

# **THE HEALTH CARE SECTOR'S RESPONSE TO WOMEN IMPACTED BY ABUSE: BARRIERS AND STRATEGIES**

by

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## **ABSTRACT**

Violence against women is established as a determinant of health with adverse health related consequences. A significant number of women in Canada each year are affected. Health care professionals are in a unique position to assist women impacted by violence. Unfortunately, these women experience numerous barriers to accessing appropriate health care. The findings from an environmental scan conducted at BC Women's Hospital and Health Centre revealed various barriers for women affected by violence, both structurally and directly resulting from the abuse, that prevent them from accessing appropriate care. The study also revealed several strategies to reduce barriers and increase access to care for women affected by abuse.

**Key Words:** violence against women; health care; access; barriers; intersectionality

**Subject Terms:** Women -- Violence against; Abused women -- Services for; Women's health services -- Canada; Abused Women;

*To all the amazing women in my life...*

*Especially my mother and grandmother who epitomize strength and  
compassion*

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# 1. INTRODUCTION

Violence against women is now established as a determinant of health with adverse health related consequences. What is, therefore, the role of the health care system in addressing this problem? A significant number of women in Canada each year experience violence from their male partners and this has devastating impacts on their health and well-being (World Health Organization, 2002; Statistics Canada, 1993). Health care professionals are in a unique position to assist women impacted by violence, especially with ensuring they have access to appropriate and sensitive health care services (Cory & Dechief, 2007; Morrow & Varcoe, 2000).

This paper will report on findings from an environmental scan conducted at BC Women's Hospital and Health Centre (BCW) that sought to see how effectively programs and services were addressing violence against women. The purpose of this paper is to identify, from the perspective of a number of health care providers and managers, some key barriers to accessing appropriate health care services for women impacted by violence and to identify strategies to improve services for these women at BCW. This information will also be useful for other health care settings to help them understand potential barriers for the women they serve who have been affected by violence to improve their services. This study hopes to contribute to the public health research on how to ensure that women affected by abuse, can access comprehensive and appropriate health care.

## 1.1 Public Health Problem

### What is Violence Against Women?

The World Health Organization (WHO) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (World Health Organization, 2000, p 1). This definition highlights the fact that violence against women is rooted in gender inequality, and that it can take many forms and may be perpetuated by numerous forces. Violence against women in relationships is defined as:

a pattern of intentionally coercive and violent behaviour 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 (El-Bayoumi, Borum, & Haywood, 1998, p 392).

The fact that the perpetrator is purposely using abuse to gain or maintain control and power over the woman is highlighted in this definition.

While this paper will primarily focus on woman abuse perpetrated by a past or present male partner, it is important to keep this phenomenon in the context of the gender-based structural violence and inequalities that occur in our society. Other forms of gender-based violence include: "rape and sexual coercion, forced prostitution, sexual abuse of girls, trafficking, forced violence against sex trade workers, forced sexual initiation, exploitation of labour, debt bondage, rape in war, sex-selective abortion, female infanticide, deliberate neglect of girls and female genital mutilation" (Dechief, 2003, p 8). The continued existence of gender-based violence stems from the inadequate attention on changing the underlying global social, economic and political inequalities that support violence against women (World Health Organization, 2004).

Other forms of oppression often intersect with gender-based violence to compound the negative effects for women (Varcoe, 2002; Hankivsky & Varcoe, 2007). These include racism, ableism, poverty, ageism, classism, immigration status, geography and heterosexism (Hankivsky & Varcoe, 2007).<sup>1</sup>

Historically researchers and media primarily focused on physical and/or sexual abuse in relationships. It is now understood that violence against women can take many other forms that can negatively affect women equally or more than physical and sexual abuse. The various forms of abuse include:

**Table 1.1: Types of Abuse**

Type	Example
Verbal	Threats, yelling, insults
Mental	Using tactics to convince her that she is crazy or stupid
Emotional	Using guilt and other strategies to make her think that she's a bad mother/partner/person. Ignoring her or using jealousy to control her
Sexual	Preventing choice about sex, birth control or STI protection. Withholding sexual affection
Physical	Hitting, choking, kicking, use of weapons
Financial	Controlling the decisions about finances, not allowing her to access money or bank accounts
Spiritual	Belittling her religion, keeping her from practicing her faith
Cultural	Belittling her culture, racial insults
Social	Isolating her from friends or family, controlling her whereabouts and who she can associate with

(British Columbia Reproductive Care Program, 2003)

It is estimated that in Canada 1 in 3 women have experienced physical or sexual abuse at some point in their adult lives and that 1 in 10 women are presently experiencing abuse (World Health Organization, 2002; Statistics Canada, 1993; Ratner, 1993; Eisenstat & Bancroft, 1999). Women impacted by violence in their relationships

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<sup>1</sup> It is also important to acknowledge that abuse also occurs in same sex relationships though this will not be discussed in this paper (Ristock, 2002)

experience various negative health effects and are more likely to rate their overall health as poor (Dechief, 2003). The estimated annual cost to the Canadian health care system for medically treating abused women ranges from \$408 million to \$1.5 billion (Cohen & Maclean, 2004).

## **2. LITERATURE REVIEW**

### **2.1 Prevalence of Violence Against Women**

Recent reports from the World Health Organization show that 29%-62% of ever-partnered women have experienced physical and/or sexual violence in their relationships worldwide (World Health Organization, 2005). Determining the actual prevalence of woman abuse worldwide, and in Canada, is difficult and potentially impossible. Most data collection methods focus only on physical and/or sexual abuse and rely on women's willingness to report woman abuse to police or to disclose during interviews (Status of Women Canada, 2002). Given the sensitive nature of this issue and potential repercussions, many (perhaps most) women will not do this. Prevalence may also vary due to how surveys and/or the women interviewed define woman abuse and the manner in which interviewers ask the questions (Cohen & Maclean, 2004).

These limitations have resulted in poor quality and limited prevalence data on violence against women in Canada (Hankivsky & Varcoe, 2007). The Violence Against Women Survey (VAWS) conducted in 1993, which had a sample size of 12,300; found that 50% of Canadian women experienced at least one incident of physical or sexual violence in their lifetime (Hankivsky & Varcoe, 2007). The VAWS also found that 25% of Canadian women experienced violence at the hands of a current or ex-spouse (married or common-law) and 23% experienced violence at the hands of a dating partner. Of the women who had experienced violence, 61% had experienced more than one incident in their lifetime (Status of Women Canada, 2002). While this survey is more than 10 years old, it is the most comprehensive and representative survey conducted on

violence against women in Canada, and therefore still considered the best data collected in Canada (Hankivsky & Varcoe, 2007). It is estimated that more than 30% of Canadian women have experienced physical or sexual abuse at some point in their adult lives with approximately 10% currently experiencing abuse (World Health Organization, 2002; Statistics Canada, 1993; Ratner, 1993; Eisenstat & Bancroft, 1999).

Males are the perpetrators of the majority of violence in our society (Anderson & Aviles, 2006). One in five homicides in Canada is committed by a current or former intimate partner and women are more than 3 times as likely to be the victims of such crimes (Locke, 2000; Cohen & Maclean, 2004). In the majority of homicides committed by men or women against their current or former partner, a history of woman abuse was present (Cohen & Maclean, 2004). Men commit ninety-eight percent of sexual assaults and 86% of violent crimes (Jiwani, 2000a). Women constitute 98% of victims of sexual assault perpetrated by a partner, kidnapping or hostage taking and 80% of victims of criminal harassment, while 90% of those accused of these acts are men (Fitzgerald, 1999; Jiwani, 2000a)

## **2.2 Intersecting Oppressions**

Although it is now recognized that violence affects all women despite their culture, socioeconomic status, ethnicity, ability, occupation or sexual orientation, some groups of women may be more vulnerable to violence and have more barriers when trying to leave an abusive relationship. Different inequalities in women's lives intersect to compound the experiences of abuse (Hankivsky, & Varcoe, 2007). These inequalities are the result of structural violence that corresponds with the way society and systems systematically oppress certain individuals. Sexism, racism, elitism, classism, ageism

and heterosexism are examples of structural violence (Farmer, Nizeye, Stulac, & Keshavjee, 2006).

Women who have lower statuses in society including poor women, Aboriginal women and other women of colour, elderly women, and women with disabilities are especially impacted by intersecting oppressions (Hankivsky, & Varcoe, 2007; Cory & Dechief, 2007; Anderson & Aviles, 2006). Social circumstances such as unsafe and inadequate housing and poverty can increase women's vulnerability and marginalization. Women who live in poverty or are financially dependent on their abuser may have greater difficulty leaving an abusive relationship because of a lack of resources (Morrow & Varcoe, 2000). Almost all women working in the sex trade have experienced abuse or violence, most more than once (Lowman & Fraser, 1996; Hester & Westmarland, 2004; Humphreys, 2007). The stigmatization of sex trade workers and the way our society normalizes violence against these women result in many barriers to reporting violence and accessing necessary help (Shannon, Rusch, Shoveller, Alexson, Gibson, & Tyndall, 2007). Women with disabilities are more vulnerable to violence; often have the abuser as their primary caregiver; and services may be located in buildings that are not accessible (Morrow & Varcoe, 2000).

Racism and other forms of oppression add another layer of complexity and risk to women's experiences of abuse (Jiwani, 2000b; Varcoe, 2002). It is estimated that at least three quarters of Canadian Aboriginal women have been impacted by violence at some point in their lives (Grace, 2003). Aboriginal women aged 25-44 are five times more likely than other Canadian women of the same age to die from violence perpetrated by a partner (Bent, 2004). These higher rates of violence are believed to stem from and be exacerbated by a legacy of colonialism, residential schooling and dismal economic factors (Browne, Fiske & Thomas, 2000). Women of colour who are experiencing violence may often face overt and/or systemic racism when attempting to

access help. Martinson (2001) found that there is reluctance among African-American women to report abuse because they fear that this will reinforce the negative stereotypes of their community, particularly African-American men (Martinson, 2001). Immigrant women face unique circumstances that affect their experiences of abuse. Immigrant women are more likely to lack a social support network, may only have citizenship through marriage and may not be able to secure stable work. This increases abusers ability to isolate and control immigrant women and creates additional barriers for women to escape the abuse (Anderson & Aviles, 2006; Jiwani, 2000b). Language barriers also affect immigrant women's ability to access information; many services are only provided in English and often the abuser or one of his family members are used as interpreters (Anderson & Aviles, 2006; Jiwani, 2000b; MacLeod & Shin, 1990).

Lee, Thompson & Mechanic (2002) argue that the social and cultural context of a woman's life is the most important determinant of how she experiences and responds to abuse. For example, barriers resulting from a woman's low socioeconomic status, and discrimination due to gender, race, or ethnicity can all compound the experiences of violence and reduce a woman's ability to access support and escape the abuse. It is, therefore, important to understand the ways that these different inequalities intersect in some women's lives to compound their experiences and/or risk of abuse (Cory & Dechief, 2007).

## **2.3 Health Effects**

Violence against women in relationships is an important public health issue because of the serious impact it has on women's health. Some researchers have argued that abuse is a stronger predictor of poor health than poverty (Weissbecker & Clark, 2007). Women affected by abuse consistently report poorer health statuses than

women not impacted by abuse (Dechief, 2003; Humphreys, 2007). Women impacted by violence experience various physical and psychological conditions that health care workers often do not detect or attribute to violence in their lives (Anderson & Aviles, 2006). Headaches, insomnia, hyperventilation, gastrointestinal symptoms, and chest, back and pelvic pain are the most common somatic complaints for women impacted by violence (Dutton, Kaltman, Goodman, Weinfurt & Vankos, 2005; Lemon, Verhoek-Oftedahl, & Donnelly, 2002).

Woman abuse is one of the most common causes of serious injury for women; homicide being the most severe consequence. The most common characteristics of injuries sustained due to woman abuse include bruises, abrasions, minor cuts, fractures or sprains; injuries to the head, neck, chest, breasts or abdomen; injuries during pregnancy; and repeated or chronic injuries (Dutton et al., 2005). Chronic pain syndromes are also found more often in abused women than non-abused women (Dutton et al., 2005). Other long-term health effects related to woman abuse are arthritis, hearing loss, sexually transmitted infections (STIs), and neurological damage (Morrow & Varcoe, 2000; Lemon et al., 2002). Violence during pregnancy can have many adverse effects for the woman and infant including low birth weight, fetal death, antepartum hemorrhage, and premature labour (Dutton et al., 2005). An estimated 40-45% of women in abusive relationships experience forced sex by their partners. Forced sex is associated with increased occurrence of pelvic inflammatory disease, STIs, vaginal and anal tearing, dysmenorrhoea, bladder infections, sexual dysfunction, and pelvic pain (Naumann, Langford, Torres, Campbell, & Glass, 1999).

## **Cost to the Health Care System**

Not surprisingly, women who are abused utilize health care services more than the general public. Abused women have higher rates of physician visits, emergency room visits, and hospitalizations, yet they do not usually present with obvious signs of abuse or trauma (Dearwater, Coben, & Campbell, 1998). The estimated annual cost to the Canadian health care system for medically treating abused women ranges from \$408 million to \$1.5 billion (Cohen & Maclean, 2004). The estimated in-patient hospital costs related to woman abuse ranges from \$37.8 million to \$70.7 million (Cohen & Maclean, 2004). Additionally one study estimated the significant annual costs of violence against women in four policy areas in Canada: social services and education (~ \$2.4 billion); criminal justice (~ \$8.7 million); labour/employment (~ \$5.8 million); and health (~ \$4.1 million) for a total annual cost of approximately \$4.2 billion (Greaves, Hankivsky, & Kingston- Riechers, 1995).

## **Links between Violence, Mental Health and Substance Use**

There is a growing awareness about the links between woman abuse, mental health and substance use. A strong body of evidence now exists that shows woman abuse often precedes substance use and mental ill health; however, health care providers do not usually recognize these connections (Finklestein, 1994; Cory & Dechief, 2007). A study by Dutton et al. (2005) found the risk of developing depression, posttraumatic stress disorder (PSTD), substance use issues or becoming suicidal to be 3 to 5 times higher for women who have experienced violence in their relationships compared to women who have not experienced violence. Logan, Walker, Cole, & Leukefeld (2002) also found that women impacted by violence in relationships had

elevated risks of developing depression (26.3% higher), PTSD (53.4% higher), and alcohol dependencies (12.2% higher).

Two systematic reviews on studies examining the link between violence against women and depression found significantly higher rates for women who had experienced violence in their lives compared to general populations of women. Cascardi, O'Leary & Schlee (1999) reviewed 14 studies and found prevalence rates of depression between 38-83%, while Golding (1999) found an average prevalence rate of 47.6% for women impacted by violence. In Canada, the lifetime prevalence rate of depression for women is estimated at 12.2% while the annual prevalence rate is 5.5% (Statistics Canada, 2003). In fact, some researchers argue that studies have found such consistent correlations between woman abuse and mental health issues as to suggest a causal relation (Golding, 1999; Humphreys, 2007).

The United Nations recognizes that the impact of violence in relationships has lead to increased alcohol and drug dependency in women (Anderson & Aviles., 2006). Many women identify their substance use as a coping mechanism for the past or present violence they experience (Cory & Dechief, 2007; Parkes, Welch, Besla, Leavitt, Ziegler, MacDougall, et al., 2007; Lemon et al., 2002), while others report being forced to use substances by their partner as a control mechanism (Illinois Department of Human Services, 2000; Cory & Dechief, 2007). Women impacted by violence are more likely to smoke cigarettes and use alcohol heavily (Lemon, et al., 2002). In a systematic review, Najavits, Weiss & Shaw (1997) found that 36-51% of women in community samples reported a lifetime history of physical and sexual abuse compared to 55-99% of women with substance use issues. Alcohol dependency is found up to 15 times more among women impacted by violence than the general public (Logan et al., 2002). Additionally, victims of violence are more likely to use multiple types of substances and to use higher

levels of substances than those who have not experienced violence (Martin, Kilgallen, Dee, Dawson, & Campbell, 1998).

The complexities between violence, mental health and substance use are especially evident when discussing co-occurring disorders. It is estimated that close to 67% of women with substance use issues have a concurrent mental health problem such as PTSD, anxiety, and depression (Zilberman, Tavares, Blume, & El-Guebaly, 2002). Logan et al. (2002) also found that 30-59% of women with substance use problems also had PTSD.

Women with mentally ill health and/or substance use issues are often discriminated against and are at increased risk for victimization (Parkes et al., 2007). The unemployment rates for people with mentally ill health are between 70% and 90% in Canada; this contributes to high rates of women with mental health issues living in poverty (Parkes et al., 2007). Studies also show that rape and attempted rape is 22.5 times higher among women with mentally ill health compared to the general female population (Teplin, McClelland, Abram, & Weiner, 2005). Women who use substances have traditionally been viewed as deviant and undesirable, which affects the way they are treated by service providers, police, and society in general (The Stella Project, 2004). Many services refuse to serve women with addictions or mental illness diagnoses, limiting access for this vulnerable population (Cory & Dechief, 2007).

## **2.4 Barriers to Accessing Appropriate Health Care**

While research shows that women impacted by abuse access the health care system more than the general public (Dearwater, Coben, & Campbell, 1998), many barriers still exist for women in accessing appropriate and meaningful health care. Lichtenstein (2006) states that violence against women in relationships “becomes a

barrier to health care because of abuser interference, victims' feelings of denial and shame, and stigmatizing attitudes towards victims in health care settings" (p. 122).

Plichta (2007) argues that while abused women access health care services as often or more often than others, they are "less likely to receive needed services... and more likely to have a poor relationship with their health care provider" (p. 226). Results from a survey of women impacted by violence found that participants rated medical professionals as the "least-effective source of help among all formal support systems encountered" (Naumann et al., 1999, p. 344).

Many women fear being identified as abused through screening approaches that have been implemented in many health care settings (Pearlman & Waalen, 2000; Dechief, 2003). When women do report abuse to health care professionals, many inappropriate responses have been reported including: being treated impersonally or insensitively; having the abuse minimized; being overtly or subtly blamed for the abuse; having only physical aspects of abuse acknowledged; and not having their decisions understood or respected (Naumann et al., 1999; Cory & Dechief, 2007; Olive, 2007). Health care professionals have also been reported to be paternalistic and distancing when interacting with women who have disclosed abuse (Naumann et al, 1999). In a survey of women impacted by violence about care they received in an emergency room, they perceived the staff as "unconcerned, controlling, rushed, only concerned with treating physical injury and lacking in humanness and compassion" (Olive, 2007, p. 1742). In one study of a psychiatric setting, less than half of women who were identified as being abused were referred to any support services (Barthauer, 1999). These factors can deter women from returning to the health care system.

Abusers can prevent women from accessing health care. Women report that their partners will sabotage their attempts to seek care, attend appointments or comply with a treatment regime (Lichtenstein, 2006; Dechief, 2003; Stark & Flitcraft, 1996). Abusers

can prevent women from accessing health care services by stealing or withholding money so she cannot travel to appointments or purchase medication; abusers may also physically assault a woman before appointments so she is too ashamed to face health care providers (Stark & Flitcraft, 1996; Lichtenstein, 2006). Additionally, abusive partners can prevent women from accessing care by stealing her medications or preventing her from taking them; preventing her from using the phone to book appointments; not allowing her to take the car or refusing to drive her to appointments; and threatening to disclose her diagnosis to family or friends (Lichtenstein, 2006; Dechief, 2003). Abusers have also interfered with women accessing appropriate health care by accompanying them to appointments and dominating the interaction with health care providers (Lichtenstein, 2006; Cory & Dechief, 2007). Finally, Women may not access certain health care services for fear of their partners learning about a condition. HIV-positive women who have not disclosed their status to their partners are particularly vulnerable to this predicament and will avoid accessing care to avoid the chance of their partner discovering evidence of their condition (e.g. medications, insurance bills, or clinic appointment cards) (Lichtenstein, 2006).

Women affected by violence report that racism and/or discrimination due to their socio-economic status also affects the health care they receive (Naumann et al, 1999). Health care services are often geared towards a white, middle class, heterosexual, English speaking population with most providers reflecting this population. Health care providers from different class and racial backgrounds than their patients may not understand the complex social circumstances and obstacles they face (Anderson & Aviles, 2006). Geographical isolation, limited availability of health care services, unemployment and/or poverty, and a lack of public transportation all act as barriers for accessing health care services for women who live in rural settings (Eastman, Bunch, Williams, & Carawan, 2007). Humphreys (2007, p. 6) argues that “isolation and lack of

access to appropriate support services need to be considered as significant aspects of health inequality for women" affected by abuse.

Finally, there is a lack of inter-sectoral collaboration between the health care system and other sectors working to address violence against women such as the mental health and addictions, anti-violence and justice sectors (Pearlman & Waalen, 2000). Without adequate communication and collaboration between these sectors, women often receive fragmented care, mixed messages and potentially harmful interventions (Cory and Dechief, 2007). For example, some health care providers falsely believe that it is mandatory to report woman abuse to the police or to the Ministry of Child and Family Development when children are involved (Taket, Wathen & Macmillan, 2004). The presence of woman abuse does not automatically indicate that children are at risk and require protection (Ministry of Child and Family Development, 2004). Police involvement may actually increase a woman's vulnerability to violence, especially if the partner is not taken into custody or when a partner is released. The removal of a woman's children may re-traumatize and re-victimize her, if she is a non-offending parent.

## **2.4 Current Strategies**

### **To Screen or not to Screen?**

The initial attempt to respond to woman abuse in the health care sector was to develop universal screening programs to identify women impacted by violence who encounter the health care system (Garcia-Moreno, 2002). This approach fit well with the medical model and established public health practices. This is because screening is seen as an effective and efficient way to identify the abuse with the assumption that once it is identified, effective interventions can be put in place to reduce or eliminate the

abuse (Cory & Dechief, 2007). Screening in public health “implies the ability to identify a condition with good specificity and sensitivity, and to provide an effective response” (Garcia-Moreno, 2002, p. 1509). There has been an ongoing debate as to whether universal screening for woman abuse is a helpful or harmful intervention (Coker, 2006).

The rationale around screening for woman abuse is that it will increase primary prevention and enable women in violent relationships to receive necessary help. Universal screening programs also aim to increase the awareness of the issue and change social norms that regard woman abuse as an infrequent and private issue. This is important to victims because it reduces the level of isolation and stigma associated with violence against women and may encourage more women to reach out for help (Coker, 2006). Some argue that asking women about abuse in a “sympathetic and non-judgemental way” is already a helpful intervention in and of itself and that, most women would welcome being asked about abuse, regardless of whether they have experienced violence in a relationship (Gielen, O'Campo, Campbell, Schollenberger, Woods, Jones, 2000).

Many medical associations have adopted universal screening policies (Family Violence Prevention Fund, 1999), though research reveals most health care professionals do not routinely screen for woman abuse (Salber & McCaw, 2000; Nelson, Nygren, McInerney, & Klein, 2004). In health care settings where screening is a policy, research estimates that only 7% to 35% of women are actually asked about abuse in their relationships (Dechief, 2003). When health care professionals do screen, they mainly target women who show signs of depression or other ailments related to domestic violence (Coker, 2006; Nelson, Nygren, McInerney, & Klein, 2004).

Garcia-Moreno (2002) argues that none of the above-mentioned conditions, accurate identification and ability to provide effective responses, for screening in public health is met satisfactorily in the case of screening for woman abuse. While the focus

on screening has raised some awareness regarding the need for the health care system to develop a response to woman abuse, there is no empirical evidence that shows screening reduces morbidity, mortality or improves the health and/or well-being of women impacted by violence (Ramsay, Richardson, Carter, Davidson, & Feder, 2002; Nelson, Nygren, McInerney, & Klein, 2004). There is also little “evidence that screening has transformed the social beliefs, routine practices, and social and health policies that place women’s safety at risk within health-care settings” (Bain & Cory, 2005, p. 1). Health care professionals may be ideally placed to identify intimate-partner violence, yet “a failure to acknowledge women’s safety, social, cultural, legal, and economic realities makes many women reluctant to volunteer this information to professionals located in institutional settings that historically have been disempowering to women” (Bain & Cory, 2005: pg 1).

A meta-analysis of qualitative studies found that women impacted by abuse did not want to be pressured to disclose abuse and wanted emotional support from physicians including confidentiality, careful and nonjudgmental listening, the reassurance they are not responsible for the abuse, and that it is normal to have negative feelings (Feder, Hutson, Ramsay & Taket, 2006). Without a safe environment and effective responses to woman abuse disclosures, there is the risk of doing more harm than good. Some additional arguments against universal screening include the potential of labeling women; prompting premature disclosure leading to adverse psychological, social and/or financial consequences; and “triggering possible reprisal violence from the abuser if he discovers she has sought help” (Taket, Wathen & Macmillan, 2004, p. 8).

One study that conducted focus groups with women in shelters who were screened during a health care visit noted a number of negative consequences of screening including “feeling judged by the provider, increased anxiety about the unknown, feeling that the intervention protocol was cumbersome or intrusive, and

disappointment in the provider's response" (Chang, Decker, Moracco, Martin, Petersen & Frasier, 2003, p.76). Also, consequences of the law, such as health care providers false belief that it is mandatory to report woman abuse disclosures to child protection agencies, is another argument against screening (Taket, Wathen & Macmillan, 2004).

While the debate on screening is ongoing, it is evident that creating safe and supportive environments in the health care sector for women is important. In addition, protocols for a coordinated response to disclosures, prompted or unprompted, are required. This will entail building on existing, and creating new partnerships in the community. Examples of this include establishing links with transition houses, mental health and other health services, sexual assault services, financial and/or housing services, and support groups (Morrow & Varcoe, 2000). While screening has been the main focus of the health care response to violence against women, the following are newer approaches that have emerged due to the concerns about the safety and effectiveness of screening for woman abuse.

## **Non-Screening Approaches**

### *Ensuring Safety for Women*

Providing a safe place for women in health care settings and ensuring privacy and confidentiality is crucial to good care (Morrow & Varcoe, 2000; Garcia-Moreno, 2002). This will allow women, who wish to disclose abuse, the privacy and confidentiality to do so. While seemingly obvious, many health care settings do not always ensure privacy before engaging with or examining a patient (Garcia-Moreno, 2002; Cory & Dechief, 2007). This inability to guarantee privacy and confidentiality can put women at further risk if discussing experiences of abuse or other sensitive health

issues that their partner is not aware of, such as, HIV status, pregnancy, or abortion (Garcia-Moreno, 2002).

Health care establishments must ensure that policies and protocols are in place to respond to woman abuse. This entails having a coordinated system of referrals and protocols on how to deal with abuse disclosures. This also demands that cross-cultural challenges to assisting abused women are met (Morrow & Varcoe, 2000). For example, providing professional interpreter services when needed, providing services that are sensitive and acceptable to different cultures, and “supporting ‘solutions’ that respect and account for women’s cultural and religious values” are important (Morrow & Varcoe, 2000, p. 5). It is also vital to create safety plans with women who disclose abuse that address various aspects of women’s safety including: places to avoid during a violent attack, what safe places they can go if necessary, their access to money or emergency funds, and important documents and supplies in case of an emergency (Olive, 2007).

### *Training and Education*

Health care professionals should have access to and participate in ongoing, inter-professional education and training in violence against women (Olive 2007). Education on the dynamics, prevalence, health impacts and appropriate responses to woman abuse will help enhance service provision for women impacted by violence and ensure that health care providers do not cause additional harm in their interactions with these women (Eastman et al., 2007). For education strategies about violence against women to be effective in the health care system, they must include opportunities for staff to address their own experiences of power and abuse and to analyse their values and attitudes towards violence against women (Garcia-Moreno, 2002).

### *Integrated and Sensitive Services*

Many women impacted by violence have co-occurring health, substance use, mental health and social issues. It is, therefore, important to move towards a more integrated model of care that link and address these issues together (Cory & Dechief, 2007; Poole, 2006). Creating relationships and partnerships with community organizations and mental health and addictions services will increase the likelihood that women are referred appropriately and efficiently to other needed services (Anderson & Aviles, 2006). Because there are currently few fully integrated services available for women, the lack of examination of how past or present violence contributes to the development of substance use issues, mentally ill health or numerous physical health ailments will act as a barrier to developing effective interventions for women (Martin et al., 1998).

One example of trying to integrate services was the Women, Co-Occurring Disorders and Violence Study (WCDVS) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States. This 5 year study was aimed at gaining knowledge about and assessing the effectiveness of an integrated services approach for women with co-occurring mental health and substance abuse disorders, who also have histories of physical and/or sexual abuse. All intervention sites were required to be “gender-specific, culturally competent, trauma-informed and trauma-specific, comprehensive, integrated,” and actively involving women (The Women, Co-Occurring Disorders and Violence Study, 2007, p. 2). In addition, each site needed to provide the following services: outreach and engagement; screening and assessment; treatment activities; parenting skills; resource coordination and advocacy; trauma-specific services; crisis intervention; peer-run services (The Women, Co-Occurring Disorders and Violence Study, 2007).

Several studies have evaluated the effectiveness of the WCDVS. One study found better treatment retention for women in the integrated, trauma-informed services. Two other studies showed greater improvement of trauma-related symptoms and coping skills for the women in the intervention sites compared to women in the control sites (Gatz, Brounstein, & Noether, 2007). Finally, evaluations have shown that the total cost of service use was the same for women receiving integrated services as for women at the comparison sites (Clark, & Power, 2005).

It is also important to ensure that health care services are culturally sensitive for all women, especially those affected by violence. Including information in different languages, providing professional interpreters, and having an awareness and understanding of the multiple barriers minority and marginalized women face, will ensure that services are culturally sensitive (Anderson & Aviles, 2006).

### *Structural Transformation*

The same inequalities between men and women in the general society can be found in the health care sector as well (Garcia-Moreno, 2002). It is argued that the way the medical model and health care institutions are structured limits the possibilities of responding effectively to woman abuse. Warshaw (1993) believes structural transformation in the health care system is essential to ensuring women impacted by violence receive appropriate care when receiving services.

By creating women-centred environments where women do not face the oppression and other forms of discrimination they may experience in their relationships, and in the general society, health care institutions will avoid contributing to the cycle of abuse. According to the BC Ministry of Health, women-centred care

recognizes that women's health involves emotional, social, intellectual, spiritual, and physical well-being and that women's health is determined by the social, environmental, political and economic context of women's lives as well as by physiology. This includes recognition of the validity of women's life experiences and women's beliefs about, and experiences of health ... Women-centred care recognizes the importance of gender differences; seeks to reduce inequalities; values women's experience in defining their problems and health goals; recognizes women's diversity in race, ethnicity, culture, sexual preference, education and access to health care; supports empowerment of women in their own recovery and as valued members of the community (BC Ministry of Health, 1998, p. 2).

In such environments, women will be seen as having expertise in their own health and have control over the decisions made about the treatments, procedures and care they receive (BC Ministry of Health, 1998). With these types of structural changes, women may feel safe to reach out for help in the health care system when they are ready (Cory & Dechief, 2007).

### **3. RESEARCH APPROACH**

An environmental scan, involving interviews as the main source of information, was conducted at BC Women's Hospital (BCW) in June and July of 2007 to see how effectively programs and services were addressing violence against women. In addition, this study was conducted to help direct the Woman Abuse Response Program's in-house initiatives to improve the health care response to women impacted by violence. The Woman Abuse Response Program operates out of BCW and works provincially and within the hospital to improve the health care response to women impacted by abuse. A total of twenty-one interviews were conducted for the environmental scan.

#### **Methodology**

A qualitative research approach was undertaken because violence against women is a very complex issue that cannot be easily captured by quantitative methods. Qualitative research allows the researcher to better understand experiences and obtain multiple perspectives on a single issue. As one researcher states "qualitative research thus refers to the meanings, concepts, definitions, characteristics, metaphors, symbols and descriptions of things. In contrast, quantitative research refers to counts and measures of things" (Berg, 1995, p. 3). This study aimed to understand and explore staff's perception of violence against women and the health care response; therefore, a qualitative approach was deemed the most appropriate.

A feminist perspective is used in this study because violence against women is deeply rooted in gender inequality, which is a focus of feminism. Feminist theory aims to understand gender inequality with a focus on gender politics, power relations, sexuality

and the promotion of women's rights and interests (Code, 2000). Most researchers in the area of violence against women agree that “feminism is the most important theoretical approach to ... woman abuse” (DeKeseredy, & MacLeod, 1997; P 42). According the DeKeseredy and McLeod (1997), there are many feminist theories of woman abuse, yet the majority of them assert that men abuse women to maintain their power and control over them.

While there are many different feminist theories, for the purpose of this study, I drew on theories that acknowledged woman abuse as a socially constructed phenomenon. These theories also acknowledged the way intersecting oppressions influenced the experiences of woman abuse as well as affected women's abilities to escape the violence. The primary theories influencing this study are socialist feminism and intersectionality.

Socialist feminism considers class and patriarchy as key variables in analyses of woman abuse and other social problems. However, “neither class nor patriarchy is presumed to be dominant. Rather, class and gender relations are viewed as equally important, inextricably intertwined, and inseparable” (DeKeseredy, & MacLeod, 1997). Intersectionality acknowledges “that gender is experienced by women simultaneously with their experiences of class, race, sexual orientation, size and other forms of social difference” (Morrow & Hankivsky, 2007). Intersectionality also recognizes that the interaction between these forms of oppression is complex and compounds one another; understanding social inequalities as interdependent and mutually constituted (Weber, 2006; Morrow & Hankivsky, 2007). Finally, intersectional analysis moves away from merely describing similarities and differences to focusing on how multiple systems and dimensions of oppression interconnect to affect one's life (Gamson & Moone, 2004).

### **3.1 Methods**

Semi-structured, open-ended key informant interviews were conducted with all participants. Interviews lasted between 30 and 90 minutes each. Topics included: awareness about violence against women; health effects; staff training; barriers to accessing services; strategies used to improve accessibility to program and services; understanding of and use of women-centred care approaches; policies and protocols around violence, mentally ill health and substance use; and type of resources and support programs wanted from the Woman Abuse Response Program.

Purposeful sampling was used to recruit participants. I contacted people who were identified, by those working in the Woman Abuse Response Program, as having extensive knowledge of how services were run and organized and had a relatively high level of decision-making power or influence. Emails were sent to potential participants and a follow up phone call was made to those who did not respond within a week. Interviews were initially requested from 15 potential participants, with 11 agreeing to be interviewed. Participants themselves identified the remaining participants during the first 11 interviews. Please see Appendix 1 for the interview schedule.

#### **Source of Information**

BCW was chosen as the research site because I completed my practicum at the Woman Abuse Response Program as part of the requirements of the Public and Population Health program at Simon Fraser University. BCW is the only facility in British Columbia devoted primarily to the health of women, newborns and families and offers a broad range of specialized services that address the health needs of women of all ages and backgrounds. BCW is one of the country's largest maternity hospitals and is the only hospital that delivers tertiary maternity care in BC. As an academic health centre, BCW

is affiliated with many post-secondary institutions across the province and supports research to advance knowledge and care for women. BCW also provides specialized training for care providers throughout the province (Provincial Health Services Authority, 2008).

Interviews were held with staff from 10 programs or departments including: Reproductive Mental Health, Aurora Centre (residential and out patient addictions service), Diagnostic and Ambulatory Maternity, Sexual Assault Services, Aboriginal Health Program, CARE (abortion clinic), Oak Tree Clinic (HIV care), Breast Health Services, FIR Square Combined Care Unit (Substance Use and Pregnancy), and the Social Work department. Most participants were in management or decision-making positions, though a few worked in front line positions. Twenty-one staff were interviewed in total. Please see Appendix 2 for a brief description of each program.

### **3.3 Analysis**

All interviews, except for one, were audio recorded and transcribed (not verbatim).<sup>2</sup> For the one interview where the participant did not consent to the use of the tape recorder, hand written notes were used as the primary data source. The analysis of the interviews was primarily guided by inductive themes. Three *a priori* themes guided the analysis, which are *Women-Centred Care*, *Structural and Organizational Barriers*, and *Marginalization* (re-named as *Discrimination and Oppression as a Barrier*). All transcripts were coded twice, once by hand and then electronically where adjustments were made. This allowed for two coding sessions, allowing themes that arose later in

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<sup>2</sup> Due to a lack of time to personally transcribe all 21 interviews in such detail. The only items not transcribed were incoherent sentences and noises other than words (e.g. coughing, clearing throat, and "um")

the hand coding session, to be applied to the earlier sections of the transcripts when the coding was inputted electronically.

An intersectional analysis was used focusing on gender and violence as key determinants, but also taking into account other determinants that may be equally or more important in shaping the response from health care services and creating barriers for women (race, ethnicity, poverty, substance use, etc). Once preliminary themes were identified, a report was disseminated and a meeting was held with participants to validate the findings. Discussions did come up about some of the findings, but none are relevant to this part of the data. This paper will primarily focus on interview questions that pertained to barriers and facilitators of receiving safe, supportive and appropriate health services for women impacted by violence.

### **3.4 Ethical Considerations**

This project received ethical approval through the Health Sciences Graduate Program Practicum course (PPH 880). An inquiry was made about obtaining ethics approval through the Ethics committee at BCW. Since the Woman Abuse Response Program was initiating the project, ethics approval was not necessary because they have ethical clearance to conduct surveys and consultations with hospital staff.

All participants were informed about how the findings would be used and gave written consent to participate before the interviews began. All efforts were made to keep responses confidential and anonymous. However, since there is only one women's hospital in BC and some of the participants work in very unique programs, it still may be possible to link some of the findings to specific programs.

### **3.5 Limitations**

There are several limitations to this study that should be mentioned. Interviews were only conducted in one health care setting and interviews were not conducted in all departments or services. Therefore, as is true with all qualitative studies, the findings cannot be generalized to other hospitals, nor can they be generalized to all programs at BCW. I was primarily responsible for conducting, transcribing and analyzing the interviews; therefore, the possibility of researcher bias is quite high. The fact that I was conducting these interviews on behalf of the Woman Abuse Response Program may have biased some participants' responses (i.e. placing greater importance on violence as a determinant to women's health).

Interviews were not conducted with very many front line workers, who interact the most with patients in the various services and programs of the hospital. It is likely that these front line workers would have a greater and more in-depth understanding of the barriers women face when trying to access services at BCW. Interviews were also not conducted with women impacted by violence who access services at BCW. Therefore, I did not collect first hand experiences and opinions about the care and treatment women impacted by violence receive at BCW, the barriers and challenges they face when attempting to access appropriate care, and recommendations to improve services. While the key informants had extensive knowledge about the programs and services at BCW, interviewing more front line workers and including women themselves, would have added to the credibility and validity of the findings.

Despite these limitations, this study has revealed many barriers to services and strategies to increase access at BCW, from the perspective of health care providers and managers. This may help to increase the knowledge base about the barriers women impacted by abuse may encounter when trying to access health care services; and the

useful strategies and systemic changes in the health care system that can be implemented to increase women's access to good health care services.

## 4. FINDINGS

The findings have been analyzed as a whole and not according to different programs for a couple of reasons. First, this was done to maintain the confidentiality of the participants, since those familiar with the programs at BCW may be able to identify what barriers or strategies were attributed to specific programs. Second, in some programs, only one person was interviewed and therefore there was insufficient data to analyze and identify common themes for specific programs. Typically between two or three people were interviewed from each program.

In general, the specialized women's health programs, especially those that addressed a complex health issue had a better understanding of the barriers women impacted by violence encounter and had implemented many strategies to ensure women had access to and received appropriate care in their services. All specialized health programs at BCW integrate health promotion principles and work in partnership with a number of community agencies and institutions to address health issues that affect women differently than men. These programs looked at complex health issues more holistically and worked from a more feminist framework. The participants working in these specialized health programs had more of a structural analysis of the barriers women may face in health care systems compared to programs that adhered to a biomedical model and were more focused on single health issues.

## **4.1 Barriers**

Participants identified numerous barriers that they believe prevent women impacted by violence from accessing care at BCW or from receiving appropriate care when they do access services. The barriers identified fell into three general categories that were further divided into themes. Some of the barriers related directly to women's lives and the affects of the abuse, others related to structural issues of programs and services, while others were more logistical barriers. The three main themes were *Abuse as a Barrier*, *Structural and Organizational Barriers*; and *Logistical Barriers*.

### **Abuse as a Barrier**

The interviews revealed that abuse, the power and control influenced over women, acted as a barrier to care for many women. During analysis, this theme was separated into several sub-categories that are outlined below.

#### **The inability to get everything in order to attend appointments**

The inability for women to "get everything in order" before an appointment was raised numerous times. This was especially true for women who wanted to attend a residential program with one participant noting that "[a women is often] not able to put other parts of their life aside for a number of weeks if she wants to do an in-house program." The inability to arrange childcare was the most common and significant barrier when it came to this theme. As one participant said "child care... [it's an] unseen issue... [she] may not want to leave children with [the] abuser and may have no one else to leave them with."

### **Lack of safe communication methods**

A lack of safe communication methods was also cited as a barrier to accessing programs or receiving follow up care. As one participant noted, “some women don’t have phones or safe phones.” Marginalized women, like those living in poverty, may not have access to a phone or have a phone that they can receive calls on. Other participants discussed the fact that “some women [in violent relationships] are not allowed to use the phone.” This lack of safe communication methods made “follow up very difficult.” Participants acknowledged, “it may be unsafe to mail a letter because [the] abuser may open it,” and that “receiving phone calls or contact may trigger suspicion [of the abuser].”

### **Emotional barriers**

Participants also acknowledged that emotional barriers could prevent women impacted by abuse from receiving good care from services and programs at BCW. The main emotional barriers identified were fear, lack of self-empowerment, and stigma. One participant said that a woman may not access their services because she may feel “terror at making a commitment for a certain number of weeks” when her life is so unpredictable because of the abuse she is experiencing. Another participant noted that women had numerous things to be fearful about when thinking about accessing services: “fear, stigma... [her] partner controlling her actions... fear she is going to lose control, or fear of the [vaginal] exam itself.” Another participant whose program did outreach programs stated, “many of the women in the target population of the clinic won’t seek screening specifically, [they] fear that [the] nurse will see bruises. Therefore [they] don’t utilize services.”

### **Partner interfering with access**

Participants identified partners as being potential barriers to accessing care for women in abusive relationships. One participant explained, “[their] partner may not want them to come in alone or come in at all.” Participants also identified that “he may be threatened by her getting help.” When accessing care with their partners, participants noted that women are often “unable to make choices for themselves.” The complexity of partner’s involvement when staff are aware of the abuse was also discussed: “[women are] caught in the cycle...[they] fear... being left by partner, [so] they leave the service because [their partner] is not allowed on the ward... we must balance the safety of the woman and [the] safety of the staff.” Another participant acknowledged that for women who have left their abusive partner, they might not continue to access services because of fear for their safety. Partners may be aware of where the services are or when they usually access care. Participants also identified that a woman may also not be able to access care because they are physically unable to do so because of injuries sustained by her partner.”

### **Fear of confidentiality breach**

Participants identified that women’s fear of confidentiality breaches was a major reason why women did not access care or would not to open up about their health and social issues. Several participants recognized that some women do not access services because of the fear information will be leaked to her partner or others and the fear of repercussions if the partner finds out about certain health issues (HIV, pregnancy, abortion, etc) or they suspect that she disclosed about the abuse. For the outreach programs, one participant explained that if women do disclose abuse “it is hard to come into a community and start asking health care providers about services. They want to know who and what happened, but confidentiality is so important.”

## **Structural and Organizational Barriers**

Participants identified numerous structural and organizational barriers for women to accessing services or to receiving good care when they do access services. It is evident by the participants' discussions that these barriers were still highly influenced by women's experiences of past or present abuse. These barriers clearly affected women impacted by multiple oppressions the most.

### **Policies and protocols**

Participants identified that "policy guidelines are rigid and standardized [but they] should be flexible enough to meet the needs of women." It was also noted, "process and systems [in the hospital] really put up barriers for women." One participant suggested, "maybe as an organization we need to look at the [strict] policies and protocols... they work for us, but what about abused women." Another participant echoed these ideas with an example, "I'm not sure all policies take safety into account or meet abused women's needs. For example, [in some services]... protocol says that [a] woman must be accompanied by someone else... what if the abuser won't bring them or if they have trouble finding child care." Many services require that a woman receive a referral by a doctor or midwife. This is a barrier because "this means women have to have a GP [general practitioner] and feel comfortable enough to discuss it [the health concern] with their GP."

Being inflexible and unaccommodating about booking, re-scheduling or cancelling appointments also act as barriers for women in abusive relationships. A woman experiencing abuse in her relationship may only be able to make appointments at certain times of the day (e.g. when her partner is at work) or may be prevented from making an appointment for a myriad of reasons (e.g. lack of childcare, partner

interference, etc). Participants also acknowledged that long waits before an appointment may prevent women from accessing care because they do not have the time to set aside for the appointments.

### **Time restraints**

Time restraints were also mentioned as a barrier for women impacted by violence trying to access services or to receiving appropriate care at BCW. Participants identified that the hours of operation for clinics or services are often inconvenient for women. Another barrier identified was the short length of time available to spend with women, which inhibited the opportunity to discuss anything other than the specific reason for the appointment. One participant also noted that even when abuse is disclosed it was "hard to keep women for too long because [their] partner may get suspicious."

### **Lack of coordination and advertisement of services**

Participants also identified that the general lack of coordination between services and the lack of adequate advertisement of services may act as a barrier for women. Participants worried that service providers, in and out of the hospital, may not be aware of their programs. A participant remarked, "[we] don't see many women from certain groups in our program, for example young women. Do they not have as many issues or are they not aware of our services?" Some participants were concerned that service providers and women were not aware of certain aspects of their program that were in place to increase access for women, especially marginalized women. For example, some programs do not require women to have a CARE Card; however, not even all service providers working in the hospital are aware of this.

Participants acknowledged the general lack of services for women impacted by violence on site and in the community as a barrier to providing good care and appropriate referrals. Participants also noted that there was a limited knowledge among staff about available community and in-house resources for women who do disclose abuse. "A number of nurses have limited knowledge of resources. Nurses usually suggest women speak to a social worker, but this may not be acceptable [to women]..." Participants also identified that there was a lack of communication between the hospital and community services when women are referred which made it difficult to know the outcome of the referral.

### **Discrimination and oppression as a barrier**

Participants recognized specific barriers that affected oppressed women's access to programs and services and their ability to receive good care. Participants acknowledged that women with disabilities, addictions and Aboriginal women all have experienced high rates of violence and are at highest risk. One participant stated, "A history of child protection and hostile environment in the health care system for Aboriginal women [are] major barriers for abused Aboriginal women to access health care or receive good care... when in hospital."

Participants identified the difficulty in finding language and cultural interpreters that were not associated with the woman, as well as, the lack of resources in the woman's mother tongue as major barriers to giving immigrant women appropriate care. Participants revealed that, at times, partners were used as interpreters and that not many of their resources had been translated into other languages. Participants acknowledged that non-status Aboriginal women may not be eligible for care, yet if they are in an abusive relationship may desperately need health care services. Health care

services may be the only services non-status, refugee or immigrant women are aware of in their communities.

Finally, women with substance use issues or mentally ill health face additional barriers to accessing or receiving good health care. Participants acknowledged that for women who have a “co-dependence on substance use and [/or] co-occurring mental health problems... [it is] hard for women to see clearly or think clearly” when trying to access health care. Some programs will not see a woman if she is under the influence of drugs or alcohol. As stated above, research shows that a high proportion of substance using and/or mentally ill women have histories of violence. One participant also mentioned that some women might not want her partner or others to know that she is seeking mental health services for fear that it could be used against her in the future, for example in custody trials.

### **Past negative experiences with health care**

Finally, participants recognized that past negative experiences with the health care system acted as a barrier for women impacted by violence. One participant said, “many women have a background of abuse and the way services are set up... women may not want to access them.” Other participants noted, “women experience violence from institutions... racial violence or prejudice” which would prevent them from wanting to return. Communication patterns in the organization were also identified as a potential barrier for women impacted by violence. Ordering patients around and being unsympathetic to a woman’s circumstances or fear about receiving treatment were cited as reasons why women may not return for care.

## **Logistical Barriers for Women**

Finally, participants acknowledged two interconnected logistical barriers, financial constraints and transportation issues. These added to the difficulty of accessing services for women, especially poor women and those living in rural and isolated communities.

### **Financial Constraints**

Participants noted that many of their clients or potential clients might not have the money to travel to the hospital (e.g. taxi, bus tickets, or gas for their car) or to pay for childcare. Some participants noted that one of the reasons women might stay with their abusive partner is because of finances. Participants also identified that a lack of money may hinder women when “trying to get pharmaceuticals.” Some women may not be able to afford to access certain programs or services because they have fees attached. One participant explained that: “working women may not be able to access income assistance to pay for our program... program costs \$1680.”

### **Transportation Issues**

Many of the participants raised transportation issues as a barrier to accessing their services for women living in Vancouver and around the province. Some participants also noted that parking is expensive and very limited at BCW. A couple of the services at BCW are the only specialized ones of their kind in the province, so women may have far distances to travel and need overnight accommodation. For example, one participant stated, “only 20% of [our] clients come from the lower mainland.” Meaning the other 80% of their clients must travel from other parts of the province to access their services.

## **4.2 Strategies to Increase Access and Ensure Good Care**

Participants also discussed strategies that were used in services and programs at BCW to increase access and ensure good care for women experiencing abuse, especially those who are impacted by intersecting oppressions. Six themes emerged during analysis of transcripts: low barrier and flexible services; coordination; confidentiality; women-centred care; acknowledging the role of oppression and discrimination in women's lives; and help with logistical problems.

### **Low barrier and flexible services**

Participants noted that some programs were easier for women impacted by violence to access. These programs did not require referrals from GPs, but instead women could self-refer or a community service provider could refer a woman. One program has a revolving-door policy, which allows women to leave and come back as many times as they want without losing their spot in the program. A few of the programs do not require women to have a CARE card to access services. One participant noted that their program had recently "started a clinic... not in-service. The clinic will welcome women even if they are late [or] missing ID." Participants also noted that certain programs allow women to "call up and ask for information even if they are not a patient."

Participants acknowledged that some programs had more flexibility with cancelling and rescheduling appointments, though participants agreed that there was more room for improvement. Some programs with outreach services put effort into learning where vulnerable women live and access care so they can ensure these women know about their services. Other programs ensure that patients are seen within a timely manner, to reduce the stress of waiting and not knowing what is going to happen next. One program ensures that all women are seen within 45 minutes of requesting their

services. A few of the programs have satellite sites or mobile vans to increase access to isolated and oppressed women. Finally, a few participants remarked that having a 1-800 number for their program or service would greatly increase access for women experiencing abuse.

## **Coordination**

Participants acknowledged that coordination between other programs and services at BCW and with community services could greatly increase access to good care for women impacted by violence. Participants explained that programs do outreach to ensure that community services are aware of their services and to build good relationships with these services. Some programs will do workshops and education sessions around the province about their services.

Some services “will call around to other clinics to see if there’s a spot available at another clinic to hurry the process if we are booked.” Another participant noted that “during counselling if they realize women are experiencing abuse they will arrange for her to talk to someone or help them get into a shelter if that is what she wants.”

## **Acknowledging the role of oppression and discrimination in women’s lives**

Participants noted that certain programs did a good job of acknowledging oppressed and discriminated women’s specific needs. One participant commented on the need to develop services tailored directly to discriminated and oppressed women, “At [their program], violence is one of the challenges these women face. They also face challenges regarding housing, food, addictions. It was a good decision to create the program because they found [these] women were further marginalized and treated poorly when accessing general [hospital] programs.”

Many participants talked about the health of Aboriginal women and the need for services to be adapted to meet their needs. One program has a patient advocate that will help women navigate through the services at BCW to ensure women receive the care they require. The fact that some programs targeted oppressed and discriminated populations throughout the province in their outreach efforts was another method participants identified that helped to increase these populations' access to care.

Participants also discussed the need to have resources available for different groups of women to ensure they have access to health information and know about other programs and services available to them. Some programs have forms in different languages and resources tailored for specific groups of women including immigrant women, lesbian women, Aboriginal women, and women in violent relationships.

### **Confidentiality**

All participants acknowledged the need to ensure confidentiality in order to keep women impacted by violence safe and provide them with the best care possible. One program "brings women into [the] counselling session alone. This is a blanket policy so that it will hopefully not raise suspicion with partners." Other programs try to create opportunities to get women alone and ensure those she explicitly lists only see her. Some programs ensure that they always provide professional translators and will not allow family or friends to translate for a woman. While other programs will not take a woman's health history around a partner because of the possible repercussions that may result if he learns about something he was unaware of (e.g. past abortion, pregnancy, STIs, etc). Participants also noted that it was important to be cautious of what they record on a woman's chart because of the chance that a partner may see it.

When programs call to remind women of their appointments, they do not identify their specific program or service, but simply say they are calling from BCW in case women have not disclosed certain health issues to her partner. No correspondence is made without the woman's explicit permission in most programs. A few programs give women the option of receiving medications intravenously so there will be no trace of medications (e.g. bottles or prescriptions) that may raise suspicion of a partner.

### **Women-centred care**

Many participants acknowledged that women-centred care approaches were vital to ensure women impacted by violence received appropriate care and to minimize the negative effects of engaging in the health care system. Participants acknowledged the importance of always involving women and offering them choices about the care they receive. One participant identified a change in the way the services and programs approach care: "[it] used to be document, document, document and 'fix it'... now [it's] about empowering women and letting them take the lead." Several participants highlighted the need to "understand the whole range of women's situations... [she] might not want to contact police or take medications for various reasons." Another participant commented on this need by saying: "[we] let women be the judge if she has children... [we] have hardly called social services.... [we] assume women have the best interests of their children at heart."

Tailoring services to women's needs was also a reoccurring sentiment of the participants. Some participants believed that basing what is done in appointments on women's needs, not the provider's needs was important for all programs. This was especially true for outreach clinics that may be seeing women who do not have regular contact with the health care system. One participant explained that their program tried to allow women to raise any issue they may want addressed and "tried not to make the

clinics so specific... not just PAPs and breast exams, even though that [is] what we are funded for.” Participants also acknowledged that there were opportunities for experiences of violence to come up during appointments: “[We] don’t have a tick box saying ‘are you being abused, but there are many opportunities for it to come up.” Some participants noted that they tried to provide as much opportunity for women to talk about their needs and problems as possible. One participant explained that staff in their program try to “open [the] door for talk or discussion, but we don’t push her to talk or take action.”

Participants noted that some programs try hard to have women-friendly and safe atmospheres and to ensure female providers are available. Some ways that programs tried to create such atmospheres were having a play area for children; help minding children when women see the provider; providing snacks and drinks; decorating waiting and exam rooms to be welcoming; and staff wearing regular clothes to reduce women’s anxiety about interacting with a person in a position of power. Participants also acknowledged that sensitivity to what other social and health issues women may be dealing with and attempting to normalize exams and procedures are important. Some programs will allow women to bring in their family and friends during the examination, but only after the provider has had a chance to ensure in privacy that she indeed wants them with her.

### **Help with logistical problems**

Participants acknowledged that certain programs do a better job than others in assisting women with logistical problems. Several programs will help with transportation issues by providing bus tickets or taxi vouchers to women who require them. One participant gave a good example of how their program ensures women’s safety by

helping with logistical issues: “[we] ask questions like ‘are you okay to go home?’ [And] ‘are you safe’ to clients... [we] will also provide support... like arrange for a place for a woman to spend the night.” Some programs will also provide IDUs, birth control, and HIV prophylaxis to women on site for convenience. Some programs provide food and/or new clothing to women who need this. Participants also noted that some programs are very good at advocating on behalf of women to ensure they receive other important services (e.g. income assistance, or counselling).

## **Other Findings**

The adoption of feminist ideas of violence against women; the understanding of social determinants of health; and the acknowledgment of intersecting oppressions vary between programs. This has created some tensions within the hospital and between programs. Some programs have a greater understanding of women-centred care and are committed to implementing this approach into practice, policy and research. A women-centred approach recognizes the unique circumstances of women’s lives and the impact of social circumstances on women’s health and this awareness is embedded in many programs and services at BCW. Other programs are still operating from a more biomedical model of care, which recognizes the role that social determinants play in women’s health to a much lesser extent. This paper has tried to be respectful of these differences without concealing information that was revealed in the interviews. However, this report may be viewed as a criticism of how some programs at BCW run their services.

The Woman Abuse Response Program is continuing this internal process by trying to build trust with and provide education to all programs about women-centred care as well as facilitate inter-program communication and collaboration. Due to the political sensitivities around some of these issues, this paper will not be published in the

academic literature or disseminated until these tensions have been resolved. As a result, the knowledge translation of these findings to a broader audience may be limited. This could prevent other health care settings from understanding potential barriers for the women they serve and evaluating their own services to improve access for women impacted by violence.

## 5. DISCUSSION

Participants identified and discussed many of the barriers to care and strategies to improve access to appropriate health care for women experiencing abuse found in the literature. The literature focuses heavily on barriers stemming from interactions with health care providers, abusive partners' control, and structural barriers. While participants identified these as barriers, the results from the interviews broadened the scope of barriers to also include logistical barriers related to BCW.

A definition of violence against women was not provided to participants prior to the interviews; however, it is clear from the results that many of the participants understood violence against women as a gender-based, social and structural issue. Most participants were also aware that violence intersects with other social determinants to negatively affect women's lives. Given BCW's focus on women's health and the participants' positions in the organization, it is likely that they had a higher level of understanding about the dynamics of violence against women and its impact on women's health compared to the majority of those working in the health care sector.

The structure of the health care system is based on hierarchy, power, and control, which are the very dynamics of an abusive relationship (Cory & Dechief, 2007). Like most systems, the health care system is highly gendered, raced, and classed (Jiwani, 2000c). This makes the health care system a very difficult place for women impacted by abuse to access and feel comfortable in. Even at BCW where all services are tailored to women, the interviews revealed that these dynamics were present. Until the oppression that occurs within the health care system itself is addressed, it will be

difficult for the system to contribute to addressing the power and control dynamics that exist in our larger society and how this influences the women it serves (Jiwani, 2000c).

As the interviews indicated, the mere fact that BCW is a women's hospital does not guarantee that all services are women-centred or acknowledge the role of intersecting oppressions in women's lives. The interviews revealed that there is often a lack of analysis of the potential harm or barriers certain policies and procedures at BCW may create for women. There is also a lack of recognition of the broader social determinants of women's lives and ability for women to have choice in and control over their care. As previously mentioned, programs that had a better understanding of the structural violence in women's lives tended to provide better care to women impacted by abuse.

Interestingly, while almost all the literature discusses recommending or not recommending screening for violence against women in some capacity, the participants in this environmental scan did not raise the issue of screening. BCW does not have a screening protocol in place and the results of the interviews reveal that participants do not identify screening as a potential strategy to increase access to appropriate health care for women impacted by violence. Instead, the strategies were mainly focused on organizational policies and changes to make the interaction with the health care system a better experience for women. Acknowledgment of the social determinants of health and intersecting oppressions for women were also raised. Inter-sectoral and inter-program communication and coordination were identified as important strategies to ensuring women impacted by violence receive comprehensive and appropriate care.

Providing comprehensive and appropriate health care to women impacted by violence can only occur if fundamental changes in the health care system are made. The recognition that a significant number of women accessing the health care system

have been impacted by or are currently experiencing violence is important. The health care system must move away from an individualistic, bio-medical approach to include women-centred care principles and acknowledge the social determinants that affect women's lives.

Some attention must also be given to specific issues that arose in the interviews regarding barriers to accessing services and programs at BCW. The fact that interpreters and materials are often not available at BCW for women who have English as a second language is of great concern. Interviews revealed that at times women's partners are used as interpreters. If a woman is in an abusive relationship her partner, acting as an interpreter, can completely control the health care encounter and she could be prevented from expressing her needs (Anderson & Aviles, 2006). A lack of resources in other languages and lack of language and cultural interpreters greatly decrease the ability to inform non-English speaking women or women from other cultures about certain health issues and services available to them; it also reduces their choice and control over the interaction.

Financial barriers are of particular importance since research shows that in Canada, 2.4 million women (1 in 7) live in poverty (Canadian Research Institute for the Advancement of Women, 2006). Certain groups of women have increased levels of poverty, including: Aboriginal women, single mothers, senior women, women with disabilities, racialized and immigrant women and women living in rural or remote areas (Canadian Research Institute, 2006). Women comprise the majority of workers in low paying, part-time or contract jobs (Reid, 2007). These jobs lack financial security and most do not offer "health care or disability benefits" (Reid, 2007, p. 202). Additionally, women living in poverty or rural/isolated locations and immigrant/refugee women are

less likely to have a GP and therefore less likely able to access some of the programs that require a doctor's referral.

BCW is located outside of Vancouver's downtown core. It is not on the Skytrain route (although it will be in the future) and is only accessible by a few buses. Hours of operation often reflect typical working hours (8:00am-5:00pm) requiring women who are employed to take time off to attend appointments; this may not be possible due to employers' unwillingness to grant time off or because women cannot afford to lose their wages. There is a shortage of adequate and affordable childcare in Canada, and this can create barriers for a woman trying to access health care for herself, especially if she needs ongoing treatment (Raphael, Bryant, & Curry-Stevens, 2004). Abusive partners may also restrict the times when women may be able to access care (Lichtenstein, 2006). For a woman living in a violent relationship who lacks freedom and control over her actions, these seemingly minor barriers for all women may significantly affect a woman's ability to access care at BCW.

BC Women's Hospital and Health Centre is unique in that it focuses primarily on women and has a variety of specialized women's health programs. The data collected in this study, however, is likely useful for other health care settings because, as the literature shows, many of the issues raised in this study reflect similar issues found in the health care system. BCW is a women's hospital, regarded as the leader in women's health in BC, and therefore one may believe that all services are women-centred and very accessible to women impacted by violence. However, participants still identified numerous issues that could prevent women from accessing their services and receiving comprehensive and appropriate care. Similar barriers identified for BCW may be occurring in other hospitals and health care settings that do not have as much of a focus on women's health and their social circumstances. This study may help other health

care settings to understand and examine potential barriers in their own services and practices for women impacted by violence who are seeking appropriate and comprehensive care.

Conversely, this study highlights the many strategies BCW has implemented to increase women's access to appropriate care, which other hospitals and health care settings could draw from to ensure their services are accessible to all women, especially those impacted by abuse. This study hopes to contribute to the research base about the barriers women impacted by abuse face when accessing the health care system and strategies that can be implemented to ensure they receive appropriate and comprehensive health care.

## **Implications for Public Health Practice**

In 2000, Health Canada established a policy "requiring gender-based analysis to be used in developing and analyzing policy, programs, legislation and research (Johnson, Greaves, Repta, 2006). The population health approach, as described by the Public Health Agency of Canada, recognizes multiple determinants of health. These include income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture (Public Health Agency of Canada, 2002). While it is important to have these issues addressed in publications and frameworks, the implementation of these ideas into practice is difficult and absent in much of the health system, including public health.

There is still a lack of gender-based analysis in the public health system, with many policies and practices remaining gender-blind or gender-neutral (Johnson,

Greaves, Repta, 2006). Much of the public health research, practice and policies do not adequately examine the way social determinants and oppressions intersect with one another to impact health and well-being (Morrow & Hankivsky, 2007). There is also a lack of recognition that the structure of the health care sector reflects many of the societal hierarchies, discrimination and oppression that negatively influence women's lives (Thurston, 1998). While the population health framework acknowledges the need to address the broader social determinants of women's lives, practice still widely reflects an individualistic focus with bio-medical or health behaviour change solutions.

The health care system is under funded and in a state of uncertainty, therefore access to health care services is an important public health issue for all Canadians. It is a more pressing issue for populations such as women impacted by violence and other intersecting oppressions. After years of trying to raise the awareness about violence against women in the health care system and implementing primarily screening interventions, there remain numerous barriers to accessing appropriate care for women impacted by violence. As the literature and the findings in this study show, strategies to address women's complex social and health issues are very important. Structural changes within the health care system must be made to increase equality and reduce discrimination and oppression of its patients and staff (Jiwani, 2000c). Acknowledging the unique challenges women face, especially those impacted by violence will also improve the health care system to provide comprehensive and appropriate care.

By improving access to health services, and the care they receive when in the health care system, there is the potential of improving the health status of women impacted by violence. The health care system may also save money because women impacted by violence will not resist accessing services until the health problem has progressed into a severe and/or urgent one. With more research like this, a future public

health goal should be to establish best practice guidelines for the health care sector to ensure it adequately and effectively supports women impacted by violence with their health care needs. Further, in accordance with feminist research it is essential that women's voices, especially those women impacted by intersecting oppressions, are included in all research, and decisions regarding policy, programs and legislation. To date there is a lack of incorporation of women's stories and experiences into research as well as a lack of studies that follow up with women after their encounters with the health care system (Dechief, 2003).

## **Models for the Future**

Integrated models of care, such as those described in Women, Co-Occurring Disorders and Violence Study (previously mentioned), will help ensure that women receive comprehensive care that acknowledges the impact of violence in their lives and addresses their complex health issues through a holistic approach (The Women, Co-Occurring Disorders and Violence Study, 2007). These models acknowledge the ineffectiveness of addressing each health and social issue in isolation. Another critical feature of these models is the strong commitment to involving the women they are serving into all aspects of planning, implementing and evaluating the services (Warshaw & Moroney, 2002). To meet the needs of women, the health care system must shift from the traditional disease focused, professional-driven services towards services that involve women, appreciate the intersecting oppressions that affect their lives and acknowledge the high prevalence of complex interconnected social and health issues in women lives.

A move from a bio-medical approach to a more women-centred approach that aims to put women and their health concerns at the centre of all health care interactions should occur within all areas of the health care system (Dechief, 2003). Interviews with

women point to key components of health care responses for women impacted by abuse. These include care; compassion; understanding; honesty; support; being given detailed explanations about procedures and treatments; non-judgmental interactions; and safety (Rodrigues, 1998; McMurray & Moore, 1994). Effective and non-victimizing health care interventions for women impacted by abuse must include a more holistic approach and recognize the various intersecting oppressions these women may face. Health professionals must understand the impact of sexism, racism and other forms of oppressions and have adequate skills in communication, referrals and inter-sectoral collaboration (Thurston, 1998).

Interagency and inter-sectoral collaboration can only occur if those working in the anti-violence sector are seen as having expertise in women's safety and therefore can equally contribute to a partnership with the health care sector. Historically, this has not occurred because of the significant differences in wages and the higher status of the health care profession in our society (Thurston, 1998). In 1989, the Ministry of Attorney General funded seven Violence Against Women in Relationships (VAWIR) community coordination initiatives around BC. There are now at least 30 VAWIR community coordination committees in BC. The goals of these committees is to facilitate an effective community response to violence against women; develop protocols for intervening agencies; identify systemic issues; maintain a process for interagency sharing; identify failures in the flow of services to victims and sanctions on abusers; and reduce victim-blaming within systems. The VAWIR committees have representation from the anti-violence, health, justice, and social service sectors and have been shown to improve the response to women impacted by abuse from the various sectors (Porteous, & Coombe, 1999). While there are many VAWIR committees established across Canada, some communities, including Vancouver, currently do not have one.

Also, many committees are under funded and lack adequate representation from all sectors. Future initiatives should include establishing VAWIR committees in those communities without them and ensuring all committees are adequately resourced. This will help reduce barriers that women impacted by abuse face when trying to access all systems, including the health care system.

## **6. CONCLUSION**

Regarding violence against women, the main priority for the health care system should be to address the health needs of women impacted by violence. The health care system, however, must acknowledge the broader social determinants of health that impact women. If women impacted by violence are treated respectfully, given choice and control over the care they receive, and helped with logistical barriers to accessing care, they will not only receive the health care that they require, but may feel safe and supported enough to disclose the abuse and reach out for help. Shifting services to reflect a more integrated approach will more adequately reflect women's social and health realities. Collaboration with other programs and community services will ensure that when a woman requests assistance related to violence or other social determinants, that their needs will be appropriately and quickly addressed and adequate referrals will be made.

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# APPENDIX 1

## Interview Questions

1. Overall how aware are you about violence against women.
2. How do you think violence affects the health of the population of women you serve?
3. What initiatives have been taken to ensure your staff is educated about violence against women?
4. Woman abuse has various health impacts. Has your staff had any training on the numerous health impacts of woman abuse and how to respond?
5. What are some of the barriers you are aware of for women experiencing abuse attempting to access your services/program?
6. What strategies have you implemented to ensure women experiencing abuse, especially those who are marginalized, have access to your program?
7. Do you have a protocol in your program for working with women experiencing abuse? What is it?
8. Do you have protocols for working with women experiencing substance use issues and/or mental health issues?
9. What is your understanding of women-centred care? Have steps have been taken to incorporate women-centred care into your practice?
10. Do you think about women's safety when developing practices, policies and protocols? - security protocol. confidentiality. documentation
11. What kind of support would you like from the Woman Abuse Response Program?

### 6 Panel- explain a little about SHE

12. Would you be interested in participating in the SHE process to assess your service for potential risks to women experiencing abuse?

## **APPENDIX 2**

### **Woman Abuse Response Program**

The Woman Abuse Response Program is a provincial outreach program that supports communities to implement health services for women impacted by abuse and to develop an integrated and coordinated multidisciplinary response between health, justice, and community agencies and advocates. The Woman Abuse Response Program offers training, resource development, consultation, and clinical support to health care staff in communities across B.C.

### **Maternity Care**

BC Women's is the largest maternity hospital in Canada, supporting more than 7,000 women a year in giving birth, and caring for several hundred very high risk newborns every year in our intensive care nurseries. In our Diagnostic and Ambulatory Program, we provide essential prenatal consultation, diagnostic and interventional services to women with complex pregnancies. We are the lead tertiary perinatal provider in the province and are responsible for the Provincial Tertiary Perinatal Program and the BC Reproductive Care Program.

### **Reproductive Mental Health**

The Reproductive Mental Health Program is a joint program of BC Women's Hospital & Health Centre and St. Paul's Hospital. Services are provided to women who experience psychiatric disorders, such as major depression, anxiety, obsessive-compulsive disorders, or psychosis related to their reproductive cycle (e.g., premenstrual syndrome, premenstrual dysphoric disorders, infertility, pregnancy loss, pregnancy and postpartum disorders, and menopause). These services are available to B.C. residents by referral from a physician.

### **Aurora**

Aurora is the largest women's-only treatment facility in B.C. providing both residential and day treatment services with twenty-nine beds and space for ten people in the day treatment program. We also conduct research on women and addictions and take a leadership role in promoting improved addiction services to women in B.C. Programs offer group counselling, self-help groups, seminars, yoga, fitness classes, and art and music therapy. The two-week pre-treatment day program accepts self-referral; the 5-week intensive day program and 6-week residential program require referral from an alcohol and drug outpatient counsellor, co-occurring disorder specialist, or addiction medicine doctor.

### **Breast Health Services**

Breast Health Services offers comprehensive clinical services including Screening Mammography (through the Screening Mammography Program of BC) and Diagnostic Services to women in British Columbia. Our multidisciplinary team includes specialized technologists, radiologists, and nurses

### **Oak Tree Clinic**

The Oak Tree Clinic provides specialized HIV care for infected women, pregnant women, partners, children and youth, and support services for affected families.

The Oak Tree Clinic is a tertiary referral outpatient facility providing specialized care in HIV/AIDS. It improves access to care, and provision of optimal woman and child friendly care in a safe environment. Oak Tree also educates patients and their families, other health care workers, organizations and institutions, and the public about the complex issues of HIV infection in women and children; advocates for improved prevention, diagnosis, care and support; and contributes to

clinically oriented research. The clinic accepts referrals from physicians, other healthcare professionals, community agencies and support workers. Self-referral is also possible.

### **Sexual Assault Services**

Sexual Assault Services is a specially trained team of female nurses, nurse examiners, doctors, and counsellors. They provide care 24 hours a day and offer medical care and emotional support to anyone 13 or older who has been sexually assaulted within the past seven days. Sexual Assault Services welcomes women, men, and trans-gendered survivors of sexual assault. Services include assessment and treatment of injuries, sexually transmitted infections, and pregnancy prevention as well as forensic evidence collection and emotional support. Referrals to health, legal, and community-based support services can also be provided. In addition to patient care, the service provides education and training to health care providers and others working in the area of sexual assault

### **CARE Program**

CARE stands for Comprehensive Abortion and Reproductive Education. The program provides safe abortions using local anesthesia, conscious sedation and other comfort measures. Counselling services are also provided to women to review their options with an unbiased counselor and to provide information about the procedure and post-procedure care. The CARE program also operates a free telephone service to help women with unintended pregnancies find support, information, and services as close to home as possible. The CARE Program also coordinates care for women who require pregnancy termination following a diagnosis of fetal anomaly or because of maternal complications.

### **Aboriginal Health Program**

The Aboriginal Health Program provides both on-site and outreach services to improve the health of Aboriginal women and their families. The on-site program includes a First Nations Patient Advocate that offers services to improve the quality of health care delivery to Aboriginal inpatients and outpatients through staff education and on-site patient support. The outreach program offers support to Aboriginal communities (both on and off reserve), and includes education about various women's health issues, cervical and breast cancer screening clinics, nurse training, and assistance with regional workshops.

### **Fir Square**

Fir Square Combined Care Unit program is the first in Canada to care for substance-using women and substance-exposed newborns in a single unit. The program works from a harm reduction model and the aim is to help reduce substance use and risky behaviors that can cause harm to mothers and their babies. Women and their babies are kept together on the ward. Care is provided from antepartum to postpartum and between hospital and community. Women also have access to counseling and instruction to enhance critical life skills, parenting techniques, and coping mechanisms. Fir Square also runs a weekly out-patient clinic where women may self refer, and a lack of a physician, ID or medical card is not a barrier to attending the clinic

### **The Social Work Department**

The Social Work Department's overall objective is the provision of comprehensive social work services according to individual need, for children, youth, women, and their families. These services include crisis intervention, individual family and group counselling; parent groups; financial/practical assistance as well as liaison with community resources. Social workers are professionally trained and are part of the clinical team assisting patients and families with the social and emotional impacts of an identified medical condition, perinatal care or disability.

(Provincial Health Services Authority, 2008)