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RESEARCH BRIEF 1

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Violence
as a Determinant of Girls' and Women's Health

Introduction

Despite the public attention and academic research on the issue of interpersonal violence, it continues to have a serious impact on the health and well-being of Canadians. While violence affects men and women of all ages, in comparison to males, females across the lifespan are considered especially vulnerable because they have less access to social, economic, and political resources. The result is that many women do not report the violence they experience. Further, women are also more inclined to stay in unhealthy interpersonal relationships where violence is present, and/or do not access the social support services they need to address this problem. In some cases women are unaware they have a right to safe and secure relationships that are free of violence and the associated trauma that often occurs. For all of these reasons, it can be argued that violence is a major determinant of women's health; one that requires targeted research and concerted action.

The aim of this research brief is to provide a snapshot of recent research pertaining to the interpersonal violence experienced by women of all ages in British Columbia (BC). The purpose is to encourage a broader understanding among health-based researchers, practitioners, governmental agencies, non-profit groups, and the public at large about:

- What constitutes violence against women?
- Which groups of women are the most vulnerable?

- What are we doing to address this problem?
- What knowledge gaps remain?
- What are the recommendations and next steps?

Which Groups of Women Are Most Vulnerable?

A woman's social location can determine the interpersonal violence she will experience across the lifespan (Benoit & Shumka, 2009). For example, factors such as age, gender, economic status, aboriginal status, geographical location, and immigrant and refugee standing (among others) can place some individuals in an especially vulnerable position. Below we highlight some of the empirical research showing how gender intersects with these important determinants of violence.

Age

Adolescent women (←18) represent a large portion of victims of sexual assault (Creese & Strong-Boag, 2008). Despite evidence indicating that 12-35 percent of female adolescents experience violence in their dating relationships (VIHA, 2007a), studies have shown that they are unlikely to seek formal supports in the instance of abusive dating relationships and indeed often blame themselves for the abuse (Banister, 2007). These adolescent women also have little access to positive role modeling of healthy sexual and emotional relationships (Banister et al., 2007), and there is currently a lack of specialized counseling services for this age group.

Older women too experience violence and abuse but unlike their younger counterparts, the abuse of older women receives little attention in the professional literature, which instead focuses on "elder abuse". The main problem with this literature is that it tends to overlook possible gender differences in elder abuse (Hightower et al., 2006; Podnieks, 2008). What's more, it often fails to acknowledge that many older abused women have a long history of such violence and trauma, perhaps reaching back to their adolescence or childhood. Such life trajectories of abuse provide a compelling reason to focus on the education and peer support of younger women. That said, the abuse of older women is a distinct issue requiring immediate attention. Older women, for example, are more likely to experience financial abuse at the hands of their children and extended family (Hightower et al., 2006). They also have a more difficult time extricating themselves from abusive relationships because of the children, property, and extended social networks that often accompany long-term relationships like marriages. In addition, the signs that an older woman is experiencing violence and trauma (e.g., depression, fatigue, anxiety,

Defining interpersonal Violence and Trauma against Women

The United Nation's Declaration on the Elimination of Violence against Women 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" (1993: Article 1). Trauma stems from the experience of violence and abuse and includes "the impact of colonialism, ableism, racism, heterosexism and other systemic oppressions that can hurt and violate women as much as an act of physical or sexual violence" (Parkes et al., 2007: 2).

and confusion), is often misattributed to age and as a result, older women often receive inappropriate care or none at all (Hightower et al., 2006).

Economic Status

Women working in the sex industry, and particularly street-based sex workers, are some of the most economically marginalized women in Canada. Because of sex work's quasi-illegal status in Canada, street-based sex workers often experience marginalization and stigmatization when interacting with our health and legal systems and by society at large. In practice this means that due to displacement policies and prohibitive legislation sex workers are pushed into isolated and dangerous areas of cities and towns where there is poor lighting and sanitation, and reduced access to health and other social services (Shannon et al., 2009a; Shannon et al., 2009b). As a result of structural conditions, sex workers working on the street have the highest likelihood of being sexually, physically, and emotionally abused compared to all other categories of Canadian women (Shannon et al., 2007a) and they are much less likely to report

the violence they experience (Benoit & Shaver, 2006). In some cases, they even suffer harassment and abuse at the hands of law enforcement agents who are supposed to serve as a safety net. Moreover, women working in street-based sex work are more likely to have unstable housing, be in active addiction, and be extremely poor (Shannon et al., 2007a). These are experiences that encourage these women to take risks – e.g., accept dates with clients who might normally be considered too dangerous – in order to provide for themselves financially. It is important to note that while street-based sex work carries with it a heightened vulnerability to violence and trauma, off-street sex workers (e.g., those working from home or in brothels and massage parlours) also report such experiences, although less so. What is clear is that when considering the health and well-being of sex workers, violence and trauma must be considered as important determinants of their health (Hallgrimsdottir et al., 2006).

Aboriginal Status and Geographical Location

Aboriginal women are four times as likely as non-Aboriginal women to experience violence at the hands of their partners. Aboriginal women are also eight times as likely to be killed by their spouses (Brownridge, 2008; Spiwak & Brownridge, 2005; Trainor and Mihorean, 2001). Farmer's (2001) concept of *structural violence* helps explain why these women are more vulnerable to violence and trauma compared to other Canadian

Research Report

According to the World Health Organization (2000):

- **Perpetrators of interpersonal violence against women are almost exclusively men.**
- **Women of all ages are at greatest risk from men they know, especially family members and intimate partners.**
- **Physical abuse in intimate relationships is almost always accompanied by verbal abuse and severe psychological trauma.**
- **Social institutions put in place to protect Canadians (e.g., law enforcement and the judicial system) often blame or ignore women who speak up about being harmed by others.**
- **Thirty percent of women who have experienced interpersonal violence have had to cease their regular activities.**
- **Fifty percent of employed women have had to take sick leave due to interpersonal violence.**

Farmer's (2001) concept of structural violence helps explain why these women are more vulnerable to violence and trauma compared to other Canadian women. Structural violence draws our attention to the systemic social, economic, and historical factors that shape how Aboriginal people (and other ethnic groups) are treated (Benoit et al., 2003; Browne et al., 2007).

women. Structural violence draws our attention to the systemic social, economic, and historical factors that shape how Aboriginal people (and other ethnic groups) are treated. For example, the Indian Act and institutions such as residential schools have resulted in embedded racism and gender discrimination and a lack of access to economic and social resources for all Aboriginal people – especially women (Benoit et al., 2003; Browne et al., 2007). As a result, Aboriginal women are placed at increased risk of physical and sexual violence from within and outside their communities (Shannon et al., 2007a). Certainly the Aboriginal women who have been injured, gone missing, or been murdered in Vancouver's Downtown Eastside, or on what has become known as the "Highway of Tears" – Highway 16 located in Northern British Columbia near Prince Rupert – are compelling examples of this kind of gendered and racial discrimination.

Compounding these kinds of problems is that Aboriginal women are more likely to live in rural areas or on remote reserves where there is less access to services and support (Varcoe & Dick, 2008). There are fewer transition houses and safe places for women to go and confidentiality can be a concern in small communities (Adler, 1996). Limited resources and cuts to social assistance funding often means that women are not able to leave isolated reserves or must return to them if they are not able to support themselves and their children. Ironically, Aboriginal women often find themselves in a double-bind in that they will avoid reporting experiences of domestic and sexual violence by intimate partners and others to ward off further racial discrimination against themselves and their communities, and to protect themselves from retaliation within their communities (Varcoe & Dick, 2008; Browne et al., 2007).

Immigrant and Refugee Standing

Navigating a new environment with an unfamiliar language and culture can dramatically increase the potential for violent conflict within immigrant and refugee families. Wage earners in the family may be unable to obtain work and remuneration that is equivalent with the qualifications earned in their home country. This inability to attain skills-related employment can lead to frustration, loss of self-esteem, and worry about not being able to make ends meet. These issues can exacerbate tensions that accompany immigration and result in violence towards the most vulnerable members of the family (Vissandjee et al., 2007). Women who have been sponsored by male relatives or brought into the country illegally are especially at risk. As the sponsored dependent, they may also be

Most immigrant women enter Canada as legally married dependents. Due to the current framework of Canada's immigration policies, these women are accorded fewer rights than primary immigrants. As a result, these women are at risk of violence and abuse as they may find themselves reliant on an abusive spouse for their immigration status (Vissandjee et al., 2007; Ng, 1996).

How Violence and Trauma Can Affect the Health of Women

There are a great many physical, emotional, and psychological health problems associated with violence and trauma. For women, some of these health concerns include:

- Depression, anxiety, psychosomatic symptoms, eating disorders, and sexual dysfunctions.
- Increase of sexual risk-taking behaviours among adolescent girls.
- Transmission of sexually transmitted infections, including HIV/AIDS.
- Unplanned pregnancies.
- Precipitation of various gynecological problems, including chronic pelvic pain and painful intercourse.

less inclined to report violence for fear that they, or their sponsor, will be deported from Canada (Dunn & Dyck, 2000; Vissandjee et al., 2007). Refugee women may be even less likely to seek help from the authorities if they have come from a situation where they experienced state-sanctioned violence as doing so could jeopardize their refugee status (VIHA, 2007a). Undocumented or illegal immigrant women often work extremely long hours, endure difficult working conditions, and sometimes face sexual and emotional abuse. They too have little recourse but remain silent about abuse because of concerns that they will be deported back to their country of origin (Stasiulis & Bakan, 1997).

Neoliberalism, Funding Cuts, and Shifting Responsibility

Research shows it is less expensive to fund early intervention programs for sexual and physical assault survivors than it is to fund long-term health care for victims after their abuse escalates to life-threatening levels (Ross and Morrow, 2003). Despite the evidence, in the last fifteen years neoliberal reforms across Canada have resulted in funding cuts to social welfare programs (Benoit & Hallgrimsdottir, 2008). Anti-violence programs, women's sexual assault centres, and transition houses have been cut back or eliminated altogether across BC and in most other Canadian provinces (Morrow et al., 2004).

This reduction in community-based support has placed an increased burden on women who are dealing with interpersonal violence. What's more, societal values such as

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autonomy and independence place women in especially vulnerable situations as they are seen as "choosing" their situations and being personally responsible for "getting out" of violent relationships (Varcoe & Dick, 2008: 490). This misunderstanding follows a larger conservative trend whereby governments shift responsibility for health and social welfare onto the individual. By making individuals feel personally responsible for their own suffering they are consequently deflected from the structural circumstances that may be complicit (Shumka & Benoit, 2008). As a result, women with fewer resources or little social capital are left without the social and financial support networks that are needed in order to break free of abusive relationships and gain economic independence in order to care for themselves and their children (Morrow et al., 2004).

Implications for Policy and Practice

While undoubtedly more research needs to be done to better understand the multiple interacting factors that are linked to the high levels of interpersonal violence experienced by women and girls, it is equally important to take action on what we *do* know. Following is a list of opportunities available to policy makers, government, and all concerned Canadians:

- Recognize that interpersonal violence against women is not just an individual concern but also the responsibility of society and its institutions.
- Encourage anti-violence strategies that seek the input of Aboriginal girls and women and take into account the historical context of colonization and oppression.
- Initiate anti-violence strategies that include input from immigrant and refugee women and offer culturally appropriate services in non-official as well as official languages.
- Implement community-mentoring programs for at-risk girls and young women to provide relationship role modeling, support mechanisms, and sexual health education.

Did You Know?

- **Eighty-five percent of all reported sexual assaults victims in Canada are female (Vancouver Island Health Authority [VIHA], 2007a: 45).**
- **BC reports the highest provincial rates of violence in Canada (Johnson, 1996; Morrow et al., 2004: 363; Rodgers, 1994).**
- **Provincial funding previously used to support community based anti-violence programs and sexual assault centers is now going towards anonymous 24-hour help lines and police-based programs (Ross & Morrow, 2003: 2).**

- Encourage non-judgmental health care resources and support for economically marginalized women working in the sex industry so that they are more likely to seek the help of law enforcement and health care workers when they encounter violent or abusive situations.
- Increase anti-violence education in rural and urban communities and improve outreach services and mobile health care for rural women.
- Provide culturally appropriate counseling resources for the victims and perpetrators of violence in abusive relationships.
- Help women remove themselves from violent and traumatic situations with improved funding for housing, child care, employment initiatives, and money management training.
- Challenge and amend the inequitable elements of enactments such as the Indian Act, the Immigration Act, and the laws surrounding sex work.

Knowledge Gaps

The excessive interpersonal violence experienced by women has been a health focus for several decades and the Canadian government has endorsed many international initiatives working to eliminate this problem (Hankivsky & Varcoe, 2007). The work undertaken by many BC researchers is exemplary of the research conducted in this area. However, there are still a number of under-researched and misunderstood issues. In particular, we need to better understand the violence and trauma experienced by other groups of women who have received less attention. These include: women who are institutionalized, elderly or disabled, those in the corrections system, women who are transgendered and in same sex partnerships, and those with substance use problems

We need to better understand the violence and trauma experienced by those groups of women who have received less attention, including: women who are institutionalized, elderly or disabled, those in the corrections system, women who are transgendered and in same sex partnerships, and those with substance use problems (McIvor & Nahanee, 1998)

(McIvor & Nahanee, 1998). The WHRN is supporting research teams to help move this agenda along by encouraging collaboration between community and academic sectors and highlighting the need for an intersectional and gendered research lens to effectively address the complexity of violence and trauma experienced by women and girls.

What Intervention Programs are in Place in BC to Mitigate the Problem?

BC Association of Specialized Victim Assistance and Counseling Programs:

- Provincial association of service providers who address relationship violence, child abuse (recent or historical), and sexual assault.
- Members work in sexual assault centres, community-based victim assistance programs, stopping-the-violence counseling and outreach programs, and similar services.
- Develops policy, guidelines, training, resources, and conducts research and analysis.

Ending Relationship Abuse Society of BC:

- Educational resources and information bulletins on treatment for men who use violence in relationships.
- Province-wide analysis of current service delivery systems of services for assaultive men and community models for increasing women's safety.

BC Women's Hospital & Health Centre Foundation:

- Aboriginal Health Program.
- Sexual Assault Services.
- Woman Abuse Response Program.

Ending Violence Association of British Columbia (EVA BC)[i]:

- Resources for community-based services that support survivors of sexual assault, relationship violence, child abuse and criminal harassment.
- Creates essential links between these programs and government policy makers, legislators and other provincial organization.

BC Coalition for the Elimination of Abuse of Seniors (BCCEAS):

- Non-profit organization committed to "protecting the legal rights of older adults; increasing access to justice for older adults; informing the public about elder abuse; and providing supportive programs for older adults who have been abused".

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The Women's Health Research Network (WHRN) is based in British Columbia, Canada, and brings researchers together who are interested in women's health, and gender and health issues. The WHRN fosters the generation, application, and mainstreaming of new knowledge to improve women's health and women's health research and encourages the brokerage of knowledge regarding the health of girls and women in British Columbia and Canada.

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