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Centro de Investigacion en Estudios De La Mujer

Health Sector Collaborations and Responses in Canada

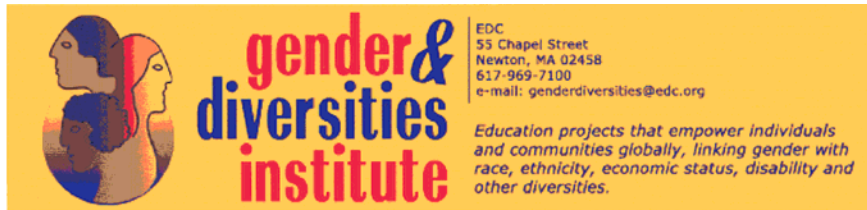
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On Dec. 6, 1989 a young man walked into the engineering department of a university in Montreal Canada, separated the female from the male students and then shot to death 14 young women. The Montreal Massacre, as it now called, was a horrific public act of violence that made clear and visible the threat that women sometimes face simply by being female.

While the Montreal Massacre was the occasion of the largest collective murder of Canadian women, we know that every year there are many women murdered by those they know, their partners or former partners. Between 1974 and 1994, a married woman in Canada was *nine* times more likely to be killed by her spouse than by a stranger. Between 1979 and 1998, 1468 women were killed by their husbands; this is approximately 75 women in each and every year. (During the same time period 433 men were killed by their wives [Statistics Canada 2000, 6].)

In response to the Montreal Massacre, in 1992 the federal government of Canada provided five year funding to five Canadian Research Centres on Violence. Although the funding has ended, the Centres do continue. Each of the Centres had a different emphasis and focus to research on violence against women. None examines the relationship of violence and health. The Centre for Research in Women's Health Violence and Health Research Program decided to focus specifically on this area.

The Centre for Research in Women's Health (CRWH) is a partnership of the University of Toronto and the Sunnybrook and Women's College Health Sciences Centre. Started in 1995 the CRWH's Mission is to conduct and foster research relevant to women's lives and to promote its application in diverse communities. The CRWH currently supports six different research programs: Pharmacotherapy, Cancers Common in Women, Women's Mental Health, Women's Life Course and Chronic Conditions, Reproductive Health and

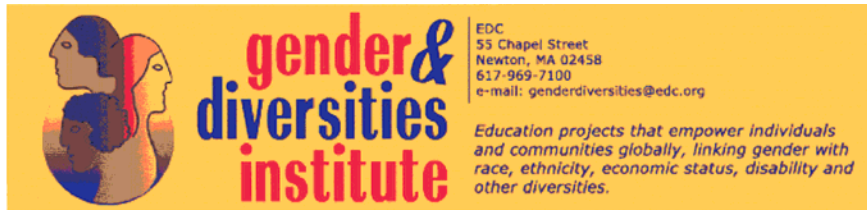


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as mentioned, the Violence and Health Research program. Women's health involves emotional, social, cultural, spiritual and physical well-being and is determined by the social, political, and economic context of women's lives as well as by biology. There are also conditions with obvious health implications that are not reflected in health statistics: stress, accidental death, and violence among them. In the Violence and Health Research Program we are committed to research on the impact of violence on women's health and the health system's response to the needs of abused women. We work with the following understanding of violence:

Violence can affect women at any stage of their lives and occurs in numerous forms including physical, sexual and economic abuse. Violence against women has enormous impact on women's lives: it causes physical and psychological harm (including homicide and suicide), on-going health problems, reduces women's autonomy and destroys their quality of life, affects their ability to care for themselves and their families, and diminishes women's productivity in wider society and in the processes of development. It also has enormous costs in terms of the government and community resources and services (e.g., health services, law enforcement and legal services) invested in responding to the consequences. [Quoted from University of Melbourne, Key Centre for Women's Health, Annual Report 2000]

One study in 1989 showed that battering is the most common way North American women are injured. In Canada, almost a million women are either physically battered or sexually assaulted each year. One in 5 women will be sexually assaulted during her lifetime. More than 50% of women experience violence during marriage or longterm relationship (Statistics Canada, VAW Survey, 1993). Of those reporting domestic violence, 45% received injuries and 43% received medical attention for their injuries. Women are four times more likely to be injured by a male partner than in a car accident. In fact, more women visited the emergency room for battering than for auto accidents, rapes, and muggings combined. Women who have been assaulted are likely to sustain multiple injuries, including but not limited to: serious bleeding, multiple bruising, bleeding of internal organs, injuries to the face and head, perforated eardrums, burns from stoves, appliances or acids, dental damage, broken bones and injuries to the breasts, chest and abdomen, especially if the woman is pregnant. Abuse frequently begins with or increases during pregnancy. In Toronto one study revealed somewhere between 5.7 and 6.5% of pregnant women reported being abused during their current pregnancy.



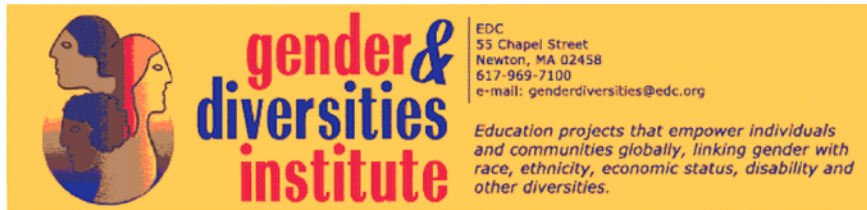
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There are additional health impacts and effects beyond the immediate physical injuries received. Other conditions may include: eating disorders, pelvic pain, IBS, ulcers, heart disease, asthma or bronchitis, anemia and vision problems. Psychological after effects may include post traumatic stress disorder, fear, insomnia, anxiety, depression and attempted (or completed) suicide. Yet, only 8 % of abused women ever disclosed to a physician. And few physicians ever ask.

The province of Ontario has undertaken a hospital-based initiative addressing sexual assault and domestic violence. Begun in 1984, the Sexual Assault Care Centres provide care to women, men and children who have been recently sexually assaulted. There are now 31 hospital-based programs in Ontario. The very first of these Centres was located at our affiliated teaching hospital. The SACC services include: emergency medical and nursing care, crisis intervention, forensic evidence collection, medical follow-up, and counselling. They are open 24 hours a day, 7 days a week and are staffed by an on-call team of nurses and physicians. The nurses and physicians provide prompt and specialized care through the emergency department. Recently, domestic violence was added to the mandate of 15 of these Centres and the expectation is that it will be phased into the remaining Centres by the end of this year.

Educating the community and other professionals about both the program and the issues relating to sexual assault and domestic violence is an important component of the SACC program, but service provision is the primary focus.

It has become increasingly clear to us that education and training are critical tasks and cannot be merely an added responsibility. Education of the community that violence against women impacts everyone: victim and perpetrator, family, friends and community. Greater awareness of the cycles of violence, of its impact on children, of programs that work to reduce its incidence. In the health sector, we see medical education and continuing education about the impact of violence on the health and wellbeing of women (and their families) as one area in which we can work towards improvement. Related to this is improving the healthcare system's response to women who have experienced abuse. We anticipate working with undergraduate and graduate faculties of medicine, hospitals staff and physicians, and healthcare providers in the general population to ensure they understand the context in which women may be physically and or emotionally injured, that they are aware of risk factors and indicators of violence, that they have familiarity with a range of screening tools and can ask patients about violence



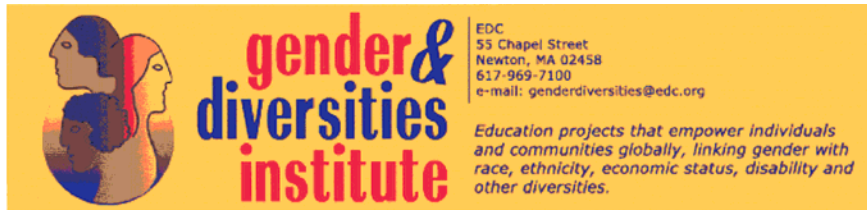
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in their lives, that they know how to document the response, and make appropriate referrals.

We have begun this work by piloting a model of hospital-based education and training. At our affiliated teaching hospital there was an active group of frontline staff with experience and expertise in issues of violence who met over a period of time to consider how to best share their knowledge with others. We have worked with them to develop a model of inservice education and training for the hospital. The program is designed to increase awareness of the issue for all health care professionals, not just doctors. And to make the hospital a safe place for women to talk about their experiences of violence. However, in developing this program, we have also come face to face with some of the institutional, professional and structural challenges that come with trying to legitimize violence as a health care issue in a large, bureaucratically complex organization.

We have seen that verbal support for the issue is provided by the senior administrators but that money, to develop materials for example, is not forthcoming. Our researchers have also noted that many frontline physicians still believe *their* patients (whether they be women from middle class backgrounds, or older women with adult children etc.) do not experience violence. It is difficult to overcome the stereotypes and resistance. We have found that with fewer resources in the hospital, and the continued threats of more funding cuts and personnel losses, it has been difficult to introduce what is seen as the “extra” work that screening, documenting and referring are believed to be. We have also found that there are “experts” in violence and that the rest of the staff are content to leave this to those individuals, rather than taking responsibility for their own learning.

On the other hand, we have also joined with a number of other hospitals and affiliated health care organizations to call upon the federal government to change the Hospital Accreditation Guidelines to include violence against women amongst the criteria hospitals must meet in order to maintain accreditation. We are advocating for the inclusion at every single Canadian hospital of policies or protocols that describe the care that will be provided to women who have been abused. Naturally, there will be an enormous amount of education and training required before those policies can be put into place. But changing the Hospital Accreditation Guidelines would provide the impetus for this change. Yet, not all abused women seek care through the hospitals. Many go to clinics, health centres or private family physicians for their health care. Here too, there is a great deal more work that must be done. Two Canadian studies conducted during the



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1990s have found that the vast majority of physicians believed that they should ask women with suspicious injuries and emotional difficulties about abuse (Ferris, 1992, 1994), however physicians describe a number of barriers to doing so. Of these, a few are highly significant: those that are patient barriers, (such as not asking for help, infrequent visits, or not responding) and those that physicians describe as due to their own personal feelings (such as fear of offending, powerlessness, loss of control); and finally, those that are more institutional, such as lack of time to spend on the issue (Brown & Sas, 1994).

However, violence against women cannot be the sole responsibility of any single sector, whether that be healthcare, the judicial system, or education. We must develop intersectoral models of cooperation and collaboration, share information, knowledge and learn from each other. In Toronto, as in many other centres, we have a coordinating committee on woman abuse with representatives from across many sectors including the police, shelters, support service agencies, hospitals, community health centres, the judicial system, and survivors. We have much to learn from each other and much to teach each other. I have no doubt education (knowledge development and knowledge sharing) will prove the means by which we are able to introduce significant change.