SHE FRAMEWORK

SAFETY AND HEALTH ENHANCEMENT FOR WOMEN EXPERIENCING ABUSE

A TOOLKIT FOR HEALTH CARE PROVIDERS AND PLANNERS

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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 woman’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.

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

“

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 try 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...
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

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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]
Chapter 1: Introduction

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.

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]
Chapter 1: Introduction

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, doulas, 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

2. Safety and Health Enhancement Model
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 graviest 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 sequelae 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.
Chapter 1: Introduction

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. 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 socioeconomic 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 marginalized 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.