



Failure to Prevent Violence against Women: The Social Costs and Consequences on Women's Health



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Abstract

The World Health Organization identifies among the top ten causes of death, illness and disability for adult women on male aggression driving, while other international bodies regularly draw attention to this issue. So far little has been done by binding, until the approval of the Convention in Istanbul in 2011 (ratified in Italy in 2012, with the Law 119/2013). In particular the welfare systems do not implement measures and strategies where this priority receives integrated responses both social and health care. Furthermore, the complex nature of the problem and the extension in quantitative terms the phenomenon involves the difficulty of developing predictive tools that help to combat this problem by acting proactively. It is argued here that only by focusing on gender category analysis and its possible declinations explanatory you can respond effectively [1].

Introduction

In Italy the experience of the Centers anti-violence to more than twenty-five years since their establishment shows that much has been achieved, albeit with continuing territorial differences, in terms of system, confirming the view that a more holistic view of the problem could lead more extensively preventive practices and increased predictive sensibilities in an attempt to deal with the problem [2]. In addition to antiviolence Centers have been set up at the emergency departments Rose codes, sign of a more mature awareness that land consequences of violence not recognized from the earliest rumblings in the relationship with the partners are a major social cost, with short and long term health consequences [3].

It is well known that failure prevention will exponentially increase the risk of developing many diseases that plague these women throughout their lives, often with cumulative effects. In our article we will make a comparative evaluation of both the Antiviolence Centers that Pink codes into two regions: Sardinia and Tuscany, in order to highlight the different professional styles in risk assessment and in taking charge of women victims of violence, with particular attention to the tools available to the social and health professions. The aim is to highlight the results of a more effectively achieved [4], which results in personal empowerment and social costs, when violence is addressed by the assumption of an alliance between knowledge feeding in structuring a network job. We would here highlight the disparity of forces in the field, and then of relations between social actors, since at the heart of

the problem is the violence emerged, i.e. the body of a woman, to give succor and answers necessarily immediate, while conversely the chances to resolve or address it must always be built, conceived, negotiated, assessed, but mostly fished out from oblivion and the collective removal [5,6].

Knowing that to resolve this problem we need a interpretative and operational discontinuity with respect to this departure and asymmetry than the symbolic violence is embedded in the system [3,6,7]. we would here highlight unresolved social policies node, one linked to a "risk assessment" in order to implement effective measures against not only repressive but also preventive. It would thus contribute to building an alternative vision to the thought and the dominant practice in social policies, characterized by a sectoral approach that relies on the inevitable emergence to solve. Undoubtedly, this practice is a first response, emergency and reparative type, but it is difficult to give a method, while looming risk burn out of social workers who work there. Therefore only by integrating health and social care and forms of prevention and empowerment will tackle more effectively the phenomenon [8].

Keywords: Domestic violence; Women; Social policy; Gender based violence; Health

What Can We Do Beyond Dealing with the Immediate Emergency?

Addressing the problem of gender based violence means analysing the related human and social costs, and also striving

to provide suitable answers to a phenomenon, which, by its very nature, has been defined as “intense and pervasive”. Ashamelessly open wound still today plaguing human rights that is in need of effective and practical remedies within a framework of policies for health and social care integration. Considering that the failure to prevent gender-based violence is a crucial issue in social policy, and that it is called into question by various fields of study (from medicine to sociology) in a partial or fragmented way, we can affirm the need for in-depth analysis and research from a gender perspective to highlight not only the consequences of both physical and psychological abuse, but also the causes and any possible solutions. In other words, the problem of violence against women requires a risk assessment, including of the consequences on women’s health, and the adoption of both effective repressive and preventive countermeasures [9].

We are aware that overcoming the problem requires profound change within society and that this can only happen if supported by actions at various levels, ranging from institutional to private, and by targeted and synergic policies. We therefore support the need for an analysis of the health and social care costs resulting from said unsuccessful prevention, after which we can formulate certain hypotheses and proposals on prevention [10].

Our paper examines the situation in Italy, by analysing the so-called ‘Pink Code’ (a tag added to the color-coding scheme of the well-known advanced triage system) and the Centres for Non-Violence in two Regions, namely Tuscany and Sardinia. Our aim is to highlight the different professional styles in risk assessment and the reception of female victims of abuse, and to focus on the skills and tools available to healthcare and social professionals.

The ‘Pink Code’ and the Centres for Non-Violence (hereinafter PC and CNV) are not alternative services: they represent different moments in the provision of care and assistance and their users differ too. The PC is surely the most delicate phase, as the victim at the Emergency Room has not yet decided if she will be laying charges against her attacker/the perpetrator of the violence. A woman who turns to a Centre for Non-Violence has already chosen to pursue a path of awareness and personal change. It is important that a regular system of exchange between these services be set up, as well as the various stakeholders in the networks, which vary in terms of function and contents [11].

The PC provides a first insight into the phenomenon. Here, we can act without any significant increase in costs, because all we need to do is to provide professionals already working in emergency response with the necessary training, thereby generating human resources. The problem is how to network accessibility for female victims of abuse, as they frequently go to the emergency room of a city of which they are not residents to avoid being identified.

The CNV, on the other hand, which provides victims with solutions, has broader problems that are more difficult to solve, including management costs (the management of counselling

services at the CNV and the management of women’s shelters), and the means needed to ‘resettle’ and reintegrate women in a new environment. This implies a greater accountability and involvement of both formal and informal support networks. A CNV needs specialised and highly-qualified professional skills, in addition to specific social labour policies. This entails elevated tutoring costs and is not immediately productive. To date, no other solutions have been provided; however, it is strongly felt that these two resources, the PC and the CNV, can be the launch pad for the development of an integrated health and social care policy for the future [12].

The Social and Financial Costs of Unsuccessful Prevention

The data of the Italian National Institute of Statistics (Istat) (2015) on violence against women between the ages of 16 and 70 are known and worrying; however, there has been a decrease in the number of episodes and an increase in the number of reported cases and requests for assistance from available services and/or support at specialised centres in an 8-year period. A lesser-known fact is the cost of said phenomenon. According to a report ‘What is the cost of silence’ (“Quanto costa il silenzio?”), domestic violence against women in Italy has an estimated cost of approximately 17 billion Euros, divided into healthcare, pharmaceutical, social, legal, and psychological costs, etc. (Cfr. Intervita, 2013).

The Pink Code Response

Until now, any available solutions were limited to social policy, whilst the healthcare sector was restricted to ‘neutral’ practices that treated physical injuries. The ‘Pink Code’ is a system of reception and protection that is activated once you cross the Emergency Room threshold. It is dedicated to victims of violence, abuse and sexual discrimination. In addition to medical care, patients have the right to psychological support in a private room. Healthcare professionals are trained to recognise the signs of abuse (which are frequently denied) [3]. This service was launched as a pilot project by the local health authority (ASL) of Grosseto in 2010. It then became a regional project, and has been active in all hospitals of the Region of Tuscany since 2014. Thanks to this service, various institutions have been grouped under the same network, so that they can take action against a common problem, with different skills. The aim is to provide the victims of violence with a solution as soon as they arrive at the Emergency Room, and to offer more effective diagnostic tools and treatment, all the while guaranteeing their privacy and safety [12].

A study launched in February 2016 and still underway [2], which analysed the ‘Pink Code’ from the perspective of the healthcare workers involved in the project, has produced a provisional report on the strengths of the ‘Pink Code’. These include:

- A. Restoring victims’ confidence;
- B. Raising awareness and informing the general public;
- C. Restoring faith in institutions;

- D. Launching training programmes in schools;
- E. Building networks with other stakeholders;
- F. Developing bottom-up or in-situ procedures;
- G. Fostering synergy with the workers of Centres for Non-Violence and drawing upon their skills and experience;
- H. Creating a cohesive group, with shared norms and rules.

Thanks to the interviews carried out, we were able to obtain detailed information to be used for further research. We were also able to gather the stories of privileged witnesses, their interpretation and assessment of the problem and possible scenarios for the future. A first indication of what we have learnt is given by the key words from the interviews, which have been grouped together in the word cloud below.

In conclusion, the interviews also revealed the four most important problem areas of the phenomenon, which also confirmed our theoretical approach:

- A. The consequences on the health of victims of abuse and violence; the health-related costs of violence need to be considered;
- B. The social and cultural dimension of the problem, with particular reference to resistance to implementing a different approach, for example raising public awareness;
- C. Possible solutions, including training which could be used as a tool to recognise both the acute and chronic forms of the problem, but also to foster synergy between the inter operational groups;

The implementation of the 'Pink Code' project, and the weaknesses of the healthcare workers themselves. These weaknesses can be attributed to problems such as recognising the phenomenon, the ensuing bureaucratic complications, available funding, privacy-related obstacles, and the challenges in maintaining and improving the project.

If we consider the problem from the perspective of the victims and if we consider what we have tried to reveal through our study, then once again we are compelled to reflect on how escaping that silent world of abuse and explicitly asking for help are indeed fundamental. In this situation, psychological factors, personal cultural and socio-economic conditions, social factors and the characteristics of the local context play an important role. Being able to rely on an institutional network of support and protection can be a glimmer of hope for victims and can ensure, if not the elimination, certainly the containment of the phenomenon. Clearly, reporting abuse is the positive outcome of a path of awareness; but more stakeholders and institutions need to be involved, and they need to engage in an open dialogue and cooperate: from the Emergency Room to shelters, from law enforcement to social workers, from volunteers to healthcare professionals. A support

system that involves the entire community is stronger, as are effective and efficient services and measures that are adopted to promote health and social care integration.

An Overview of Cnvs In Sardinia: Areas for Discussion from a Recent Monitoring Programme

As recommended by the Istanbul Convention [4], in addition to the tools and actions adopted by the entire international community, we have a parallel process underway which involves the 'regionalisation' of the problem, i.e. of the means with which we can tackle it (D.i. Re - Donne in Rete contro la violenza, 2014).

One such tool is the establishment of CNVs and shelters (also known as a refuge or safe house), which in Italy date back to the early 1980s. They were set up as part of the feminist movement, within the broader framework of violence against women, perceived as a social phenomenon linked to the patriarchal family model. At the moment, there is no national law recognising the essential role of CNVs.

In Sardinia, Regional Law 26 of 12 September 2013 applies. It reads as follows: Actions to prevent and counter gender-based violence and stalking. Amendments and supplements to Regional Law 8 of 7 August 2007 'Regulations on the establishment of Centres for Non-Violence and shelters for female victims of violence'. Therefore, Law 8/2007 is the law governing the non-violence network in Sardinia.

In 2008, the Autonomous Region of Sardinia regulated the organisation and operations of:

CNVs: facilities that perform the following activities: preliminary interviews to identify needs and provide preliminary information; prepare a personalised way out of violence to reinforce the victim's faith in herself and her abilities and promote a new and independent way of life; interviews of a legal, informative character; mentor women using public and private services, all the while respecting their cultural identity and freedom to choose; Shelters: facilities that receive and protect women and children from violent homes, in the framework of a personalised programme of recovery and social inclusion. They help victims restore their agency, while fully respecting their privacy and anonymity.

Since 2009, 9 Centres for Non-Violence and 5 shelters have been subsidised by predominantly regional resources in Sardinia. A consultation of the technical reports of the CNVs reveals that violence occurs more frequently in the home. As for the types of violence, in gender-based violence the aggressors are known to their victims. Indeed, regardless of the type of abuse, in none of the cases studied was the aggressor a stranger. This confirms the theory that the closer the relationship between perpetrator and victim, the higher the risk of being abused: almost all of the cases studied can be classified as examples of domestic abuse. After reading 5 out of 9 technical reports of the CNVs in Sardinia, the following problem areas were identified:

- A. Difficulty identifying in advance any cases of violence in different contexts: in the family, at school, amongst young people, through the use of social networks;
- B. Underestimating the risk of witnessing violence, something even those working in this field ignore;
- C. The importance of working on prevention, both at schools and in families, to foster training and information exchange and thereby produce new forms of communication based on non-violent models;
- D. Difficulty for services to use an integrated method for receiving victims; the method should involve a planned way out of violence, that respects their determination and with which they agree;
- E. Weakness in handling any major issues, to be addressed during initial contact when a victim expresses all her doubts as to what to do next, before possibly laying any charges.

One way of improving the services offered is to adopt a continuous, active and effective planning process involving the entire territory. Otherwise, we risk implementing a project, which, although built around the needs of female victims of violence, will be fractured and separate from the territory. This, in turn, will make the implementation of reception projects and their long-term development, in particular, rather difficult.

Professionals volunteering their expertise and other workers tend to work at CNVs and shelters: psychologists, psychotherapists, educators, social workers, lawyers, counsellors and cultural mediators. The team tends to work together to develop, along with the victim, a new life development plan through individual work and networks [10,11]. The question is how can we create greater interest and participation in these networks, because, in primis, a network is necessary (the technical reports showed that only 50% of the victims were offered legal counsel; for the other 50%, a support system was provided throughout the legal proceedings. Special support was provided to women with children who had to appear in family court).

The role of networks is particularly significant when it comes to launching integrated social and employment programs for women who, based on their skills and past education/work experience can be incited to re-discover their self-esteem and secure job autonomy. With a view to improving the services offered by the CNVs, we need to strengthen the staff, by providing (inter alia) a tutor who monitors activities and who offers psychological assistance to victims undergoing training or searching for a job. It is therefore important that we review the skills and territorial presence, in terms of numbers, of professionals operating in the sector, who are interested in promoting the coming together of numerous stakeholders searching for a solution to the problem.

It is difficult to safeguard the independence and self-regulation of the single components of a network and still guarantee their link to the CNVs. It is especially difficult to identify those responsible for

governance together with social services, because, frequently, these individuals are volunteers or from the third sector with a mission, a vision and social autonomy, which do not always coincide with the dictates of a public body, i.e. the municipality and the region.

Overall, it would seem that all facilities offer personalised ways out of violence and legal services. They also organise events and awareness campaigns. However, it is worth noting that each Centre for Non-Violence is a hub of formal and informal knowledge, which needs to be analysed and studied from an empirical perspective, particularly because, thanks to the stories of privileged witnesses, we can identify solutions to be incorporated in social policy.

Without a doubt, the aforementioned Italian practices that we have analysed (centres for non-violence and the 'pink code') are merely a first response to the problem. They are well organised, but still not enough to counter the phenomenon. Nevertheless, they are the most important components of a network and the premise for teamwork characterised by "syncretism and contamination" and involving different professionals. They may well lead to a comparison of the cases to be handled, from a theoretical point of view (through training) and a practical perspective. They are a means to advance in a congenial atmosphere of planning, with the conviction that "we are doing what is right", as underlined by those working in the sector, who feel motivated and engaged in a process of shared accountability for the problem of gender-based violence.

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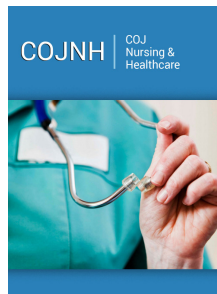
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