognize that revictimization can take place in clinical interactions and that the distortion of meaning and denial of experience that are used as tactics of psychological control in abusive relationships can be inadvertently repeated in health care encounters if the clinician is unable to recognize and validate the traumatic context in which a person's symptoms develop and are perpetuated."
> - Dr. Carole Warshaw [174]

The medical model

The World Health Organization agrees that the medical ideologies that are "inhibiting health professionals from seeing women (or men) as whole persons living within social and family contexts" are an enormous barrier to adequately addressing woman abuse [80].

> "The medical approach reduces male violence—a social process rooted in gender inequality—to biological, individual, or situational factors."
> - Demi Kurz and Evan Stark [266]

By focusing on the individual for answers to the problems, a medical model approach

can make women feel blamed for the abuse or be prescribed unnecessary or inappropriate medications or treatment [34, 122, 175, 207, 210, 267-269].

Under a traditional medical model, health care providers are trained and expected to identify and attend to women's symptoms as the problem, rather than recognizing and tackling the broader issue of abuse [270-274].

This approach can result in women being pejoratively characterized and labeled as neurotic, hysterical, hypochondriacal, having personality disorders, or as a "well-known patient with multiple vague complaints" [170, 190, 221, 224, 231, 257, 269, 275]; that these outcomes may be effects of abuse or signs of coping with it is rarely recognized [79, 276].

Researchers in one study found that 81% of women identified as abused reported the subsequent health care to be neither helpful nor informative. They felt that health care providers were concerned only with their physical injuries, minimized their experiences, did not respect their confidentiality, and that the encounter was generally humiliating [93].

> "I went to the ER after my husband beat me and was not taken seriously. I was pushed aside by someone with a migraine, who said, 'Your problem is domestic.' Because my husband is in the medical field, the doctor didn't believe me. 'Oh, come on now, he wouldn't do that.'"
>
> - Woman abuse survivor

Health care providers as experts

The notion that health professionals are experts in all matters pertaining to health has the potential to make both women and their care providers feel powerless. Health care providers are trained and expected to solve their patients' problems [277]. However, because health care providers cannot "fix" woman abuse, their image of themselves as healers can be challenged [124, 175].

This has been demonstrated at WomanKind. "Medical providers are trained and expected to solve problems… These health professionals describe their sense of futility and frustration talking with the victim of domestic abuse when she doesn't seem to take any immediate steps towards safety or change or, in fact, may actually deny the problem… Recovery for a battered woman is often a long-term process… Without this understanding, hospital staff may convey judgement instead of support and concern. Telling the victim that she should take action that she cannot begin to contemplate at that moment only confirms her belief that no one understands her situation." [157]

The doctor as expert serves to undermine women's expertise about their own situations [37]. Further, the patient role as a dependent one also serves to support subservient relationships more generally [274].

> "If I need a note to stay home from work, if I need medication, whatever I need, the doctor gets to decide. He even gets to decide if there's anything wrong with me. He even gets to say, 'Well, it's all in your head'. He has all this power."
>
> - Woman abuse survivor

Echoing or compounding abuse

Women in one study describe how negative health care encounters resonated

with aspects of their abusive relationships, and explain how these experiences unintentionally provided legitimacy to the abuse, further contributing to a loss of health [10].

> "I had to lay there on the bed and he [the doctor] wanted to touch me inside my vagina and I couldn't, I didn't let him. I said 'No' … [but] he was insisting that he has to examine me."
> - Woman abuse survivor

> "I was already feeling horrible. This man [my abusive partner] is making me feel horrible and stupid. And then I come out to try and get help… and I went to my doctor and he yells at me for going back [to my partner]. I know he meant well, but I just felt even more stupid."
> - Woman abuse survivor

How health care is delivered can echo the dynamics of woman abuse, such as: being disrespectful, taking consent for granted, taking control away, ignoring her choice, denigrating her decisions, conflating health conditions or issues with the impact of abuse or blaming women for their health condition [252].

> "Many abused women who seek help from the health care system experience their contact with the "helping" professions and systems as another form of abuse. These women are doubly victimized, first by violent partners and then by practices and procedures that are insensitive to their needs."
> - Health Canada [1]

Other examples include breaching confidentiality, inappropriate interactions or exchanges with partner, labeling, judging, discrediting or ignoring women who reveal abuse and recommending unsafe or unrealistic treatment plans.

> "The doctor had a medical student in there with her [for the results of my HIV testing]. This was the moment when my whole life could change, I was so scared, and she had invited someone else to witness it without asking me. It felt so disrespectful."
> - Woman abuse survivor

A study of physicians' attitudes towards violence against women found that physicians became frustrated with women who were not "compliant" and did not follow their prescribed advice concerning the abusive relationship, which typically consisted of directives to leave the abuse or press charges [254, 260]. Yet, if a woman's problem is coercion and control in her relationship, an appropriate health care response should not involve health care providers imposing edicts [224, 276].

Retraumatizing women

> "When one's notion of competence is tied to achieving an idealized state of mastery and control, having to deal with feeling helpless or powerless, or having to feel empathy toward someone who is being victimized, can be particularly difficult. This increases health care providers' potential for retraumatizing patients and for being retraumatized themselves."
> - Dr. Carole Warshaw [172]

Requiring that women leave an abusive relationship for the situation to be considered to have a successful outcome, or making them feel guilty if they choose to remain in the situation for the time being further undermines women's autonomy and is unlikely to be part of a helpful health care response to woman abuse [10].

> "All they were concerned about was me pressing charges. I remember countless times saying, 'If I press charges, how are you going to help me? Because he's going to come back and get me'. 'Well, you know, [the police] can put a restraining order on him', [they said]. 'Well, are they going to be able to protect me 24 hours a day?' [I asked]…. And when I didn't want to [pursue a restraining order], they looked at me like 'Well, then, you deserve it. You deserve getting hurt.'"
>
> - Woman abuse survivor

Routine procedures and treatments – including vaginal examinations, ultrasound, dental work, touching, interviewing, child birth, containment, and restraints – can retraumatize women who have experienced abuse [1, 10, 172, 252].

> "I had an ectopic pregnancy and the next thing I knew I was in the hospital and my arms were tied to the bed and my legs were tied to the bed, needle in this arm, blood in that arm. And then, after that, they used me as a guinea pig for the medical students. So I've got all these medical students shoving their fingers up my vagina, and that's when… I just died that day."
>
> - Woman abuse survivor

Case study of a routine practice: Screening for woman abuse

"Medical screening" is a routine procedure that focuses on identification of a problem. Its origins are from a medical model, and it is an extremely important assessment tool that has contributed to the detection of a number of medical conditions.

Because of the current debate about whether screening for woman abuse is a safe and effective practice, we have committed a section of the *SHE Evidence Paper* to exploring this issue. We have cast a wide net in terms of reviewing evidence, and have committed ourselves to including women's experiences as well as conventional forms of research.

Evaluation of such models generally has not focused on impacts to women's health and safety but rather on compliance rates of providers in asking questions and women in answering them [10].

There is no evidence that asking women about abuse actually increases identification rates. The only study found to employ randomized control groups found no increase in identification in primary care clinics with a screening intervention. In each of the five control and comparison settings, 3% of the female patient population were identified as abused [278].

The assumption of screening is that health care providers "can significantly improve the health status of women through increased identification and appropriate intervention." [16]

However, additional research indicates that we cannot assume that screening will increase the identification of abused women, that identification of abuse will lead to positive interventions or outcomes [86] or that screening protocols meet the basic criterion of "do no harm" [89, 279].

> "How one asks questions and the safety of the setting in which questions are asked have a tremendous impact on the information that is obtained by physicians and the messages that are received by patients. The nature of the clinical interaction can itself provide relief and hope or increase despair and entrapment."
>
> - Dr. Carole Warshaw [172]

The lack of evidence regarding the benefit to women, widespread resistance to it by abused women and health care providers, and the possibility of it leading to a cascade of negative interventions are raising significant doubts about the acceptability of screening for woman abuse [85, 86, 119, 215, 280-283].

> "A woman and her physician don't always have a relationship that allows her to feel safe enough to tell the truth. The risk of the truth needs to be understood."
> - Physician [79]

This has led many researchers, including Dr. Garcio-Moreno of the World Health Organization, to question the widespread calls for "domestic violence screening" [10, 12, 85].

Evan Stark and Anne Flitcraft, researchers and practitioners in the area of violence against women and the health system for almost three decades, write that, "to date, physicians have concentrated on changing professional awareness and implementing changes in clinical practice, based predominantly, although not exclusively, on case finding and documentation… Ironically, if physicians' role is essentially that of case finder or mandated reporter, women will be reluctant to tell their physician about the real cause of their injuries and clinicians will engender the offence of patients while reaffirming their suspicion that domestic violence is indeed a Pandora's box. Clearly another role for physicians is needed." [190]

Examples of the conflict that health care providers find themselves in with respect to screening can be found in the Registered Nurses Association of Ontario (RNAO) and the Society of Obstetricians and Gynaecologists of Canada (SOGC). These professional associations have recently published clinical practice guidelines that simultaneously question the efficacy and safety of screening and yet recommend standardized screening tools for use by health care providers [284].

These contradictory messages can be found in many research publications, suggesting that, despite compelling evidence that screening is ineffective and possibly harmful, health care providers ultimately rely on solutions to problems found within a familiar or routine model.

Is there any harm in asking a question?

Asking women to volunteer personal and protected information for the purposes of health care ignores the potentially negative consequences related to disclosures [285].

> "And I was there in emergency and the woman at reception was asking my name … and who's this that brought me in. And I remember her asking me this question, 'Are you in an abusive relationship?' which at that point I was like 'Of course not, I'm not' and it's still hard for me to understand that's what I've been through. And he was standing there and the whole time she's asking me all these questions.
>
> I remember feeling sort of embarrassed and at a loss but also put on the spot because I wasn't thinking clearly and here they're asking me these questions and he's there so I know he's going to question me about my answers.
>
> Then they wheeled me over to the next check-in spot and I had to go through a lot of the same questions again."
> - Woman abuse survivor

When women do disclose abuse, the outcome may be negative. In one study, 53% of women who were identified as

abused reported responses that were insensitive or dehumanizing, and received no assistance or information once the issue of abuse was raised [98]. In another study, only one in six women received helpful health care [62].

In a nation-wide survey of 1000 abused women in the US, 9% of the women who sought help from health care reported that the health care encounter had actually increased the violence in their relationships [92].

A phenomenological study with four abused women who had multiple hospital admissions for injuries from violence reports several themes regarding their experiences:

- disengagement and loss of status (e.g., a sense of rejection once they had been labeled as a "domestic violence case"; being made to feel they deserved it, judged, and given no practical support);
- Disempowerment and lack of control (e.g., being called a "bloody idiot", lack of encouragement for them to participate in their own care, coldness, lack of empathy, treatment that heightened their fear, embarrassment, humiliation, degradation, depression and further isolation);
- Stigma and social isolation (e.g., being made to feel humiliated and unworthy); and
- Being misunderstood (e.g., felt they were being blamed instead of their abuser) [100].

Other studies suggest that a significant proportion of women do not find screening questions acceptable, and express fears and concerns about negative consequences of routine screening [85, 285].

> "You have somebody sitting across from a desk with a computer, clack-clack-clack-clack on the keys and you just feel like you're spouting out this information and I might as well be saying it on a phone because that's about all the interaction you feel you're getting. So you don't really have a sense that this individual [the health care worker] really cares about your problem, or why you're here, or what your answers are."
> - Woman abuse survivor

When identified as experiencing abuse, women who used drugs or alcohol were less likely to experience compassion or receive information about community resources [266, 286].

The inability to guarantee privacy and confidentiality can put women at more risk and can be a barrier to disclosure, as fear of retaliation by a partner, lack of a trusting relationship with a health care provider and concern about confidentiality are reasons for not wanting to talk about abuse [86].

Where abuse has been disclosed, confidentiality of such information is especially important in small communities, including cultural communities within larger cities. It is not always possible to control the use of information in women's charts, which can be used to her detriment by the courts, child protection services, insurance companies and even by abusers [78, 79, 86].

> "The patient will make the correct choice not to disclose, even in the presence of ongoing abuse, if confidentiality cannot be assured."
> – Dr. Elaine Alpert [124]

Who gets questioned?

Through screening and identification of abuse, women may experience a compounding of other forms of discrimination they already face.

Research in health settings reveals that poor or racialized women are more likely to be asked questions about abuse, making many women feel that they are being targeted due to discriminatory assumptions about their culture, race, or socio-economic background [49, 93-97, 287].

Who gets ignored?

On the other hand, women in one research study felt that their health care providers did not appear to consider the possibility that they might be in an abusive relationship, especially if they were white, middle-class, university educated, assertive, knowledgeable about women's issues, or seeking care for health problems other than physical trauma [10].

Limandri and Tilden [96] similarly found that physicians and nurses have a tendency not to think that individuals who are similar to themselves could be in abusive relationships, and to blame those women they see as different.

The irony of course is that significant numbers of physicians and nurses have themselves reported experiencing abuse in their intimate relationships [254, 288-290]. For example, 31% of female health practitioners in one study said they were abused as a child or adult [288], and 37% of nurses in a BC hospital report experiencing abuse at some point in their adult lives [289].

Screening programs generally neglect health professionals' personal experiences of relationship abuse [95, 119].

Health care providers have also expressed apprehension that one to three hours of training do not adequately prepare them for addressing woman abuse [86].

Additionally, health professionals have been made to feel guilty that they are not doing anything to address violence against women if they do not screen for abuse in the lives of their female patients [260], and forced compliance to the screening model has even been suggested [95, 280].

Introducing a routine practice such as screening for abuse is inexpensive but is not primarily guided by the experience and needs of women or health care providers. It also fails to demand change in the health care system or larger society or allocate responsibility for resolving abuse beyond the woman affected and the health care provider who is charged with "fixing" her [291].

Institutional practices

Ellen Pence, a leading researcher in the area of safety audits, reminds us how robust institutional practices can be and how change within such entrenched arenas requires a sustained commitment at all levels of the institution [292].

Economic factors

An ethnographic study of two British Columbia Emergency Units reported that nurses were so focused on the "efficient processing" of patients, physical problems, and cost savings, that only blatant physical injuries were dealt with and the other sequelae of relationship violence were otherwise obscured [97].

"The pressure under current practice arrangements to make rapid assessments, diagnoses, and treatment recommendations often pushes clinicians into a mode of taking charge and

maintaining control of clinical encounters. For someone whose life is controlled and dominated by another person, the subtly disempowering quality of many clinical interactions serves to reinforce the idea that this is what is to be expected and adapted to in order to survive." [172]

Changing health care delivery models, coupled with economic factors such as fee-for-service medical treatment and drastic shortages of health care personnel, mean that women are more likely to experience an impersonal, rushed health care encounter [150]. Current allocation of resources and billing practices do not facilitate professionals taking the time to counsel, support and advocate for patients [293].

Shortages in personnel, space, and time are named by women experiencing abuse as affecting issues of privacy, the building of trusting relationships, waiting, rushing, and the impersonal tone of many health care experiences [10].

For physicians, primarily because of the method of receiving payment for services in Canada, the lack of financial reimbursement for spending needed time with women impacted by abuse is a deterrent to intervening [294].

As health care becomes increasingly governed by private sector and business models, physicians are expected to see more patients in shorter periods of time [175].

Time constraints and the rapid processing of patients are widely recognized to be significant barriers to providing good care for women impacted by abuse [64, 124, 163, 168, 224, 262].

> "The ten minute factor is huge. There I am, I'm supposed to explain to [my doctor] the most important aspect of my life, before [they see] their next patient, who's sitting out there waiting. Why bother to even start?"
> - Woman abuse survivor

Limited availability of physical space and shortages in staff numbers and time create a climate that is not conducive to good care for women who are struggling to regain their health as a result of experiencing an abusive relationship.

> "[I felt so] vulnerable, that anybody and everybody could be listening to this information."
> - Woman abuse survivor

Hierarchical structures

Inequality between men and women, common in most societies, is usually reflected in the health sector [86]. The health care system itself is a gendered, racialized and classed hierarchy that in many ways mirrors society in general [224, 232, 276, 295].

> "The western health care system is a system where the majority of doctors are male, and the majority of nurses are female - again gendered on power lines; where the people of colour tend to be found either in the roles of the patients, or in the kitchens, laundries, and janitorial services of most hospitals."
> - Dr. Yasmin Jiwani [150]

Commonalities between women in the health professions and women impacted by abuse have been recognized. "The origin of the plight of abused women and the struggles of female health workers lie in the worldwide social and economic inequality of women," writes Lee Ann Hoff "[and] the concomitant devaluation of women and their work keeps battered women with violent men, and

women, especially poor women of colour, in inequitable service roles." [169]

In a study of one Toronto hospital, researchers found that racial minority nurses were severely underrepresented at the decision-making and supervisory levels. Further, they were more frequently passed over for promotion, while white nurses were promoted at rates significantly higher despite sharing similar levels of qualification with black nurses [296].

As long as the health care system reflects the inequality in our society that creates the conditions in which violence against women occurs, it cannot be well situated to systematically address woman abuse within its walls [297].

Tier Four: SAFETY AND HEALTH ENHANCEMENT: Do No Harm

> "If we can begin to understand what sustains and transforms abusive power dynamics in both individual and institutional forms, we can perhaps begin to develop a template for changing those dynamics within our own institutions, communities and lives."
> - Dr. Carole Warshaw [172]

Incorporating change into practice is not simply a matter of health care providers deciding to do so. Individual practice takes place within the contexts of the health care system and the larger society; aspects of these contexts can facilitate, or conversely, hinder the implementation of such change. To facilitate practice-level change, programming for the prevention of violence against women should address structural level forces that perpetuate and reinforce abuses of power.

Understanding potential harms to women

Frontline advocates, service providers and researchers in Duluth, Minnesota – a community recognized for leading efforts to eliminate violence against women – have found that when reform efforts focus simply on individuals in the system "rather than on building safety considerations into infrastructure, the system could actually become more harmful to victims than the previously unexamined system" [298]. Thus, efforts to address woman abuse should focus on building safety considerations into health systems and structures.

Conducting safety audits in health systems is a promising approach that has been used to assess women's safety and build safety considerations into legal and child protection systems. According to Ellen Pence and Martha McMahon, "by using the safety and accountability audit as a method of seeing how unintended and harmful case outcomes are produced in the complex maze of multi-agency interventions, advocates and reform activists have been able to focus on women's safety." [299]

Dr. Garcia-Morena of the World Health Organization has pointed out that too often recommendations developed for health providers address only the individual provider and do not take into account the realities of the health system in which the provider works [300].

Re-shaping institutions

Understanding the context in which individual health care providers work can improve clinical practice and help develop more realistic strategies [224].

Innes and colleagues, in their review of health services related to woman abuse, concluded that one of the four factors that impede effective program development for woman abuse is the continued use of a traditional model to deliver services [291].

Rather than adding on to existing structures that can serve to perpetuate the problem, researchers suggest that an effective response needs to work at changing those structures. The findings support models that focus on the broader context and earlier prevention of the problem by addressing its root causes and working in collaboration with a larger community [120, 124, 301].

The implementation of programs is most successful when the program philosophy is adopted as an agency philosophy [302].

> "In order for clinicians to develop and sustain appropriate responses to domestic violence, they must have the support of the institutions in which they practice."
> - Dr. Carole Warshaw [172]

In the practice and structures of health care, power relationships must be addressed to prevent the perpetuation of inequality. At the level of the individual practitioner, it has been suggested that physicians must gain a deeper understanding of the abuse of control and authority in their professional – and personal – lives [174].

To address the power relations between doctors and patients, many researchers argue that the existing hierarchies within the health care system need to change [150, 256, 257, 303].

In the same way that women know best their home situations, health care providers know best the context of their work. In recognizing that abused women know what strategies are possible within the circumstances of their relationships, it must be recognized that health care providers understand best what sort of a response is possible within their own practice [68]. Health care providers are more likely to support and become involved in institutional responses to woman abuse when they are involved in creating them [226].

Addressing cultural safety more appropriately within its structures may mean that the health care system needs to hire and promote more people to management who represent the patient population being served [150, 231].

Women-centred care and trauma-informed treatment

Research has demonstrated that the health sector needs to shift paradigms away from an identification model to a model guided by women-centred care and trauma-informed service principles and approaches. Dr. Carole Warshaw observes that the crucial aspect is having the health sector realize that "for someone who has been abused… experiencing equality, safety, mutuality, and empowerment are essential to the process of healing and reclaiming one's sense of self and place in the world." [172]

Although women-centred, advocacy or "empowerment" models were part of the early formal health care responses to woman abuse, screening for abuse has become popular on grounds of efficiency

and familiarity. Some programs have continued to be, or were since developed, based on women-centred ideas. The role of health care providers in these models is one of advocacy for the woman and the wider social context.

> "We often know what we need, and we often know what's wrong. [It would be good] if there was some way for us to be more involved in that process and have more options [and] be supported [in exercising them]."
> - Woman abuse survivor

These models are predicated on the fact that a woman impacted by abuse is the best judge of her situation, and the role of a health care provider is to support and facilitate her decision-making process through ensuring confidentiality and privacy, building trust, listening non-judgmentally and validating her experience while also advocating for change at a systemic level [22, 68, 91, 118, 121, 124, 157, 159, 162, 167, 171, 271, 304].

The Framework for Women-Centred Care recognizes the importance of "an awareness of power issues between providers and women and the effects of the abuse of power." [2] It suggests that health care providers should "listen to women, [and] take their concerns, opinions and feelings seriously. [Providers are advised to] take time to build relationships, provide room for women to tell their own story, and be non-confrontational… [They should] acknowledge the likelihood of any woman having experienced violence and abuse and recognize the consequences of violence on women's physical and mental health… [and] provide an environment that welcomes diversity and those with different needs." [2]

Thus, the notion of "identifying and managing cases of abused women" could be replaced with a view that "the woman living in the violent situation is the best manager of her own risk." [80]

> "[The health care provider] has to listen to you and she has to see what you need, not what she thinks you need."
> - Woman abuse survivor

Other systems have discovered that it is insufficient to work with victims in a one-to-one situation because for every victim we access there are a hundred more that we will never know [101].

Since abuse is likely part of the experience of many of their patients given its magnitude and pervasiveness in our society, health care providers will be more effective in supporting women if principles from trauma-informed service models are applied.

Practitioners who are aware that any of their patients may be experiencing abuse may be more likely to recognize the impacts of abuse on health. Yet, even if they are not aware of abuse in the lives of particular patients, health care providers can validate and include their patients' knowledge of their home situation and other contextual and social factors into their treatment plans.

> "When I had a baby, something happened that was very positive. After having a baby, my baby and me were both very healthy, and they kept us for one week. And it just dawned on me that they knew what was going on, without ever letting me know. Because every time I saw the nurse, I started crying. They asked me, 'Do you have any support in the house, do you have any relatives? I said, 'I don't. It's only my husband and me. That's it'. So they kept me until I really recovered…. That's a very good thing that these doctors

did for me. I've heard so many horrible stories of people just being kicked out [of] the hospital, and I hope they would make exceptions for women who've had this experience [of abuse] – because it can get worse. ”
- Woman abuse survivor

Trauma-informed models, which have their roots in the women's mental health and addictions fields, offer a template for service design and implementation that will avoid the need for identification of individual women.

"Trauma-informed services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors." [239]

“Changing to a trauma-informed organizational or service system environment will be experienced by all as a profound cultural shift in which consumers and their conditions and behaviours are viewed differently, staff respond differently, and the day-to-day delivery of services will be conducted differently. ”
- Angelique Jennings [237]

"A trauma-informed system is one in which all components of a given service system have been reconsidered and evaluated in light of a basic understanding of the role that violence plays [and]… uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization." [239]

Few studies were located that evaluated the impact of advocacy and empowerment focused health responses to woman abuse. What they reveal, however, provides evidence that advocacy can help women increase safety behaviours, decrease violence, and improve health, as well as have a positive impact on the health care providers implementing the programs [305-307].

Dr. Warshaw observes that the health care system needs "to change the doctor-patient relationship itself, a relationship in which the unacknowledged need to maintain control and power reproduces an abusive dynamic antithetical to the care a battered woman most needs." [122]

Women-centred care means clearly recognizing the importance of one's support, presence, perspective and concern, as well as the limits of any one person's abilities to control the batterer's behaviour or to change the victim's situation [172].

In addition to understanding the dynamics of abuse and its potential impacts on women's health and access to care, women-centred care involves a focus on care and compassion, safety and respect, shared control, consent and confidentiality, and coordination with other systems [171].

Care and compassion

Hall and colleagues found that female patients were more satisfied with caring health care providers who showed concern, talked about psycho-social problems, were emotionally supportive, and appeared interested in what they were saying [308].

“Positives [are] where people are there to help me, to help me get healthier. People that are listening. The caring part, the talking to me like I'm a human being, like they would the person next to me. And my specialist takes care of me – it's not just checking my pulse and listening to my heart. She's there to talk to me and see how my everyday life

is, my stress, and things like that. Not just, 'Here's a prescription. See you later.' "

- Woman abuse survivor

Rodriguez and colleagues heard in telephone interviews with a random sample of 375 ethnically diverse, abused women in San Francisco that experiencing compassion and understanding in health care encounters was very important [309]. For many women, this was much more important than a clinician's gender [310].

"[The doctor] didn't judge me as being stupid for having been abused or make me feel blamed for what had happened to me. She was very respectful of me.... It made me feel like a human being she was interested in.... The whole manner with which she dealt with me, I felt that she was compassionate and she cared.... She never said, 'Oh, don't be so stupid as to go back to that', nothing like that. It was just heartfelt concern and it felt genuine. "

- Woman abuse survivor

Safety and respect

McMurray and Moore described women's needs as including honesty, support, understanding, explanations, non-judgmental attitudes, a feeling of safety, being listened to and feeling that a nurse was close to them [100].

"Let people know that, 'Yes, we know you're here, and we know it's going to be a long wait... but I'm keeping my eye on you, and how are you holding up?' "

- Woman abuse survivor

The women in their study needed to have respect for their decisions, including the decision to return to the abuser, and the freedom to disclose or not, to talk or not, and to be counselled or not [100].

"Support her no matter what. No matter what her decision is, you're respecting that decision. "

- Woman abuse survivor

Sharing control

Plichta and colleagues found that all women prefer responsive and egalitarian physicians [27].

Hall also reports that, in addition to emotional sensitivity, women want an egalitarian doctor. Female patients were more satisfied with less dominant health care providers, such as those who talked about the patient-provider partnership as a "we", actively listened, asked fewer close-ended questions, and did not interrupt [308].

"[I want to be asked a question in such a way that gives] the option that if you didn't want to answer it, you didn't have to. "

- Woman abuse survivor

Bertakis and colleagues reported that patients were most satisfied with physicians who did not dominate the conversation, and when the number of biomedically-oriented questions decreased [311].

"I saw a psychiatrist years ago, and he just sat there and listened with a bored look on his face, and I thought, 'I don't really have anything to talk about, what a waste of time.' And seeing [a counsellor since, there was instead]... a feeling of acceptance, they're going to listen to you and accept what you're saying and be non-judgmental. I felt really intimidated by my psychiatrist, that he's going to really judge me. Whereas my counsellor was there to help me. "

- Woman abuse survivor

First Nations women reported that an important element in affirming health care encounters is the sharing of knowledge and power over health care decisions, where health care providers encourage women to ask questions, are unconcerned about time constraints, and help women to increase control over their health [63].

The BC Women's Hospital Consultation Report found that women want the health care system to be a supportive environment that creates conditions for women to be empowered; women want attention paid to their daily lives, they want validation for what they feel and they want knowledge and skills so that they can take control of their health [294].

> "Just having somebody listen to me and support me in my concerns was such a relief. I felt like a big load was lifted off my shoulders."
> - Woman abuse survivor

Sharing the control of health care encounters with women impacted by abuse can be facilitated by asking open-ended questions in privacy, listening carefully to the responses, and acknowledging women's expertise about their own situations and health [10].

> "[My doctor] really listens and she will ask you, 'What do you want me to do?' If you have any suggestions, she'll do it. If you don't have any suggestions, she'll tell you what your options are and you can tell her what you want. That's a good thing about her."
> - Woman abuse survivor

Sharing control involves giving options and information rather than directive advice, and supporting the decisions women make. This includes supporting women's choices around documentation and disclosure of the details of their relationships.

Research suggests that practitioners should approach women with experiences of abuse as survivors of life-threatening situations who are adaptive and have many strengths. The types of questions raised should be "What do you want to do?" and "In what way can I be helpful to you?" [22]

Consent and confidentiality

Hathaway, through interviews with 49 clients of a hospital-based domestic violence program, found that care and follow-up are important components of good health care [312]. In addition to hearing that they want to feel cared for, Hathaway found that the women she interviewed needed to feel no pressure to undertake any specific course of action, and to have their confidentiality respected [312].

> "Informed consent is an essential feature of all services to victims of violence. When someone suffers an act of violence, they have often experienced feelings of helplessness and lack of control over the situation. It is therefore important to restore control to them during service delivery."
> - The World Health Organization [12]

Supporting women's decisions requires maintaining the confidentiality of disclosures and not making referrals without a woman's consent [10].

> "Everything is confidential. Nobody has to know. This is what a woman in [an abusive] situation wants. That this news is not traveling anywhere."
> - Woman abuse survivor

The Sexual Assault Service at BC Women's Hospital and Health Centre underwent a four-year process to determine how best to ensure women consent to all services they undergo, including whether they should collect DNA samples from unconscious

women. In reviewing all available evidence and consulting a range of stakeholders, they determined that the answer needs to be 'no'. This practice is based on recognition that after being assaulted, women experience a profound loss of control and sense of powerlessness. Returning control to the survivor is the primary approach in helping her regain control of her life and begin the process of recovery [313].

> "The nurse must structure a situation in which a trusting relationship with the client can develop. Privacy and assurance of confidentiality are essential for trust to develop. Probably the most critical element in gaining the client's trust is an attitude of unconditional acceptance on the part of the nurse, including situations in which the client denies that she has been battered. The battered woman may leave and return to the marital relationship many times, resulting in feelings of frustration, helplessness and anger among health care providers."
>
> - M. Brendtro & L.H. Bowker [121]

Coordination: Part of a larger response

A fundamental dimension of women-centred care is fostering connections between those who work in all areas and at all levels to address violence against women [2].

According to WHO, staffing patterns, internal and external resources, such as services for referral and development of stronger partnerships with NGOs that have been working with women in abusive situations is likely to enhance the effect and sustainability of interventions [86].

While it is a departure from traditional models of delivering health care, providers have engaged in larger initiatives to address violence against women such as co-ordinating committees addressing violence against women in relationships [166].

Coordination requires that health care providers respect the knowledge of community advocates who support women in abusive relationships and develop respectful, mutual relationships with advocates.

As program developers in the health care system recognize the need for health professionals to work closely with community groups, anti-violence women's advocates have also been invited into the health care system to form partnerships in addressing woman abuse [171, 314, 315].

WomanKind, an innovate program in health care, is one example. At three sites across Minnesota, advocates from the anti-violence women's community are situated within hospital settings to provide support for women experiencing abuse, education and consultation for health professionals and a link to the larger community of women's services [157].

In Fort St. John, a partnership was formed between the local hospital's Emergency Department, the Specialized Victim Assistance Program and the Sexual Assault Centre. Together they raised funds to establish a hospital-based sexual assault service with many links in the community [7].

In Powell River, a 'Finding Common Ground' committee has formed which includes Adult Mental Health & Addictions, Specialized Victim Support Services, the local transition house, RCMP Victim Services, and "Stopping the Violence" Counselling and Outreach Programs. It is a group of agencies with different mandates but that share a common goal to increase women's safety. Using a multi-disciplinary team approach, they consolidate resources to develop and implement ongoing safety planning for women while developing,

maintaining and promoting best practices [316].

Working in coordination, health care providers can benefit from the expertise and experience of frontline advocates about women's safety and other needs.

Another benefit is that, when women want to be connected to other forms of support, health care providers are knowledgeable about community resources, provide women with sufficient detail about these resources, and promote referrals to resources that also adhere to the principles of women-centred care.

> "Have resources at hand, ideas, things to think about. Because [women in abusive relationships] really will know what's best for their situation… every situation is going to be different."
> - Woman abuse survivor

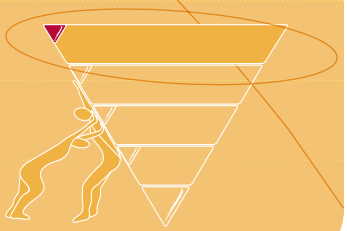
Health care providers working alone cannot meet all the needs of patients who are abused, nor can they prevent domestic violence [172]. McCauley and colleagues found that women's groups were often a good referral for women impacted by abuse, and that psychiatrists often were not [208]. Coker, too, found in a population-based survey of women who have experienced abuse in South Carolina that 100% of the women who used support groups found them helpful [214].

Addressing violence against women in a meaningful way, in its larger social context, requires the health care system to become part of a broader community-based response aimed at stopping violence against women [62, 86, 171, 224, 277, 300, 301, 306, 317].

As we explore in the fifth tier, this can be fostered, or hindered, through policy and research.

Seeing the Big Picture

Policy and Research TIER 5



Tier Five: Values always drive policy and research, either explicitly or implicitly [318]. Thus, analyzing policy and research can help us to understand the values and social context influencing health care, including aspects that compound the harms of violence against women.

> "Wife battering is a serious problem because it alerts us to the fact that despite some improvements in women's status and options, many women are still not given the options and benefits they warrant or need."
> – Health Canada [32]

Research or policy that jeopardizes women's equality and safety:

- Ignores international and national policy committed to ending violence against women;
- Does not translate into meaningful action to address gender-based violence and abuse;
- Is "gender-blind" and thus supports the status quo by having an unequal impact on women, while rendering those impacts invisible;
- Has been developed without knowledge translation between policy, research and social action;
- Has the health care system working in isolation to address woman abuse without collaboration with other sectors, including the anti-violence women's sector;
- Puts the onus on individual women or often under-funded women-serving organizations to address the issue, rather than advocating for social and institutional change;
- Is not developed in collaboration with women's advocates or survivors of abuse; and
- Focuses on quantifying, rather than understanding, woman abuse.

There are, however, examples of promising directions in policy and research related to woman abuse, including those that:

- Put women's safety first;
- Are linked to action;
- Include women's voices and experiences;
- Further our understanding of the issues and ability to respond appropriately;
- Incorporate a gender-based analysis;
- Work to change social norms; and
- Work with other sectors to develop strategies to reduce and ultimately eliminate the harms done to women.

NOTES

Tier Five: COMPOUNDING HARMS: Lip Service

> "Women's interests – in all their diversity – are poorly served when government's capacity or willingness to identify and articulate the gendered impact of its policies is reduced.... Policies which undermine the social and economic well-being of significant numbers of women, particularly those who are already marginalized, are harmful to the interests of women more generally."
> - Katherine Teghtsoonian [319]

Policy should determine action, but action in health care that is being taken on the issue of violence against women is rarely based on international policy, research, the reality of women's lives, or what is happening in other sectors of society. These are all factors which have a tremendous impact on women's ability to live independent of abuse. Policy and research that ignores women's reality can put women at greater risk.

International policy on violence against women

International policy outlines the role that societies need to play in the reduction of woman abuse, and specifically notes the health sector's responsibility within a larger response.

The Convention on the Elimination of All Forms of Discrimination against Women (1979) is the most extensive international document dealing with the rights of women. In 1992, the Committee on the Elimination of Discrimination Against Women (CEDAW) which monitors the implementation of this Convention, formally included gender-based violence under gender-based discrimination. General Recommendation No. 19, adopted at the 11th session (June 1992), deals entirely with violence against women and the measures taken to eliminate such violence.

Regarding health issues, it recommends that States should provide support services for all victims of gender-based violence, including refuges, specially trained health workers, and rehabilitation and counseling services [81].

The World Conference on Human Rights (1993) adopted the Vienna Declaration and Program of Action. It states that gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice are incompatible with the dignity and worth of the human person, and must be eliminated. This can be achieved by legal measures and through national action and international cooperation in such fields as economic and social development, education, safe maternity and health care, and social support [81].

The International Conference on Population and Development, held in 1994 in Cairo, adopted a Program of Action which emphasizes that advancing gender equality and the empowerment of women and the elimination of all forms of violence against women are cornerstones of population and development-related programs (principle 4). Governments were called upon to take full measures, including preventive action and rehabilitation of victims, to eliminate all forms of exploitation, abuse, harassment, and violence against women, adolescents and children [81].

In 1996 the World Health Organization's World Health Assembly Resolution 49.25 proclaimed violence to be a priority public health issue [81].

The Gender and Health Unit of the Pan American Health Organization (PAHO) developed an "Integrated Model of Attention to Intra-Family Violence" in 2001. What is unique about this model is the explicit objective to translate this "framework into a concrete social response, with emphasis given to the pivotal role of the health sector." The goal is to develop community networks and "replicate the model at the national and regional levels, involving members from local networks and national organizations in emphasizing policy change and the institutionalization of the model." [320]

Unfortunately, there are many ways in which international policy has yet to be fully translated into action in Canada.

National policy

Despite a 1993 Health Canada commissioned report stating that "violence against women, a prime area of concern as a health issue, is rooted in the social, economic and political inequality of women" [1], a lack of gender analysis in Canadian federal government budget decisions has meant that "though the economy grew by 62% between 1994 and 2004… a growing number of women over the same decade were finding their pay rates virtually stagnant while the costs of basics like housing, tuition, child care, transit and utilities continue to soar." [321]

Along with all United Nations member states, Canada was expected to develop a national plan to advance the situation of women nationally and globally [322]. Setting the Stage for the Next Century: The Federal Plan for Gender Equality (1995-2000) was presented at the 4th UN Conference on Women. The eight objectives in the plan are linked to the twelve critical areas in the Beijing Platform for Action, including the reduction of violence in society, particularly violence against women and children, and promotion of global gender equality. Some key achievements will be reported under the *Safety and Health Enhancement Model*, but the implementation of gender mainstreaming and gender-based analysis is "still in its infancy." [323]

The Canadian Task Force on Preventive Health Care (CTFPHC) produces national guidelines on different health issues. Regarding violence against women, the guidelines are sparse, citing the insufficient evidence for supporting routine screening but not making clear alternate suggestions [324].

> "Overwhelmingly, governments lack the necessary expertise to develop and implement policy relating to violence against women. Therefore a more cooperative approach between governments and civil society should be built to combat violence against women.... Giving attention to the real-life context of the battered woman, her hopelessness, dependency, restricted options, and her consequent need for empowerment should underpin every approach. The goal is to work with her to develop her capacity to decide her own future."
>
> – UNICEF [325]

Provincial policy

British Columbia will be used as a case study for looking at the compounding harms of policy at the provincial level, but similar political processes and impacts have been well documented in other provinces across Canada.

The 1995 BC Provincial Health Officer's Annual Report concluded that "[a]ll forms of violence have significant impact, sometimes acute and sometimes long-term, on a woman's health." [83] The BC Ministry of Health outlined the responsibility of the health care sector in addressing this issue. The 1997Health Goals for British Columbians explicitly stated that the reduction of "family" or "interpersonal" violence was necessary to meet three of its six broad health goals [326].

At this time, the Women's Health Bureau (WHB) within the Ministry of Health was the central policy area for issues related to women's health. The Minister's Advisory Committee (MAC) included a Violence Against Women subcommittee, which was formed in October of 1997 to look specifically at how it might address the health implications of this issue [327].

This committee determined that "all forms of violence have damaging short and long term effects on the mental, physical, and spiritual well-being of women" and that "living in fear of violence or with violence is contrary to the fundamental conditions and resources necessary for health." In the policy making process, the issue of violence against women was identified and put on the health care agenda in BC a decade ago [62].

However, the government's approach of assigning responsibility for addressing the issue to only one area of government, rather than supporting inter-sectoral collaboration, was a barrier in the advancement of this policy making process.

Attempts to coordinate efforts to address the issue came in the form of Coordination Committees on Violence Against Women in Relationships in communities in BC. Health, justice and social service organizations worked together to identify and develop ways to better work together across sectors to support the implementation of the Attorney General's Violence Against Women in Relationships Policy (1993) to improve services for women and children impacted by violence. Many of these included health subcommittees to "address problems women encounter when accessing services from… the health system" [328].

However, according to policy analysts, the issue of violence against women in relationships was effectively taken off the agenda with the change of provincial government in 2001. BC's new government saw the elimination of the Ministry for Women's Equality, the Women's Health Bureau, the Minister's Advisory Committee on Women's Health, and funding for Coordination Committees on Violence Against Women in Relationships [319].

According to policy analysts, neoliberal agendas are generally hostile towards women's social policy bodies, and often make decisions that perpetuate and reinforce gender inequality while, at the same time, declaring gender irrelevant [319].

By making women's safety peripheral, and rendering them "special interests", the impacts of policies are often erased [319]. Provincial policies, including cuts to services, which do not recognize inequality inevitably more deeply impacts those who are already affected by the social determinants of health. Women, especially if they are poor, aboriginal, disabled, living in rural areas, etc., are disproportionately affected and their health further deteriorates [329-335].

As well, women have been unequally burdened with having to provide unpaid care to elderly and young family members as a result of cuts to health services [333, 335].

Such cuts additionally affect women's ability to live free of violence. Provincial policies and cutbacks such as those that decrease income assistance, legal services and childcare, and eliminate women's centres and Ministries and advisory councils responsible for women's issues, have enormous known and potential impacts on women's ability to escape abusive relationships, maintain custody of their children, and exercise their basic human rights [331-335].

This gave the BC CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women) Group cause to question in 2003 if British Columbia was moving backwards on women's equality [330].

BC's 2006 budget shows that the province has low unemployment and a strong economy with government surpluses over the past four budgets totalling almost eight billion dollars. Unfortunately, according to policy analysts, these funds have been allocated to "tax cuts and debt reduction [instead of] of enhancing public services in a manner that improves women's ability to enjoy a healthy standard of living, to make real choices about their personal and family lives, and to participate fully in society." [336]

Health Policy

As with national and provincial policy, most policies developed by health institutions and professional associations are not rooted in international policy, the equality of women, broader responses to violence against women, or the experiences of women themselves.

Decisions about health care delivery have usually been the domain of professionals and health officials, with women's voices being noticeably absent from health service planning and evaluation [9].

The policy making process does not generally include the perspective of women experiencing violence or the women's groups that serve them. Therefore, health policies related to woman abuse generally do not take into account that "[t]he patient knows most intimately the kind of danger she is confronting, and she must be an integral part of the decision-making process regarding steps to be taken in her case." [221] Policies grounded in the medical model rather than in the reality of the women's lives can affect women's access to services [101].

As discussed in Tier Four, some professional bodies are promoting screening for woman abuse. Such policies are developed by relying on institutionally-shaped tools and practices, despite explicit reservations raised in the academic literature about screening. These health policies tend to be developed in isolation from the input of international experts in the field of violence against women or the voices of women themselves who have experienced abuse. Such policies may gain widespread adoption and implementation because they come with little cost and require no real institutional or professional transformation. In many institutions, a policy on screening is the only policy that has taken into account violence against women in relationships. In all other policies, this reality is left unaccounted for [236].

What the health system has not adequately done is create comprehensive policy that takes into account that: women's safety needs to be paramount; health impacts must be addressed in the context of abuse; women face barriers to care; health care must be based on the knowledge that one in three women have been abused but may

not feel safe disclosing this; and that our systems of care may further compound the harms women face.

Screening without system-wide changes

Hennessy writes that "what we found within the system was a reluctance to take responsibility for the safety of victims and children. The system continued to blame the victim for her victimization. The system also blames the victim for exposing her children to the pattern of domestic violence." [101]

Focusing our efforts on screening has kept the health sector from advancing their role by keeping the focus of the problem on the woman, on her needing to disclose and to take action. There is a growing awareness that putting energy into identifying women impacted by abuse may be colluding with a system that medicalizes and minimizes the problem and ignores the dynamics of power and control. This type of collusion is in the best interest of systems because it does not force any change, and it supports the best interests of the offender [101].

> "If the medical system… is worried about women getting abused, this is not a "quick-service" [issue]…. This is a very important issue and it has to be looked at in a professional way, not just [being asked for] your address 'and, oh by the way, have you been beaten up by your husband?' "
> - Woman abuse survivor

Providing a referral to resources is described as an intervention and has often supplanted a meaningful health care response. A focus on referral assumes that women have not already attempted to access resources, that there are adequate and accessible resources and that health care providers are knowledgeable about current services. It ignores the reality that many of those resources may have been cut or were already inadequate to serve the demonstrated need. For example, in 2001, over 2000 women and children were turned away from transition shelters in one BC municipality alone [234].

Where there are services that support women experiencing abuse, these services may be limited due to geographic isolation, cost of services, lack of commitment to culturally-specific services, lack of transportation to the services, restricted hours of operation, inadequate funding or staffing for services, lack of accessibility to women with special needs (e.g. women with disabilities, mental health diagnoses, or with drug and alcohol issues), and lack of interpreters [329].

Thus, simply giving a woman a list of phone numbers cannot be considered an adequate intervention.

Documentation and reporting

Many health policies developed by professional practice organizations also encourage health care providers to extensively document abuse, assuming that this will be helpful in future legal processes [337].

However, these guidelines have been developed without recognition or knowledge of the discriminatory practices found in the legal system. According to research conducted in BC, health records of women in abusive relationships are much more likely to be used against them in court than to support their case. The very impacts of abuse – mental health issues, substance use, poverty, etc. – are used to undermine the credibility of women in abusive relationships and remove their children from their care [79]. This re-affirms the right of the abuser to wield power and control over his

partner and the message to her that she will be punished for speaking out [101].

In the United States, working together with the American Medical Association, the government of California passed a state Assembly Bill (AB 890) mandating that all hospitals and licensed clinic have policies and procedures to screen patients for violence, use domestic violence referral lists, and report all cases of identified or suspected domestic violence to police [221]. Unfortunately, it has been determined that this legislative policy "may result in women not disclosing the cause of their injuries, or worse, fleeing the health system altogether."[221]

Such policies do not take into account unequal relationships between women in abusive relationships and their health care providers nor does it address relations of power within health care institutions.

Untransformed institutions

According to the World Health Organization, many people, "especially advocates of human rights, challenge the assumption that disclosure of intimate partner violence is always beneficial to women," and caution about "individual agents of change working within untransformed institutions and the risks of unforeseen outcomes of well motivated change." [338]

If social, political and economic inequality are the basis of violence against women in relationships, then health care policies which reinforce gender and race inequalities reflect and reinforce norms, and women who work in the system are not made any more safe [150, 338].

One example of policy development that has further entrenched race and gender inequality in health care is the contracting out of housekeeping and food services in several provinces. This has meant that many women, mostly women of colour, have lost their jobs or were re-hired at as little as one-half their former wages [329].

According to researchers from Johns Hopkins University, "evidence suggests that without system-wide reforms and support, single training sessions or routine screening policies rarely produce long-term changes in the quality of care for survivors of violence." [339]

Disconnect between research and policy

Policy needs to be based in evidence that is grounded in women's experiences. However such research is often seen as lacking credibility or scientific rigour, or as "anecdotal" information, and is rarely used to shape policy.

Research itself may also contribute to decreasing women's safety by focusing on quantifying the problem to the detriment of understanding it [283].

It is misguided to base policy on prevalence rates because focusing on quantifying the extent of violence against women, rather than understanding the experience of women, shows little of its complex nature. This has led to the development of narrow and simplistic practices and policies within the health care field [31].

We need to evaluate current approaches utilizing research that accurately portrays the nature and consequences of abuse. When analyzed through women's experience, and contextualized within the overall goal of increasing women's safety and health, no evidence exists to support the continued call for screening in practice or in policy [10, 85]. The approach does not demonstrate relevance to women's safety and health needs.

Too often, discussion or conclusion sections of articles make claims about screening for violence, among other practices, that the data section does not show. Researchers must take responsibility for the potentially harmful tendency to advocate practice or policy that they do not actually have the evidence to support.

Existing ethical review policy may not be able to address the ethics of disclosure consequences of asking women in abusive relationship about their experiences of violence [13, 283]. As well, not recognizing that many women say "no" to screening questions for safety reasons or because they may not define their experiences as abusive, can lead to a misinterpretation of low disclosure rates [86].

> "New-found interest in population-based surveys, while positive, leads substantial room for costly methodological mistakes, breaches of ethical standards and other actions that may put women at risk of harm."
> - World Health Organization [338]

According to the Canadian Research Institute on the Advancement of Women, "over the past twenty years, governments have commissioned or funded literally hundreds of studies about violence against women… Government has taken no action on the majority of the recommendations in these hundreds of report." [340]

The selective knowledge exchange from research has allowed the health care system and various levels of government to ignore violence against women or develop policy that pays only lip service to the issue, while potentially perpetuating and exacerbating its impacts. On the other hand, much illuminating research which includes the voices and experiences of women impacted by abuse has not been influential on policy developed in their name.

Tier Five: SAFETY AND HEALTH ENHANCEMENT: Seeing the Big Picture

> "In order to address women's safety, we must shift the responsibility for victim safety away from the victim and on to the wider community."
> - Don Hennessy [101]

Successful health care responses to violence against women will advocate for changes at a societal level by addressing the status of women [34, 135, 260, 300] and related forms of violence women face, including poverty and cultural genocide [341]. A Health Canada commissioned report states that to effectively address woman abuse, we need changes in employment, income, health, education and social services policies, a change in the ways service providers work with one another, and a change in our ways of living and working together [120].

The health care system clearly cannot do this in isolation. It must recognize that violence against women in relationships is not exclusively a health problem. By viewing woman abuse as a complex social issue with implications for women's health and the practice and structures of health care, the health care system can, however, help work towards solutions. Any response

must be developed in collaboration with other sectors and anti-violence women's organisations [86].

Being guided by international policy

According to the World Health Organization, although support and care services for victims are important in mitigating the physical and psychological consequences of violence and reducing individual vulnerability, considerable attention needs to be given to preventing the development and perpetration of violence in the first place [12].

In terms of making real change at the provincial or territorial level, the Committee on the Elimination of Discrimination Against Women (CEDAW) recommends changing fiscal arrangements between the federal Government and the provinces/territories so that national standards of a sufficient level are re-established and women will no longer be negatively affected in a disproportionate way in different parts of Canada [322].

CEDAW also recommends "making gender-based impact analysis mandatory for all legal and program efforts at the federal level and, through, its respective Consultative Continuing Committees of Officials, at the provincial and territorial levels." [322]

Gender-based policy analysis

A critical aspect of developing policy that works to reduce discrimination and violence against women is to analyze its impact on women, especially those most marginalized [12, 322].

According to WHO, gender analysis of policies and policy outcomes is part of the gender mainstreaming process. In the pursuit of gender equality and equity, a two-pronged approach of both adopting dedicated gender policies and giving attention to gender equality and equity in policies usually considered to be gender-neutral will be most effective in safeguarding women's human rights. Equal status may require differential treatment in favour of women to correct inequities arising from the historically unequal power relations between men and women [12].

Gender mainstreaming

The strategy of incorporating gender concerns into all policy is referred to as "gender mainstreaming."

The United Nations Economic and Social Council defines gender mainstreaming as "the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in any area and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension in the design implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres so that women and men will benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality." [342]

According to the UN and WHO, a crucial aspect of gender-mainstreaming is including women who have experienced abuse and their advocates in policy formation, review, and implementation [12, 342].

Participation and representation by relevant interest groups is key to successful policy formation [343]. Because any policy that is developed has the ultimate goal of improving the health outcomes of women

experiencing violence, "participation in the policy making process [should take] place directly by individuals and their chosen community representatives", so that resulting policy takes into account "women's needs, perspectives, and experiences as they are articulated in different racial, class and situational positions." [344]

Multi-sectoral policy development

Both WHO and CEDAW recommend that investing in multi-sectoral strategies for the prevention of woman abuse is not only a moral imperative but also makes sound scientific, economic, political and social sense, given the clear public health dimensions of the problem and its solutions [12, 322].

WHO suggests that "the health sector must advocate not only for improved health services for victims of violence, but also for improved psychological, social and legal services and more effective linkages between these services to make sure the full range of services required by victims is addressed." [12]

National policy

In 2003, Health Canada issued a media release in response to the World Health Organization's recommendations of the world report on violence and health, and its commitment to addressing the nine recommendations [345].

In recent years, the government of Canada has also strengthened its commitment to translate policies at the international level into meaningful changes by agreeing to submit progress reports to the UN Convention on the Elimination of Discrimination against Women on the steps it is taking to ensure equality for women – in both principle and practice – and the future steps required in that regard [322, 346].

As part of this, the government of Canada developed a Federal Plan for Gender Equality, a collaborative initiative of 24 federal departments and agencies, led by Status of Women Canada. The eight objectives of the plan are:

- Implementation of gender-based analyis throughout federal departments and agencies;
- Improvement of women's economic autonomy and well-being;
- Improvement of women's physical and psychological well-being;
- Reduction of violence in society, particularly violence against women and children;
- Promotion of gender equality in all aspects of Canada's cultural life;
- Incorporation of women's perspectives in governance;
- Promotion and support of global gender equality; and
- Advancement of gender equality for employees of federal departments and agencies [323].

As part of this plan, the government of Canada has taken some steps towards putting funding and programs into place to address the issue of violence against women, including the establishment of five national Centres of Excellence' on women's health [345]. However, the funding for the national Centres of Excellence for women's health needs to be secured core funding to be truly effective.

Other key measures taken by the federal government include: the introduction in the 1998 federal budget of a caregiver credit which partially recognizes the unrenumerated work women do; strengthening the federal Employment Equity Act; and a $4.3 million

Shelter Enhancement Program which resulted in upgrading of existing transition shelters [323].

The Canada Women's Health Strategy was also launched, which provides a framework to guide Health Canada in addressing biases and inequities in the health system [323].

Through the Public Health Agency of Canada, a training toolkit on "family violence" is being developed for use by programs funded by the Community Action Plan for Children and Canada Prenatal Nutrition Program. The advisory for this project included women-serving organizations from across the provinces and territories.

In terms of implementing gender-based analyses, "within the federal government, Status of Women Canada (SWC) leads the process of implementing the 1995 gender-based analysis policy, although individual departments and agencies have responsibility for undertaking their own follow-up."[323] It is imperative, however, that gender-based analysis is not simply an option for all departments and agencies but is mandated and supported.

> "Gender-based analysis is a tool for understanding social processes and for responding with informed and equitable options.... [It] challenges the assumption that everyone is affected by policies, programs and legislation in the same way regardless of gender, a notion often referred to as "gender-neutral" policy."
>
> - Status of Women Canada [347]

However, despite a surplus of $13.2 billion in the 2006 federal budget, Heritage Minister Bev Oda announced $5 million in cuts to Status of Women Canada (SWC), about 40% of its annual budget. The cuts were coupled with the closure of most of the federal agency's SWC regional offices as well as changes that will end funding to women's organizations that lobby, advocate or conduct research on rights issues [348].

We can instead look to Spain as an example of a national government translating gender equity policy into legislation which has significantly reduced cases of domestic violence. The government also spent US$71 million in care and social intervention measures, prevention and sensitization measures, legal aid and research. More than 60,000 health care professionals, social workers, teachers, counsellors, police officers, and lawyers have had specialist training in dealing with domestic violence cases. Other initiatives include helping women to get a job because, as the Minister of Work and Social Affairs noted, "a lack of personal autonomy and hence a lack of accessibility to jobs, may be an important factor behind the persistence of domestic abuses." [21]

The government of Spain attributes the success of their ambitious plans in reducing violence against women in relationships in part to the collaboration between the Women's Institute and the Ministries of Justice, Education, and Health, the Home Office, the governments of the autonomous regions, and several non-governmental women's organizations [21].

Provincial policy

Despite cuts to their budgets, various provincial ministries in BC have continued to implement policy guidelines on community coordination, based on a provincial model created by the BC Association of Specialized Victim Assistance and Counselling Programs, with funding support from the National Crime Prevention Centre [349]. This model, Community Coordination for Women's Safety (CCWS)

supports individual and local advocacy and provincial policy development. At CCWS tables, senior officials from various ministries look at systemic and policy-level changes that could help to solve problems identified by front-line workers. Two funded coordinators and one policy analyst facilitate the processes around the province which have resulted in positive changes in various systems for women impacted by abuse [349].

An inter-sectoral model of policy formation, where all of the relevant groups are represented at the policy table, has occurred for the benefit of women impacted by abuse in other areas, as well. In creating guidelines to address child protection concerns in cases of violence against women in relationships for the Ministry of Children and Family Development, several ministries and women's organizations were involved [350]. Training for social workers and women's organizations is currently being developed based on these guidelines.

A report to the British Columbia Ministry of Health recommended that "best practices" for woman abuse are those that support a women-centred framework [62].

The 2004 Advancing the Health of Women and Girls: A Women's Health Strategy for British Columbia also suggests that provincial health strategies would rest on concepts of women being at the centre of their care, recognizing diversity, and promoting equity. Identified strategic priorities include: supporting women-centred approaches to mental health, problematic substance use and addictions; sustaining access to maternity care, and; women-centred research strategies. Policy development is considered an important part of implementing this strategy [351].

Drs. Marina Morrow and Colleen Varcoe have co-authored a guide on violence against women for health authorities, health care managers, providers and planners. It includes sample policy statements that can be modified and adopted at both provincial and local health authority levels [7]. Each policy statement recognizes that violence against women is a social problem with serious health implications, and includes commitment to:

- Developing systemic and sustained responses to support women;
- Ensuring all practice responses are appropriate for the diversity of women;
- Working collaboratively and in partnership with a range of health and community stakeholders;
- Establishing interministerial coordination;
- Supporting further education and training; and
- Evaluating programs and developing indicators of success [7].

Health policy

At the regional health level, the Northern Violence and Health Network has been the first to use Morrow and Varcoe's guide to draft policy for their health region in northern British Columbia. The network is taking steps to have the policy adopted by the Northern Health Authority [352].

The World Health Organization concludes that without real commitment towards systemic change, "one-off" training regarding woman abuse does not create sustainable change in knowledge or practice. "Rather than starting a screening program for intimate partner violence, it might be more appropriate for health workers to enlist the support of communities in changing socio-cultural norms condoning violence and developing programs to empower women, and… their rights" [86].

The World Health Organization also suggests that other policy areas within health that may not seem directly related might still play a significant role in shaping the range and quality of services available to victims of violence. These areas include: abortion; HIV/AIDS prevention, counseling, testing and treatment; treatment for drug and alcohol use; working conditions of service providers; and the general structure of services in terms of their public or private provision, available aid, or fees required [12].

Recognizing that violence is a public health problem that can be prevented by addressing its underlying causes has expanded the role of the health sector. Although the health sector needs to take a role, it must be with the involvement of many other sectors (both within government and among non-governmental and civil society groups), an essential component in building the type of sustained multi-sectoral response required to prevent violence [12].

The coordination of support services is key to enhancing the safety of women who are targets of violence in their relationships [104, 126, 298]. At the agency level, coordination is enhanced by appropriate policies and protocols that are effectively implemented; these policies/protocols should address information sharing within and between agencies, inter-jurisdictional issues, institutional accountability, and administrative issues (i.e., forms and records) [292].

The Powell River 'Finding Common Ground Committee' recently signed off on their protocol document to guide a range of health and community groups in working together around issues of violence against women, trauma and substance abuse. The basis of the policy is to work towards their common goal to increase women's safety [316].

In the United Kingdom, through innovative and positive approaches, the Stella Project works to promote, at both practice and policy levels, the development of inclusive, integrated service provision for survivors and perpetrators of violence against women who experience problematic substance use. The Stella Project supports drug and alcohol and violence against women/anti-violence agencies to effect sustained change in service delivery and outcomes. At a strategic level, the project works to influence and support policy development with the view of catalysing change on the ground. Underlying the project's approach is the belief that where woman abuse and substance use overlap, interventions undertaken in partnership across the sectors will improve the safety of clients and prevent ineffective repeat interventions [236].

Health Canada's Bureau of Women's Health and Gender Analysis includes in its mandate ensuring "that gender considerations are addressed in all departmental programs and policies."[353]

WomanKind staff at hospitals in Minnesota are part of biweekly team meetings on the medical, surgical, and behavioural service units in the hospital. They also participate in lecture series and attend hospital department meetings and influence hospital policies and protocols across the board [157].

An example of a policy change at the health organization level that resulted in increased safety for women experiencing abuse was the development of the Privacy Block Guidelines at BC Women's Hospital. The new guidelines offer all women the opportunity to use an alias without having to identify why. Under the guidelines, information about a woman's presence in the hospital is limited to a list of approved visitors, and

heightened measures are taken to protect the information on her chart. Since the implementation of this policy, the number of women requesting a privacy block has increased ten-fold. Many of these women had a violent partner against which they held a restraining order [354, 355].

Gender-based research

According to Canada's Women's Health Strategy, a population health approach to research is necessary to promote good health through preventive measures and the reduction of risk factors that most imperil the health of women. Population health approaches rest on a body of research demonstrating that a combination of personal, social and economic factors, in addition to health services, plays an important role in achieving and maintaining health [353].

We have a vast amount of data on the prevalence of woman abuse in Canadian society, the health burden arising from it, and the context which perpetuates it, but very little information on the barriers women face in accessing services or the kinds of supports women in abusive relationships need to decrease risks to their safety and health [10].

WHO suggests holding focus group sessions with community members and potential service users (taking particular care to include groups that are marginalized within their community and/or experience a high incidence of violence) to identify any barriers to accessing services [12].

Research can offer important opportunities for abused women to have a say in defining what success should mean in terms of health care interventions, and their related policies and protocols [86, 294, 327, 341, 356, 357].

Rather than focusing on identification and referral rates, research into women's experiences of health care suggest that the success of health care responses to woman abuse should be measured by their quality (i.e., the extent to which health care encounters provide protective measures for abused women). This translates into criteria of program success being reframed and evaluations of programs becoming more sophisticated and moving beyond tallies of the women asked, identified and referred for woman abuse [10].

> "Evaluation of women-centred care practice is critical for policy makers so that future policies can be built upon what has been learned. Research that takes a gendered approach and uses data to describe the context of women's lives, rather than solely counting the number of clients, is crucial for all concerned."
> – Robin Barnett [3]

WHO states that promoting the primary prevention of violence involves encouraging and supporting the development, implementation and evaluation of programs explicitly designed to stop its perpetration. Feeding the results of these efforts into the policy process will ensure that lessons learned from experience, and rooted in local realities, will bring maximum benefit [12].

WHO and CEDAW also recommend "mainstreaming" violence prevention in research, that is, the integration of violence prevention research into national research agendas for health and other science disciplines [12, 342].

The BC Centre of Excellence for Women's Health (BCCEWH) has an explicit mandate to incorporate gender in all of its research agendas. As one example, the BCCEWH

administers the Integrated Mentor Program in Addictions Research Training (IMPART) which incorporates issues of sex and gender into addictions research. Training and mentorship for the participants of the multi-disciplinary program includes looking at the intersection of violence and abuse with women's use of substances. The mandate of the program also includes a focus on the important connections between practice, research, and policy [351].

Linking policy and research

The World Health Organization spells out the ethical obligations of researchers and funders to help ensure that their findings are interpreted properly and used in the development of policy and relevant interventions [338].

WHO recognizes that research can play an important role in how we understand an issue, the policies and programs that are developed, and our understanding of the impact of policy on violence [12].

In its guide to implementing the recommendations of the World Report on Violence and Health, WHO suggests monitoring policy-driven interventions, such as social welfare grants for families with income below the poverty line, universal access to primary and secondary education, and job-creation programs, in order to address the underlying risk factors for violence and help to reduce the magnitude of the problem [12].

CEDAW "urges the government of British Columbia to analyze its recent legal and other measures as to their negative impact on women and to amend the resources, where necessary." [330] Research evaluating the degree to which the provincial government has taken up this recommendation could contribute to advancing the safety of women.

At the health system level, "we need to carefully and regularly monitor the risk to the woman of the system in which our intervention is set." [101] The possibility of compounding harms demands that we integrate an overall response in a way that holds both the system and the provider accountable to women's safety. While it may be difficult to assess prevention of woman abuse directly, researchers can measure proxies such as decrease in isolation and economic and political inequality [66].

WHO recommends policy audits and situational analyses [12]. Characterizations of women impacted by abuse in their medical charts could be observed for changes in stereotypes or assumptions about women in abusive relationships. The involvement of health care providers in community co-ordination is a measure of the involvement of the health care system in the larger community movement to end violence against women. The promotion of more women and minorities to decision-making positions within health care can be a proxy measure for the dismantling of hierarchies on the basis of gender, race or other factors. The adoption of women-centred policies and protocols can be a measure for organizational support for women-centred care. These, and many other indicators, could be collected and analyzed to measure systemic and contextual changes [10].

Conducting safety audits

Safety audits for risks to women have not, to our knowledge, been conducted in the health sector. However, Ellen Pence, researcher and author of numerous safety audits across North America has developed a methodology and template for conducting audits in legal and child protection systems [299].

Pence observes that safety audits have a record of creating change in institutions by identifying and decreasing systemic risks to women's safety and attending to women's safety first. The power of safety audits is that they can expose the sources of contradictory and counterintuitive outcomes in a system designed for health and safety but which too often fails on both accounts [299].

The audit team includes institutional and community-based advocates. Pence notes that, in recent years, advocates have expressed their interest in working with and within legal and social service systems [299]. Conducting safety audits is one way to work across sectors to reveal the threats and opportunities related to women's safety.

In a safety audit, the reference point is women's safety. This helps to focus the efforts of the audit team on the fit (or lack of fit) between a woman's experience as a victim and the institution's constructions and reformulations of her situation as a case to be processed and resolved by those institutions [299].

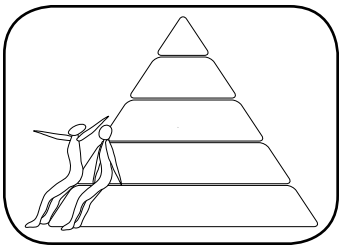
Audit questions usually reflect questions about "how" routine practices and beliefs came about. Typical questions include:

- How are workers organized to think about and act on a particular kind of case in ways that bring about unintended, unfair, or harmful results?
- How is a woman's safety accounted for in such a process?
- How are victims of battering made safer or more vulnerable by the actions of the interveners?
- How does victim blaming occur in policy or procedures of the system? [299]

Safety audits are focused on understanding and changing structures. They are not performance appraisals. When the actions of individual practitioners are organized due to institutional rules, the individual should not be held responsible for the problems or for transforming the problem. This is the role of the institution.

In the next chapter, we draw on the knowledge generated from the use of safety audits in other systems to develop a toolkit specifically for use in the health system. The process of analyzing a health setting's policy, programming and practice for its potential to compound harms is a significant step towards transforming the care we provide, such that it serves only to enhance women's health and safety.

IV chapter four



IV. SHE Toolkit

The *SHE Toolkit* is a structured risk/safety assessment process to identify and eliminate harms for women experiencing abuse and to implement proven or promising safety and health enhancement measures. The *SHE Toolkit* has been developed as a step-by-step guide for a team of health care providers, planners and policymakers and their community partners to identify compounding harms within their health care setting, using the two contrasting models to guide the process. Any health care setting can embark on this review process – a clinic, a unit of a hospital, an entire institution, a provincial program, even a health region. Essentially, this review process is about transforming practices and policies from the *Compounding Harms Model* into the righted *SHE Model* to enhance the safety and health of women who have been impacted by abuse.

> "A gap between women's experienced reality of violence and institutional reality is potentially produced in each and every case management step in processing a case. The opportunity for institutions to create reality rather than to respond to the empirical social world of victims is great."
> - Ellen Pence [81]

The Safety and Health Enhancement (SHE) Process will take between six months and one year to complete and has four major components:

A. Establishing the Safety and Health Enhancement Team;
B. Using the *SHE Models* and *Evidence Paper* to guide the identification of compounding harms relevant to the health setting under review;
C. Developing a Safety and Health Enhancement Action Plan for the team's health setting; and
D. Implementing the Safety and Health Enhancement Action Plan in both the short- and long-term.

A step-by-step description of each of these components is found in The Steps of the SHE Process section below.

Why conduct a Safety and Health Enhancement (SHE) Process?

> "By using the safety and accountability audit[7] as a method of seeing how unintended and harmful case outcomes are produced in the complex maze of multi-agency interventions, advocates and reform activists have been able to deepen their focus on women's safety."
> - Ellen Pence and Martha McMahon [299]

The *SHE Toolkit* guides a team of practitioners through a review of their health care setting using the illustrated contrasting models - *Compounding Harms* and *Safety and Health Enhancement* - as a guide. Each of the five tiers within these models pinpoints priority areas for review, assessment and action. The SHE Process is always conducted from the perspective of women impacted by abuse, which guides the SHE Team to uncover the sources of risk in the system and point to safety and health enhancing measures. The focus is on the fit, or lack of fit, between her experience as a woman being abused and the institution's interpretation of her situation as a case to be treated.

> "Adopting a standpoint grounded in the experiences of the battered woman herself diverts

7 The concept of conducting Health and Safety Enhancement audits draws on the extensive work of Dr. Ellen Pence, whose work in safety audits spans decades and has a history of positive results in the legal and child protection fields. We have adapted this approach for the health care system in the SHE toolkit.

> the team from the common tendency to want to address the legal, bureaucratic, and professional structures of the organization as a whole or to critique the idiosyncratic actions of individuals within the system. Instead, the attention is on institutional processes. It traces institutions as sequences of organizational activity. This is the audit's innovative contribution. "
> - Pence and McMahon [299]

Benefits of the SHE Toolkit

Two goals of the Safety and Health Enhancement Process are to:

- Assess dimensions of risk within each of the five tiers of the models, keeping a central focus on women's safety; and
- Increase protective measures in order to improve health and safety outcomes for women.

Two major tasks of the Safety and Health Enhancement Process are to:

- Locate where enhanced health and safety can be built into the system; and
- Translate safety and accountability into concrete practices [298].

The SHE Process:

- Provides a process for reviewing institutional ways of organizing and coordinating work to identify unintended outcomes that may not be visible or known to health care providers. Focusing on institutional transformation takes the focus off individual health care providers' performance. The SHE approach is about reviewing the process, not the people;
- Identifies systemic practices which overshadow individual safety needs of women and jeopardize the safety and health enhancement of women;
- Describes the ways in which women experience violence and ways in which agencies take up those experiences as cases to be treated;
- Creates a dialogue between representatives of the health institution, women-serving organizations, and the women whose lives are being treated;
- Helps to close the gap between the perspectives of women experiencing abuse and the health sector; and
- Enables health care providers, planners and policy makers to create safer environments and practices for women experiencing abuse.

The steps of the SHE Process

The SHE Process requires the commitment of a small group of dedicated individuals with the belief in and ability to enact the transformation of their health setting into one better equipped to enhance the health and safety of women impacted by abuse.

The 16 Safety and Health Enhancement Steps include:

A. Establishing the Safety and Health Enhancement (SHE) Team

STEP 1 Identify potential team members and share the SHE Framework
STEP 2 Determine Safety and Health Enhancement (SHE) Co-Coordinators
STEP 3 Initial meetings – Discuss process and establish commitment
STEP 4 Initial meetings – Reach agreement on Consensus Statements

B. Using the SHE Models and Evidence Paper to guide the identification of compounding harms

STEP 5 Team members take away *SHE Models* and *Evidence Paper* for in-depth review
STEP 6 Team meets to identify and discuss compounding harms in the health setting related to Tier 1: Violence Against Women
STEP 7 Team meets to identify and discuss compounding harms in the health setting related to Tier 2: Health Impacts

STEP 8 Team meets to identify and discuss compounding harms in the health setting related to Tier 3: Access to Health Care

STEP 9 Team meets to identify and discuss compounding harms in the health setting related to Tier 4: Health Practices

STEP 10 Team meets to identify and discuss compounding harms in the health setting related to Tier 5: Policy and Research

STEP 11 Coordinator(s) compile(s) master list of compounding harms for all five tiers onto the Rating Risk and Feasibility Worksheets

C. *Developing a Safety and Health Enhancement Action Plan for the team's health setting*

STEP 12 Team meets to discuss and rate the "risk" of each compounding harm (identified in STEPS 6-10) and identify and rate the "feasibility" of safety and health enhancement measures for each of the identified harms

STEP 13 Between meetings, co-coordinators order the safety and health enhancement measures based on ranking and transfer them into the Safety and Health Enhancement Action Plan

STEP 14 Team meets to review the priorities listed in the Safety and Health Enhancement Action Plan and determine implementation steps, responsibility and timeline

D. *Implementing the Safety and Health Enhancement Action Plan in both the short- and long-term*

STEP 15 Team implements short- and long-term action items

STEP 16 Team continues to meet for follow-up and to review implementation process.

These steps are described in greater detail below, using examples from our pilot in mental health and addictions services in the community of Powell River, British Columbia.

A. Establishing the Safety and Health Enhancement (SHE) Team

The first four steps are undertaken in order to establish a team comprised of individuals from the health sector and anti-violence agencies.

STEP 1 Identify potential team members and share SHE Framework

In all likelihood, the SHE Framework has come to the attention of one or a few people who see the immense value in this process. The goal now is to identify allies in both the health and anti-violence women's sectors who share an understanding of the dynamics of woman abuse, who are interested in and able to participate in such a process, and who represent a range of perspectives from front-line workers to decision-makers. Partnerships that already exist can be built on, and other relationships may need to be initiated. It is key that practice and protocols are analyzed by those involved in using them, that the people responsible for making changes within a health area are present and supportive, and that the experiences of women in abusive relationships are brought forward by advocates from community-based anti-violence organizations.

Examples from Powell River…

In Powell River, the need for the SHE Process was initially identified through the Health Subcommittee of the local Coordinating Committee on Women's Safety. That first group then asked themselves "Who else needs to be here?", keeping in mind the need for participants from within the health sector and anti-violence organizations, as well as representation from front-line and management.

The group should be large enough that appropriate representation is achieved and the workload can be shared, but not so big that dialogue and consensus-building becomes difficult. We suggest between 6 and 12 team members.

Examples from Powell River…

In Powell River, there were eight team members, who represented front-line and managerial positions in addiction and mental health services, Specialized Victim Support Services, Stopping the Violence outreach, and the local transition house.

Sharing the SHE Framework, or the pamphlet developed from it, with potential team members will be useful in giving them an idea of the process that will be undertaken and the guiding models that will be used.

It may also be helpful at this stage to host a workshop in your community or health area on the SHE Framework in order to raise awareness and identify interested team members.[8]

STEP 2 Determine Safety and Health Enhancement (SHE) Team Co-coordinators

It is important to have dedicated people responsible for coordinating the team. Responsibilities include setting up meetings, facilitating the process, and compiling documents based on information gathered at the meetings, and sharing those documents with the team. We suggest having two co-coordinators, one from health and one from the anti-violence women's sector, sharing the responsibility.

Ideally, the coordinators would have the support of their supervisor/institution to include this work as part of their job description rather than "working off the side of their desk".

Alternately, the coordinating responsibilities could be rotated amongst team members, who would take turns organizing meetings, facilitating the group process and compiling and distributing documents.

STEP 3 Initial meetings – Discuss process and establish commitment

The first meeting with potential team members is the opportunity for everyone to ask questions, discuss potential opportunities and challenges, share their vision of the process and outcomes, and determine commitment to using the *toolkit*. If it is determined that not all the necessary people are at the meeting, this is an opportunity to identify and invite additional members.

It may be useful to invite the SHE Framework's authors to this first meeting to answer questions potential team members may have.

The process will involve at least eight meetings, including the initial meetings, with some work to be done between most of the meetings. Meetings can be scheduled at intervals that work best for the team and so that all team members can participate in all meetings. A good schedule of meetings will be frequent enough to allow for team members to complete the required work between meetings but not lose the momentum of the process.

Once established, the Powell River SHE Team met approximately once a month for three hours for a period of seven months, with almost full attendance at each meeting.

In this first meeting, it is important that the scope of the health setting under review is determined. This will ensure that the team is clear on what aspects of health care they should be thinking about when working through each of the tiers. Once established, this can be added to the SHE Coversheet (Appendix B), along with the SHE Team's starting date, members and coordinators.

It is also imperative to discuss group process and decision making. Decisions must be made at this point regarding

8 Please contact the Woman Abuse Response Program to set this up.

the level of participation expected of each other and how the team will share information outside of the process. Mutual respect and equal acknowledgment for each team members' unique contribution is vital to the success of the process, given the mandate to redress imbalances of power within health care and between sectors. Notes specific to the SHE Team's discussion about each topic can be compiled by the coordinators in the spaces provided on the SHE Coversheet.

Group commitment to:
» ***confidentiality within the team*** *notes:*
» ***how consensus will be reached*** *notes:*
» ***participation in the process*** *notes:*
» ***the use of materials and outcomes*** *notes:*
» ***respect for the knowledge and experience of each team member*** *notes:*
» ***equality amongst team members*** *notes:*

STEP 4 Initial meetings - Reach agreement on Consensus Statements

This step can happen as part of the first meeting or as a stand-alone meeting.

The Consensus Statements will determine the core commitments and guiding principles of the team. Establishing a common understanding about violence against women and how the group works together prior to embarking on the SHE Process will create a safe and productive SHE Team. Therefore we encourage the group to spend as much time as necessary discussing and reaching agreement on the Consensus Statements. We have provided a number of statements that reflect what is essential in the SHE Process and encourage you to revise and refine as necessary and add what you feel is missing to reflect your unique community and team.

The Consensus Statement worksheet (Appendix C) is divided into two columns. The left column includes the proposed consensus statements. The right column reflects key points that we hope you will consider in the discussion of each statement. Coming to consensus on these underlying principles is key to the success of the SHE Process.

Our suggested Consensus Statements[9] include:

CONSENSUS STATEMENTS
Woman abuse advocates and health care providers who have initiated and joined this process are allies and bring a wealth of knowledge that will contribute to the SHE Process.
The SHE approach is about reviewing your health setting, not reviewing individuals and their practice. In identifying compounding harms and potential risks, there is no implication of intentional harm and rarely a single reason for unintended outcomes.
Women's reality of experiencing violence and abuse are complex and must be central to the SHE Process.
Woman abuse is rooted in gender inequality.
Women are not responsible for the abuse they are experiencing.
Improving women's safety in health encounters and health settings is the primary goal of the SHE Process.
Change takes time.

9 Adapted from Pence and McDonnell [298]

Revisions to the Consensus Statements can be recorded by the coordinators to compile and distribute to team members for final agreement along with the completed SHE Coversheet.

B. Using the SHE Models and Evidence Paper to guide the identification of compounding harms relevant to the health setting

In the next seven steps, the team explores the *SHE Models* and *Evidence Paper* in-depth. Guided by the *SHE Evidence Paper*, the team members identify compounding harms within the health setting under review. This process will be employed for each of the five tiers, one meeting per tier.

The coordinators will compile the compounding harms on the Rating Risk and Feasibility Worksheets (Appendix D) and are also encouraged to track any safety and health enhancement measures and actions that are proposed, all of which will be used in Step 12.

STEP 5 Team members take away SHE Models and Evidence Paper for in-depth review

Team members will now take the SHE Framework away with them for in-depth review. If they have not done so already, members will read the introductory chapters, including the overview of the *Compounding Harms* and *Safety and Health Enhancing Models*.

Each member will then work through Tier 1: Violence Against Women in the *Evidence Paper*, making note in the spaces provided down the sides of the pages where evidence is relevant to the health area being examined. Team members can use the examples indicated in the evidence for compounding harms to assess whether aspects of their health setting have the potential to compound the harms experienced by women in abusive relationships. While reviewing the Safety and Health Enhancement section of the tier, notes can be made of promising safety and health enhancement measures that are already in place in the health area.

Throughout the examination of each of the five tiers, team members can use a variety of methods for examining the health setting, such as:

- Reviewing forms;
- Examining how the activities of practitioners shape individual interchanges;
- Reading charts to understand how documentation reflects interactions and health care providers' assumptions about women;
- Reflecting on routine practices and procedures and the culture of the health setting;
- Reviewing policies and manuals; and
- Observing the physical environment.

Anti-violence workers can reflect on health care experiences of women they have supported, as well as on their own services in terms of risks and safety measures.

STEP 6 Team meets to identify and discuss compounding harms in the health setting related to Tier One: Violence Against Women

The goal of this meeting is to generate a list of Tier One compounding harms for the health setting under review. We suggest a minimum of a two-hour meeting. In our experience these meetings serve an educational purpose for the team as well as an opportunity to discuss the compounding harms identified.

The team may also want to invite the authors of the SHE Framework to this meeting to help guide the process and facilitate discussion about violence against women.

Team members will bring in notes from their in-depth review of Tier One in the *Evidence Paper* to share and discuss. Working through the tier together, the team will generate a list of compounding harms, to be put in the first column of the Tier One Rating Risk and Feasibility Worksheet (Appendix D). We suggest that the coordinators use a blank template, such as a flipchart, to record all of the identified risks. The coordinators can them input this into an electronic copy which will be disseminated for STEP 12.

Examples from Powell River…Tier One: Violence Against Women				
COMPOUNDING HARMS	***RISK High/Urgent (3) Moderate (2) Low (1)***	***SAFETY & HEALTH ENHANCING MEASURES***	***RISK High/Urgent (3) Moderate (2) Low (1)***	***TOTAL***
Women feel judged regarding their personal experiences related to mental health and substance use	RISK RATING		FEASIBILITY RATING	
Women and health care providers do not always understand the dynamics of abuse, power and control	RISK RATING		FEASIBILITY RATING	

Coordinators will compile and keep the team's list, and may need to keep a 'parking lot' of compounding harms that relate to other tiers as well as any safety and health enhancing measures to be applied later.

The team then goes away and repeats the process for Tiers Two - Five, meeting to discuss each tier separately.

STEP 7 Team meets to identify and discuss compounding harms in the health setting related to Tier Two: Health Impacts

Again, the team meets to discuss and generate a list of compounding harms identified in this tier for the health area under review.

Example from Powell River…Tier Two: Health Impacts				
COMPOUNDING HARMS	***RISK High/Urgent (3) Moderate (2) Low (1)***	***SAFETY & HEALTH ENHANCING MEASURES***	***RISK High/Urgent (3) Moderate (2) Low (1)***	***TOTAL***
Health care providers and women don't fully understand health impacts of abuse.	RISK RATING		FEASIBILITY RATING	
Links between woman abuse, substance use and mental health are not always made eg. what health care providers see as primary, women may see as secondary and vice versa	RISK RATING		FEASIBILITY RATING	

STEP 8 Team meets to identify and discuss compounding harms in the health setting related to Tier Three: Access to Health Care

Again, the team meets to discuss and generate a list of compounding harms identified in this tier for the health area under review.

Examples from Powell River...Tier Three: Access to Health Care				
COMPOUNDING HARMS	**RISK High/Urgent (3) Moderate (2) Low (1)**	**SAFETY & HEALTH ENHANCING MEASURES**	**RISK High/Urgent (3) Moderate (2) Low (1)**	**TOTAL**
Women want support groups but don't want to go through a mental health intake and have a mental health diagnosis.	RISK RATING		FEASIBILITY RATING	
Women are hesitant to call police or access health care.	RISK RATING		FEASIBILITY RATING	
Health care parking lot in a small community cannot maintain confidentiality, security or anonymity. Therefore, women can't safely access health care setting.	RISK RATING		FEASIBILITY RATING	

STEP 9 Team meets to identify and discuss compounding harms in the health setting related to Tier Four: Health Practices

Again, the team meets to discuss and generate a list of compounding harms identified in this tier for the health area under review.

Examples from Powell River...Tier Four: Health Practices				
COMPOUNDING HARMS	**RISK High/Urgent (3) Moderate (2) Low (1)**	**SAFETY & HEALTH ENHANCING MEASURES**	**RISK High/Urgent (3) Moderate (2) Low (1)**	**TOTAL**
Charting, creating permanent medical records may be a problem when used as legal notes.	RISK RATING		FEASIBILITY RATING	
Look for symptoms and interpret symptoms from a mental illness paradigm which may result in treating secondary problems and not addressing primary issues or safety concerns.	RISK RATING		FEASIBILITY RATING	

STEP 10 Team meets to identify and discuss compounding harms in their health setting related to Tier Five: Policy and Research

Again, the team meets to discuss and generate a list of compounding harms identified in this tier for the health area under review.

Examples from Powell River...Tier Five: Policy and Research				
COMPOUNDING HARMS	***RISK High/Urgent (3) Moderate (2) Low (1)***	***SAFETY & HEALTH ENHANCING MEASURES***	***RISK High/Urgent (3) Moderate (2) Low (1)***	***TOTAL***
Provincial Post-partum Depression Framework doesn't include link between violence against women and mental health.	RISK RATING		FEASIBILITY RATING	
Health research is focused on quantitative data. It is difficult to get funding for qualitative research to investigate women's health care experiences and needs.	RISK RATING		FEASIBILITY RATING	
The Canadian criminal code doesn't include psychological abuse, making these forms of abuse and their health impacts less visible.	RISK RATING		FEASIBILITY RATING	

STEP 11 Coordinators compile master list of compounding harms for all five tiers onto the Rating Risk and Feasibility Worksheets

After the team has met to review each of the five tiers, the coordinators can compile all of the compounding harms onto the Rating Risk and Feasibility Worksheets (Appendix D).

C. Developing a Safety and Health Enhancement Action Plan for the team's health setting

The next three steps guide the team through the prioritizing of risk reduction, identifying and ranking feasibility of corresponding safety and health enhancement measures using the Rating Risk and Feasibility Worksheets (Appendix D) and the development of a Safety and Health Enhancement Action Plan (Appendix E).

STEP 12 Team meets to discuss and rate the "risk" of each compounding harm (identified in STEPS 6-10) and identify and rate the "feasibility" of safety and health enhancement measures for each of the identified harms

At this meeting, each team member has a copy of the Rating Risk and Feasibility Worksheets which the coordinator has compiled. This enables the team to see the entire list of compounding harms they have generated over the past five meetings for each of the tiers. The team will go through the list together, deciding for each compounding harm the level of risk it poses to women experiencing abuse: (3) for high risk or urgent issue, (2) for moderate risk, and (1) for low risk to women. Each team will define these a little differently but just need to remain consistent throughout the process.

Next, the team can start identifying safety and health enhancement measures for each of the identified harms. Most likely, throughout the previous steps team members have identified possible safety measures which the coordinators have been keeping track of. These can now be revisited and transferred onto the Rating Risk and

Feasibility Worksheets. Once the list of safety and health enhancement measures is completed, the team can begin to rank the feasibility of each measure. For each safety and health enhancement measure the team will assign a feasibility rating: (3) for completely do-able, (2) for challenging but still possible, and (1) for unlikely or not possible. Again, each team will define these a little differently but just need to remain consistent throughout the process.

When assessing feasibility it is important to take into consideration a number of factors, such as:

- The time line required for implementing the identified SHE measure (short or long term);
- Available resources, both financial and human capital;
- Capacity of health setting to implement measure;
- Support of management and decision makers; and
- Willingness of relevant stakeholders to be involved.

Thus, every compounding harm listed should have a corresponding safety and health enhancement measure. If safety and health enhancement measures were identified through the team's review of the tiers that do not relate to an identified compounding harm, the team can now identify the compounding harm that these safety and health enhancement measures are addressing, and add them to the second column of the worksheet.

An example from the Powell River SHE Team's worksheets:

Examples from Powell River…Worksheet: Rating Risk and Feasibility

COMPOUNDING HARMS	***RISK High/Urgent (3) Moderate (2) Low (1)***	***SAFETY & HEALTH ENHANCING MEASURES***	***RISK High/Urgent (3) Moderate (2) Low (1)***	***TOTAL***
Women feel judged regarding their personal experiences related to mental health and substance use	2	Throughout interaction, emphasize woman's strengths and what she is doing to stay safe	3	5
Women and health care providers do not always understand the dynamics of abuse, power and control	3	Provide pamphlets outlining broader health impacts of abuse Education and training for nurses and doctors	3 2	6 5
Women hesitant to call police or access health care	3	Training for police Ensuring nurses and physicians involve police only with women's permission.	1 2	4 5
Charting, creating permanent medical records that may be a problem when used as legal notes	3	Grand rounds video conference on charting, based on *Reasonable Doubt*	3	6
Post-partum Depression framework doesn't include violence against women	3	Colleagues at BC Women's to arrange meeting with Reproductive Mental Health to discuss framework.	2	5

STEP 13 Between meetings, co-coordinators order the safety and health enhancement measures based on ranking and transfer them into the Safety and Health Enhancement Action Plan

For each of the ranked compounding harms and its corresponding safety and health enhancement measures, the coordinators add up the total. The safety and health enhancement measures are then transferred onto the Safety and Health Enhancement Action Plan (Appendix E) based on their total rank, in order from the highest number to the lowest.

From Powell River's example worksheets, the priority list would be:

- Provide pamphlets outlining broader health impacts of abuse (6 POINTS)
- Grand rounds video conference on charting, based on Reasonable Doubt (6 POINTS)
- Throughout interaction, emphasize woman's strengths and what she is doing to stay safe (5 POINTS)
- Education and training for nurses and doctors (5 POINTS)
- Ensuring nurses and physicians involve police only with women's permission (5 POINTS)
- Colleagues at BC Women's to arrange meeting with Reproductive Mental Health to discuss framework (5 POINTS)
- Training for police (4 POINTS)

Thus, the safety and health enhancing measures which address the greatest risks to women and which are most feasible to implement are at the top of the list. Actions which either address a lesser risk to women or which are determined by the team to be harder to implement (ie. providing training to police in the case of Powell River) are lower down on the list. It is important, however, that none of the items are actually dropped from the list, only ranked in order of priority.

STEP 14 Team meets to review the priorities listed in the Safety and Health Enhancement Action Plan and determine implementation steps, responsibility and timeline

At this stage, the team meets to discuss how to put the prioritized safety and health enhancement measures into action. For each item, the team decides on the steps required to implement the action, the person responsible for taking the lead on it, and the dates different steps will be complete. An example from Powell River:

Examples from Powell River…WORKSHEET: Safety and Health Enhancement Action Plan

Safety and Health Enhancing Measures *(transferred from Risk and Feasibility Worksheet)* ***(What will be done?)***	***Implementation*** ***(How will it be done?)***	***Responsible Agency/ Person*** ***(Who will take the lead?)***	***Timeline*** ***(When will it be done?)***
Provide pamphlets outlining broader health impacts of abuse	Review & update resource material and information in waiting room Create pamphlets and have copies of book *When Love Hurts*	Stopping the Violence, Specialized Victim Support Services & Transition House MHAS Team	February 2007
Grand rounds video conference on charting, based on Reasonable Doubt	Plan education for all staff re: accurate charting & duty to report with possible panel discussion including RNABC, VCH Legal, BC Women's Hospital	Woman Abuse Response Program MHAS Team Vancouver Coastal Legal Dept.	May 2007
Throughout interaction emphasize woman's strengths and what she is doing to stay safe	Train ER nurses & physicians to shift from medical model to women centred care approach Focus on harm reduction, women-centred care, safety first by MHAS staff Discuss at regular Tuesday team meetings to ensure ongoing focus on women's safety	WARP MHAS Manager MHAS Manager and Team	May 2007 Ongoing Ongoing

If safety and health enhancement measures already in place in the health setting were identified during the review of the tiers, these can be included in the plan and marked 'completed' in the timeline. It is important to recognize and build on the work that may already be underway in enhancing the health and safety of women impacted by abuse.

D. Implementing the Safety and Health Enhancement Action Plan in both the short- and long-term

STEP 15 Team implements short- and long-term action items

This is the most important step, yet the most difficult to describe how to do. The unique Action Plan each team has created for their specific health setting will require very different approaches for implementation. What is key, however, is the commitment each team member and their respective organization maintains in continuing to further the goals of the plan in both the short and long-term.

In Powell River, the SHE Team will continue to meet as part of the Health Subcommittee of the local Coordinating Committee for Women's Safety to report on continued successes.

The team may want to prepare a report on its Safety and Health Enhancement Action Plan for wider distribution within the health setting, and to invite more people to participate in implementing the identified changes.

We hope that you will share your plan with us and with other health settings who are undertaking the SHE Process.

STEP 16 Team continues to meet for follow-up and to review implementation process.

To ensure the continued commitment and overall success of the SHE Team in implementing their Safety and Health Enhancement Plan, the team should continue to meet at regular intervals for follow up and check in. This will provide team members with an opportunity to collectively problem solve any barriers to implementing the actions that arise as well as for sharing successes.

Conclusion

We commend you for working to make a difference in the lives of women who have been impacted by abuse and violence and who continue to suffer the health consequences. You will note that the Powell River SHE Team considered the SHE Process simply the beginning of addressing what is needed for women's safety in health care. The process of transforming health care to better support women's safety and health is one that will continue indefinitely. We hope that the SHE Framework has been a useful guide in helping you to start this process or simply supporting a process that was already underway.

Finally, we leave you with some of the positive outcomes reported by the Safety and Health Enhancement Team in Powell River through participating in the SHE Process in their mental health and addictions service area:

> "It was validating to find common ground between community workers and mental health and addictions services and to acknowledge the connection between mental health, substance use and woman abuse."

"This process has made me really think carefully about how the practices and policies in the program I coordinate might create additional harms and barriers for women."

"The SHE Process has made me examine my assumptions about abused women and I will hold dialogue with my agency on identifying established practices that may be echoing the dynamics of abuse and re-traumatizing the women we serve."

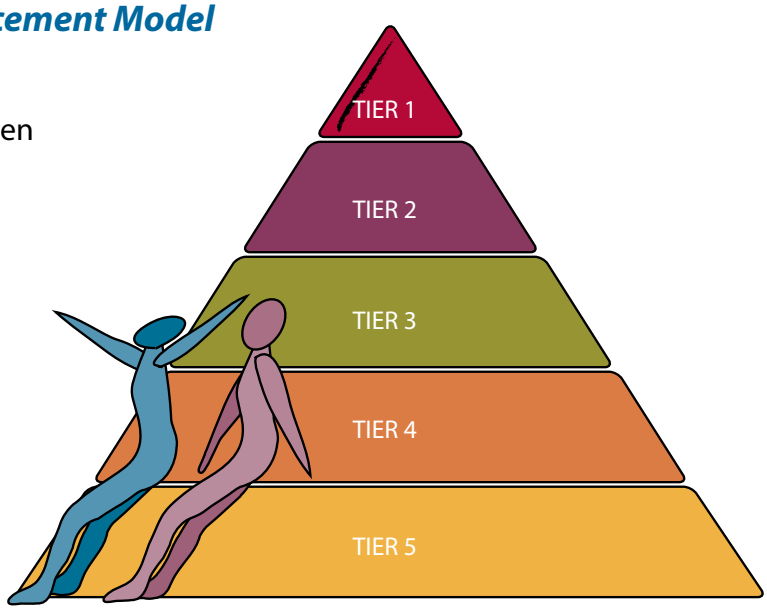
"I have learned the importance of decreasing the barriers in all aspects of service to abused women and the need for addressing policy and research to create systemic change."

"I have realized how important it is to work with other sectors, because we are often serving the same woman."

"The SHE Process has motivated me to work towards a women-centred approach in our services."

Safety and Health Enhancement Model

TIER 1 Violence Against Women
TIER 2 Health Impacts
TIER 3 Access to Health Care
TIER 4 Health Practices
TIER 5 Policy and Research



"The problem of violence against women is enormous and troubling. There are no easy answers. The health sector cannot solve it alone. Still, with sensitivity and commitment, it can begin to make a difference."

- World Health Organization [81]

Afterword

We embarked on this project because we saw that the health system lacked the necessary models to truly incorporate women's experiences of abuse and was therefore not attentive enough to women's safety needs. Our thinking has continued to evolve since we first made these observations and began writing the SHE Framework. So, too, has the field evolved. Impressive contributions have come from health organizations that have made the links between gender-based violence and health and who view violence against women as rooted in gender inequality in our society. Women's health research is also contributing to our knowledge about the enormous health burdens that women bear and the barriers they face as a result of being subjected to abuse, emphasizing important health sector responsibilities. The SHE Framework cannot capture all the evolving evidence, but it does provide the analytic structure for measuring the contribution of new research. Using the SHE Framework, additional or emerging evidence can be evaluated through the lens of the *Compounding Harms* and *Safety and Health Enhancement Models* to assess its merits. In our quest for evidence-based practice, we must also not forget about practice-based evidence.

One thing is clear from the evidence: we cannot continue to focus on individual women and on micro-level practices. We can no longer justify the promotion of practices that focus on women changing their circumstances by themselves. We must use our positions of knowledge, privilege and decision-making to support system-level change, to be more accountable to women and their safety.

Still, the health sector continues to grapple with the question of whether to implement micro-level practices. Recently, at an international health and violence conference we attended, screening for woman abuse was still a primary discourse. At the same time,we were excited to hear new discourses emerging that focused more on women's safety and on macro-level practices. However, we saw that the desire on the part of many researchers and practitioners to look at new practices and ideas still seemed constrained by the idea that rejecting screening as an intervention would mean we were doing nothing. We hope that the SHE Framework demonstrates that there is much we can do and that the work must be directed at all levels of health care to find solutions. If we are truly interested in enhancing women's safety and health, the SHE Framework confirms that we must include macro-level changes.

The *SHE Toolkit* was created because we know it is not enough to have evidence. We must take action. Evidence must make an actual contribution to women's safety. There are flaws in the system, but there is also much hope. We have documented many promising policies, practices and programs. Compiling this information in the SHE Framework is the start of transforming evidence into action. Ultimately, however, it will be SHE Teams who take the knowledge and evidence from the SHE Framework and transform their work and the health system. This will move the health sector towards the goal of providing safe health care for women impacted by abuse.

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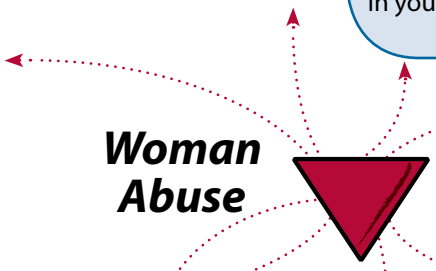
HANDOUT: How is SHE relevant to my practice?



Substance use

» Many women with substance use problems have experienced physical and sexual abuse either as children or adults[1]

» Substance use may represent an abused woman's strategy for coping with distress or it may reflect pressure from the abuser to consume substances with him

» Women in abusive relationships are more likely to be inappropriately prescribed medication than women not experiencing abuse

Mental health

» Violence and trauma are higher in both mental health inpatient and outpatient populations[2]

» A BC study which surveyed women at Riverview Hospital found that 58% had been sexually abused as children[3]

» Abusers often describe a woman as mentally ill to minimize or discredit her concerns.

Youth clinics

» Young women are at a higher risk of violence and of being killed

» 54% of girls under age 16 have experienced some form of unwanted sexual attention; 24% have experienced rape or coercive sex; 17% have experienced incest[4]

» Dating violence and sexual assault have been linked to eating disorders in young women[5]

Sexually Transmitted Infections

» Women are often unable to negotiate safe sex practices with their partners

» Women impacted by abuse, including sexual assault, are at increased risk of being infected by HIV/AIDS and other STI's by an abusive partner

» Rates of gonorrhea and chlamydia are highest among teenage girls between 15 and 19 and the highest rate of increase in HIV/AIDS diagnoses is among young women.[6]

Emergency

» Physical violence can result in bruises, lacerations, abrasions, burns, sprains, fractured bones, broken teeth, choking, head injuries, and internal abdominal injuries

» Long wait times and routine admission assessment questions may deter women from accessing health care

Injury prevention

» In an average year in Canada, it is estimated that about 200,000 women are threatened, slapped, kicked, punched, choked, beaten, or sexually assaulted by their partners[8]

» Chronic pain at the site of previous injuries is common for women who have experienced abuse. Long-term or permanent disability, such as hearing loss, visual impairment, disfigurement, brain damage, or paralysis can result from injury

Family physicians

» Beyond physical injuries, the health impacts of woman abuse can include: sleep deprivation, eating disorders, gastrointestinal illness, chronic headaches or back pain, hypertension, forced pregnancies and abortions, STI's, cervical cancer, post-traumatic stress disorder, mental illness, substance use, and more

» Abusers often stay at a woman's side unceasingly during medical visits and/or interfere with women's treatment regimens at home

Reproductive health

» Forced pregnancies, abortions and unintended pregnancies can be linked to abuse

» 16% of women accessing abortions have been raped at conception[7]

» Many routine procedures, from vaginal exams to ultrasounds, may deepen women's trauma.

» Other gynaecological symptoms of abuse include chronic pelvic, abdominal or vaginal pain, vaginal bleeding or infection, fibroids, pain with intercourse, urinary tract infections, pre-menstrual syndrome, and dysmenorrhoea

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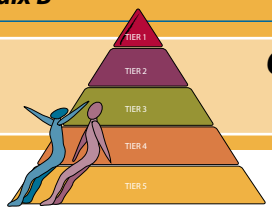


COVERSHEET: Safety and Health Enhancement (SHE) for Women Experiencing Abuse

Health Setting:	Starting Date:

SHE Team:

SHE Co-coordinators:

Group commitment to:

» *confidentiality within the team*

notes:

» *how consensus will be reached*

notes:

» *participation in the process*

notes:

» *the use of materials and outcomes*

notes:

» *respect for the knowledge and experience of each team member*

notes:

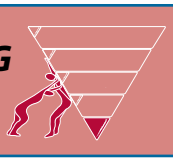
» *equality amongst team members*

notes:

WORKSHEET: Consensus Statements Supporting the SHE Toolkit

EXAMPLE CONSENSUS STATEMENTS	THINGS TO CONSIDER
Woman abuse advocates and health care providers who have initiated and joined this process are allies and bring a wealth of knowledge that will contribute to the SHE Process.	• Anti-violence workers are not always recognized as peers or colleagues • Health care as an institution is often viewed as having more credibility • Salary differences may be used to imply hierarchy of knowledge • Life and work experience are as valid as formal education
The SHE approach is about reviewing your health setting, not reviewing individuals and their practice. In identifying compounding harms and potential risks, there is no implication of intentional harm and rarely a single reason for unintended outcomes.	• The process relies on being open to identifying potential risks that reside within institutional and routine practices • Blaming individuals or sectors will not help move the SHE Process forward • The health system is complex • Understanding how different sectors work and finding common ground is essential • Useful discussion will rely on people in the group feeling safe with each other
Women's reality of experiencing violence and abuse are complex and must be central to the SHE Process.	• Social myths and stereotypes of woman abuse (e.g. mutual battering; abuse is about discrete incidents of physical violence, etc.) are very different than women's lived reality and can compromise women's safety • Power and control is at the core of abuse • Anti-violence workers can bring to the table women's complex and diverse experiences of abuse
Woman abuse is rooted in gender inequality.	• Almost all victims of violence in relationships are women • Women have less economic, social and political power than men and are thus less able to free themselves from an abusive situation • Women are not a homogenous group and the inequality of women intersects with inequality based on race and ethnicity, age, physical and mental ability, etc. • Violence against women in relationships is one piece of a larger picture of gender-based violence occurring around the globe
Women are not responsible for the abuse they are experiencing.	• Abusers are responsible and accountable for their behavior • This is a concept that many people struggle with because of social myths such as "mutual battering", "it takes two to tango", etc. • We must acknowledge perpetrator and system responsibility rather than perpetuate victim blaming
Improving women's safety in health encounters and health settings is the primary goal of the SHE Process.	• Assessing current practices relative to the primary goal of safety and health enhancement is the central task of the SHE Process • Women's safety must take priority over institutional or professional needs or routines
Change takes time.	• Patience, understanding and support are required both for women trying to escape an abusive situation and institutions involved in a process of transformation • Celebrating small steps is important

Tier One - Worksheet: Rating Risk and Feasibility

COMPOUNDING HARMS 	RISK High/Urgent (3) Moderate (2) Low (1)	SAFETY & HEALTH ENHANCING MEASURES	FEASIBILITY Do-able (3) Challenging (2) Not possible (1)	TOTAL
	RISK RATING		FEASIBILITY RATING	
	RISK RATING		FEASIBILITY RATING	
	RISK RATING		FEASIBILITY RATING	
	RISK RATING		FEASIBILITY RATING	
	RISK RATING		FEASIBILITY RATING	
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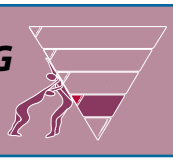
	RISK RATING		FEASIBILITY RATING	

Tier Two - Worksheet: Rating Risk and Feasibility

COMPOUNDING HARMS 	RISK High/Urgent (3) Moderate (2) Low (1)	SAFETY & HEALTH ENHANCING MEASURES	FEASIBILITY Do-able (3) Challenging (2) Not possible (1)	TOTAL
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	RISK RATING		FEASIBILITY RATING	
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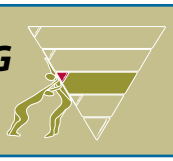
Tier Three - Worksheet: Rating Risk and Feasibility

COMPOUNDING HARMS 	RISK High/Urgent (3) Moderate (2) Low (1)	SAFETY & HEALTH ENHANCING MEASURES	FEASIBILITY Do-able (3) Challenging (2) Not possible (1)	TOTAL
	RISK RATING		FEASIBILITY RATING	
	RISK RATING		FEASIBILITY RATING	
	RISK RATING		FEASIBILITY RATING	
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	RISK RATING		FEASIBILITY RATING	
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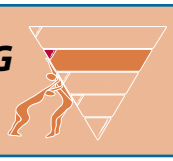
	RISK RATING		FEASIBILITY RATING	

Tier Four - Worksheet: Rating Risk and Feasibility

COMPOUNDING HARMS 	RISK High/Urgent (3) Moderate (2) Low (1)	SAFETY & HEALTH ENHANCING MEASURES	FEASIBILITY Do-able (3) Challenging (2) Not possible (1)	TOTAL
	RISK RATING		FEASIBILITY RATING	
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	RISK RATING		FEASIBILITY RATING	
	RISK RATING		FEASIBILITY RATING	
	RISK RATING		FEASIBILITY RATING	

Tier Five - Worksheet: Rating Risk and Feasibility

COMPOUNDING HARMS 	RISK High/Urgent (3) Moderate (2) Low (1)	SAFETY & HEALTH ENHANCING MEASURES	FEASIBILITY Do-able (3) Challenging (2) Not possible (1)	TOTAL
	RISK RATING		FEASIBILITY RATING	
	RISK RATING		FEASIBILITY RATING	
	RISK RATING		FEASIBILITY RATING	
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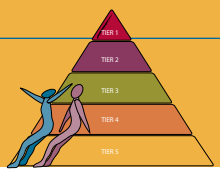

WORKSHEET: Safety and Health Enhancement Action Plan

Safety and Health Enhancing Measures *(transferred from Risk and Feasibility Worksheet)* *(What will be done?)*	**Implementation** *(How will it be done?)*	**Responsible Agency/ Person** *(Who will take the lead?)*	**Timeline** *(When will it be done?)*

Library and Archives Canada Cataloguing in Publication Data

Cory, Jill, 1957-

SHE framework : Safety & Health Enhancement for women experiencing abuse : a toolkit for providers and planners.

Available also on the Internet.

Funded by: National Crime Prevention Centre.

ISBN 978-0-7726-5729-9

1. Abused women – Services for - British Columbia. 2. Abused women – Health and hygiene - British Columbia. 3. Women – Health and hygiene - British Columbia. 4. Women's health services - British Columbia. 5. Wife abuse. I. BC Women's Hospital and Health Centre. Woman Abuse Response Program. II. Title.

HV6626.23.C3C67 2007 362.82'9209711 C2007-970074-3


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An agency of the Provincial
Health Services Authority


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