WDVHP
Women's Domestic Violence Health Project

Comparing Descriptions of Domestic Violence Health Policy Communities in Five Countries:

The Women and Domestic Violence Health Project (WDVHP)

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January 2007

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WEBSITE: www.ucalgary.ca/wdvhp

A CIHR Global Health Research Initiative planning grant supported the development of an existing partnership between the University of Calgary and Edith Cowan University, Perth, Australia to include partners in Afghanistan, Bangladesh and Thailand and planning for a shared international research program advancing knowledge of participation in and gender analysis of health policies with the focus of addressing domestic violence. A five-day face-to-face meeting brought the team members together to develop the program of research, and a pilot project was selected as the most appropriate beginning to assess our capacity to conduct research in five countries, to communicate with stakeholders, and identify future collaborators. The project, supported by a Global Health Research Initiative pilot project grant, was designed to investigate the participation of women in the development and implementation of effective domestic violence health policies. Research was conducted by local teams in each of the five countries, and resulted in individual country reports, as well as a comparative report, which are all available on the website.

Women's Participation in Domestic Violence Health Policy Development: Afghanistan Component. Jennifer Hatfield, Wilfreda E. Thurston & Sadiqa Basiri. June 2008.

Women's Participation in Domestic Violence Health Policy Development: Australian Component. Colleen Fisher, Lynne Hunt & Rhonda Adamsam. April 2005.

Challenges and Gaps in Addressing Domestic Violence in Health Policy of Bangladesh. Kaosar Afsana, Sabina Faiz Rashid & Wilfreda E. Thurston. October 2005.

Women's Participation in Domestic Violence Health Policy Development: The Southern Alberta Aboriginal Community [Canada]. Wilfreda E. Thurston, Jennifer Hatfield, Leslie Tutty, Cora Voyageur & Amanda Eisener. December 2006

Characteristics of Women's Domestic Violence Health Policy Communities in Thailand. Pimpawan Boonmongkon, Orasa Kovindha, Wilfreda E. Thurston & Niporn Sanhajariya. June 2005.

Comparing Descriptions of Domestic Violence Health Policy Communities in Five Countries: The Women and Domestic Violence Health Project (WDVHP). Wilfreda E. Thurston & Jennifer Hatfield, with the WDVHP Team Members. January 2007.

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This report results from a pilot research project in a program of collaborative research to study the role of policy communities in creating a health sector response to domestic violence. There were five countries involved in this project – Canada, Australia, Afghanistan, Bangladesh and Thailand. Each local team wrote a report on their data and these were the principle source of data for this comparative report.

It is with grateful appreciation that we acknowledge and thank the people in each of the countries who gave of their time to participate in our study and shared their knowledge and experience with us to answer our questions.

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Executive Summary

Domestic violence, as one of the most widespread human rights abuses and public health problems in the world today, warrants the concern and attention of health researchers and health care practitioners internationally. Awareness of the wide-ranging impact of DV is increasing but it has not been widely incorporated into mainstream policy and there has been inconsistent response to the problem from the health sector.

The Women and Domestic Violence Health Project is an international collaboration of researchers from five countries – Canada, Australia, Afghanistan, Bangladesh, and Thailand. Canada and Australia report that domestic violence has been a public policy issue for decades but that the health sector still plays a relatively small role in prevention. Team members from Afghanistan, Bangladesh, and Thailand confirm that the governments of their countries have only recently begun to recognize domestic violence and that the health sector has little involvement. In the "Women's Participation in Domestic Violence Health Policy Development" project, research conducted by local teams studied the role of policy communities in creating a health sector response in their countries, paying close attention to how indigenous women and their concerns are included. Each country has a different type of government and each country is facing particular challenges that have affected and may continue to affect the development and implementation of DV health policies. With the separate reports of each country as the principal source of data, and returning to the original data as needed for clarification, this comparative report integrates the analyses, looking for commonalities and differences. A conceptual framework of public policy, policy communities and policy provides the context.

The Nature of DV Prevention Policy Communities

Participants in the DV prevention policy community are most likely to reside in non-governmental specialized services for DV victims or perpetrators. In every country in this study, the perceived leaders around prevention of DV and development of policy and programs were representatives of the civil society sector, specifically women in women's advocacy organizations, along with a few academics, who have advocated for and developed programs and provide the public voice on viewing DV as a social problem and a public health problem. These women's organizations were developed outside of government to improve the status of women in that society and to provide services and/or advocacy for women's right to equality. The numbers, characteristics, histories, and networking capacities of women-focused organizations differed among countries. There was evidence of an international trend towards specialization within the non-governmental organizations of the DV prevention movement, women's movement, and women's health movement. Working in seemingly parallel streams, there is definitely networking and overlap among participants in these movements; however the networks are neither always dense nor well-integrated, with communication often lacking and resources and opportunities to exchange information nationally and internationally limited.

Human rights advocates are among those active in the DV prevention policy community in LMIC countries, but less so in countries where it is *assumed* by many that women have achieved equality. Safety and security issues for women seemed more salient and pronounced in these countries and these concerns were shared across policy networks. Lack of safety actually overtly

limits the ability of female members of the women's rights policy community to travel, hold meetings, and carry out their business of protecting women from all types of violence, including DV.

In Canada and Australia, countries where decades of changes and training around DV have occurred in the justice sector, special services have been developed and people working in these are active members of the DV prevention policy community. In all countries, the legal and justice framework prevailed as a proposed mechanism to engage the state in controlling domestic violence by placing it in the domain of criminal behaviour. This is, in part, a response to human rights issues, as women have the right to security of the person and to safety in their homes and communities. It is also integral to the desire to move DV from being a private personal matter to being a public policy issue. The need for shelters and sanctuaries for women and children is assumed to coexist with the need for enhanced police and justice sector response. There was also a movement to deal with perpetrators and attempt to get them to change their abusive behaviour through therapy and clinical interventions.

The non-governmental organization sector carries a double load: raising funds for and providing the services to victims; and lobbying governments to change the justice sector response. Human rights advocates share the work in the latter case, as well as trying to improve the general status of women in a country to allow more options for individuals to prevent DV. The segmentation of the DV prevention policy community and the specialization within sectors leads to some challenges in the process of policy development.

Defining the health sector as government departments of health (including Aboriginal band councils) and the services they provide; semi-governmental bodies, such as regional health authorities and the services they provide; and private, semi-private and charitable clinics or services that provide medical care, we conclude that the health sector is not well-represented in the DV prevention policy community. DV is not represented as a priority in the national, regional, or local government health sectors. The health sector responses mentioned in the data tended to be limited projects or services at the operational level offered in separate parts of the health sector, perhaps representing a tendency to test potential policy options for public acceptability. Many of the projects mentioned originated from partnerships with community groups rather than being initiated from within the health sector, highlighting the importance of networks.

The Impact of Competing Discourses on DV Prevention Policy Opportunities

Tertiary prevention and justice discourses predominated. With tertiary prevention, the focus is on intervening in cases (what could be done to save lives, protect children from exposure, and/or prevent further abuse to women had been subjected to DV), rather than creating an environment or a society where DV is unacceptable. In the justice discourse, people in the study inevitably spoke of the need for laws or the need for police to enforce laws. A lack of laws and enforcement was construed as a big 'cause' of DV, as the lack of legal consequences was perceived to be implicit condoning of violence against women. It was also evident the justice sector as a site for solutions is limited. A legacy exists in Canada and Australia whereby women are accused of being complicit in their own victimizations or being of questionable character, and women who decline the role of actively pressing charges or who lack skills in presenting forensic evidence may be characterized as not adequately participating in the legal processes and are likely to have

their situation deemed not to warrant intervention. We saw these same trends developing in Afghanistan, Bangladesh and Thailand.

The different lenses for defining and characterizing DV used by DV prevention policy community members in different sectors was identified in the data as a major dilemma for the broad and deep understanding of DV. In Afghanistan, for instance, lack of women's rights was seen as both a cause and an effect of violence. Canada and Australia have not taken a "human rights" approach to prevention of DV, and directly questioning patriarchy and oppression of women is no longer an acceptable policy option. Shelter workers are engaged in the discourse of dangerousness as they have struggled with the need to triage calls. There was a tendency among all professionals to focus on the worst cases of DV. This has focused the DV prevention policy community on the extreme end of the spectrum, framing the DV problem as one only of urgent life saving and an issue of rescuing the most desperately affected. The dilemma here is that the majority of women who are struggling with chronic situations of a less life threatening nature are missing in the focus of the DV prevention policy community, resulting in little or no awareness or services directed toward them.

In spite of the rhetoric of DV as a "major public problem", there persists a lingering belief that DV is a "private" matter, created by the individuals, and seen as their own failure. Therefore, shame and disgrace is associated with breaking the silence around abuse, especially, but not exclusively, for the abused women. This is related to the notion that practices of physical, sexual, emotional, and financial abuse are so much part of "traditional" norms and beliefs, are so much part of "culture", that women do not even self-identify as abused, and men do not identify their behaviour as abuse. These two themes seem contradictory – on the one hand believing abuse is normal practice and on the other believing that naming it abuse is shameful. They most likely represent common discourses that are circulating, existing together and separately in various parts of the DV prevention policy communities and outside of those communities.

Policy networks and advocacy coalitions within policy communities make strategic choices around how to motivate policy makers and to influence public opinion that may exclude other members of the policy community who cannot find overlap with their priorities or who have ideological differences. The varying (non)ownerships of solutions to issues related to DV and women creates a set of policy networks within the DV prevention policy community that are loosely connected and often pursuing different agendas. In fact, some sectors may be working at conflicting agendas. The continuum of gender-based violence (lack of access to basic human rights, health, education, and economic resources; verbal, emotional, and sexual abuse; physical abuse; acid murders) is contested and dependant upon the sector interviewed and the agenda of the individual policy community member. In our data, the lack of attention to policy options around this continuum of abuse and the focus on tertiary prevention suggests that the social construction of DV is problematic for development of strong DV prevention policy communities. The differences of views create more widespread limitation of intersectoral collaboration.

Gaps in DV Prevention Policy Development

An international human rights agenda is an underused analytic lens for understanding the role of DV and other gender-based violence. Despite years of human rights legislation and public awareness campaigns to eradicate DV and stranger rape, abuse of human rights is not routinely included in definitions of DV or rape in Canada, Afghanistan, Australia, Bangladesh, and

Thailand. There seems to be a large gap between signing of international declarations concerning the end to discrimination against women and integration of the understanding of the implications of gender-based violence in policy and practice. One explanation for the gap is the failure to mainstream gender-based analysis and the suggestion that women in high income countries have obtained equality, therefore, DV cannot be related to inequality. Another explanation is the lack of connection in the DV prevention policy community between human rights policy community members and gender-based violence policy community members. The differing understandings of what constitutes DV are significant for victims.

Internationally, the focus is on women solving the major social problem of DV one by one. The individual level solutions proposed are only partially successful and create "gaps in the system" that call for fine-tuning that never addresses the actual dilemmas and roles of social institutions in perpetuating a culture where DV can exist. Population health moves away from the individual level attributions to how community level factors affect populations. It increases our understanding of the determinants of health and reaffirms the need for public health professionals to critically examine social inequities and policies that maintain them. The dominance of a justice discourse may not be conducive to developing a population health discourse and has precluded a health sector discourse that moves towards other solutions through health policies practiced by health professionals.

Although the networks of women's rights, women's health, and DV prevention exist, the overlap in membership is weak. In some countries, networking capacity has decreased due to changes in government funding that have reduced the numbers of civil organizations that are concerned with women's issues and that can provide liaison among various policy communities. People in these three women's equality centred networks may have different lenses through which they view DV and different ways of understanding the problems and seeing potential solutions, making problem and solution analyses of DV also weak. In addition, women's health is continuously defined only as reproductive and/or breast health from a biomedical perspective, and that is where health system resources flow. This reductionist perspective excludes the social and economic determinants of health and comfortably situates DV as outside the health sector in all but those cases that require immediate medical intervention.

Implications

Engaging the Health Sector

The opportunity exists to broaden the understanding of DV by discussing it in terms of a threat to the health of populations. International organizations, such as the World Health Organization, provide a leadership role in bringing DV and other gender-based violence to the policy table, with the result of increasing interest in the health issues of DV and opportunities to form coalitions. International organizations must keep pressure on national governments to implement human rights agreements.

Countries such as those represented in WDVHP can engage in international work and policy around DV. One advantage of international work is that external advocacy groups can often say things and stand up to speak about DV when it would be impossible for people inside a country to do so. It requires a balance of networking and trust building for 'outsiders' to work within a

country's DV prevention policy community so as not to disrupt or minimize the efforts of in-country leaders.

Individuals affiliated with organizations that have credibility in the health sector may be identified as potential leaders within the DV policy community. These leaders can engage the health sector through building trust and partnerships. This process can begin by having forums where different perspectives can be shared respectfully, and thereby encourage development of policy networks.

The common international perception that mental health services for women and men involved in DV need to be improved is a potential opportunity for engaging the health sector. There is growing recognition that violence against women must be linked to the impacts of traumas that require mental health policies. This opportunity fits with the overall need for interdisciplinary and intersectoral policy communities that can work together to obtain a nuanced understanding of the complex problem of DV.

Working Across Sectors

A challenge for action is to identify solutions that can unite the health sector with parties working in other sectors. Research in the health sector can aid other sectors in understanding the language and the priorities expressed by the health sector, and how policy functions within the health sector.

Development of mechanisms for the exchange of knowledge, understanding and insights is necessary to engage the health sector in a DV prevention policy community. The health sector relies on professional and academic journals, professional conferences, professional development, and accreditation as major sources of information exchange. An open-ended invitation to a DV related conference may be seen as a professional education device. On the other hand, strategically inviting health sector policy representatives to address an audience from another sector may enable them to build credibility and networks. It is also critical to understand that the health sector is not homogenous and that the power politics of health are played out in the divergent nature of the health sector players, from physicians to nurses to administrators. People in the health sector have also stressed that health professionals should receive training about DV in their professional training. Education sessions may also build membership in the DV prevention policy communities. An international effort to train all health professionals about gender-based violence, and DV in particular, as a population health issue may help in the long term.

To develop an advocacy coalition for DV with health included, it is necessary to identify mutually beneficial goals and outcomes (e.g., reduction of injury, reduction of use of the health system, improved access to the health system, improved rates of maternal morbidity and mortality). One way to engage the health sector is to view it not as a huge monolithic bureaucracy, but to strategically engage with specific interest groups within the system. It can be useful to differentiate governance policy and operational policy when trying to change the health sector and move the agenda. Operational policies are more widespread and amenable to engagement. One may find a champion for DV prevention at the level of governance, and this can be strategic when people down the ladder of authority need a sponsor or supporter for their DV policy; however, one may also draw from a larger pool of potential leaders among the

managers and directors closer to the front lines of patient care. This insight can lead to more creative interventions where motivated individuals from the health sector help in understanding that sector.

Guidelines for developing successful collaborations or partnerships between the health sector and other sectors can help sustain the work. Once the need for collaboration has been decided, members work together to clearly state the roles responsibilities, rules and focus of this relationship. As a result, different sectors can learn about each other, their differences and commonalities, and gaining a better understanding of each others' perspectives and policy agendas.

Working Across Genders

A gap in our interviews and discussion has been an underlying assumption that the perpetrators of violence against women are always men. An important constituency to be included in the DV prevention policy community is that of activists around the rights of gays, lesbians, bisexuals, trans-gendered, and two-spirited people (GLBT). Discussion of the issues faced by GLBT can help make clear our assumptions in understandings of gender-based violence and of human rights. Inclusion of men's rights and discussions about how to include men in programs for the prevention of violence against women also has the potential to be helpful. In each country in this study the need to engage men in prevention efforts was identified.

Within the health sector, the roles of men and women vary widely and internationally. Access to medical training, academic medical positions, and administrative positions in the health sector and in medical professional associations reveal health organizations as gendered in particular ways. Women are implicitly expected to care for children, the sick, and the elderly under most models of health care, for instance, yet the organization of medicine does not accommodate this in medical practitioners.

A Global Response to a Global Epidemic

With global recognition that DV is a threat to the health of populations, more needs to be done to enable an analysis of the problem at a global level.

An effective DV prevention policy community does not require that everyone in the various networks and advocacy coalitions share the same understandings of the problem, but debates are needed to discover underlying frameworks and to ensure that these are not counterproductive. Networks can coalesce around points of agreement and shared understandings while seeking opportunities to influence policy and create programs as policy windows open. The implications of trying to organize a global coordinated response to DV are huge because the spectrum of definitions is great. At a minimum we need the opportunity to learn from each other. A potential benefit of an international policy community is sharing how to introduce policies so that public opposition is minimized. A strongly connected DV prevention policy community increases potential for the people involved to strategically prepare their communities (or populations) for a new policy and to identify how to promote a policy in a political constituency. Another benefit may be avoidance of apparent conflicts among advocacy coalitions.

The World Conference on Family Violence is an excellent example of willingness of government and international organizations to share knowledge and experience. A key role for conferences at the local, regional, national, and international levels is to keep DV on the policy agenda. These can link DV and other gender-based violence in ways that move the development of the policy agenda forward, bringing people from diverse backgrounds to discuss the issues from many perspectives. As discussed earlier, representation from the health sector may have to be carefully nurtured.

Globalization has provided greater opportunity for scholars from high income and LMIC countries to work in other countries and to collaborate on DV research than in any other historical period, and the benefit from these exchanges goes both ways. However, inequities in access to scholarly literature (e.g., journals), in funding of universities, and in acceptance of women as scholars continue to challenge the area of DV research. Countries vary in the extent to which feminist scholarship has been permitted or nurtured. Women from LMIC countries who have the opportunity to obtain advanced education in other countries may be enabled to return to more powerful positions in their home countries. It also enables them to build an international community of DV scholars upon whom they can call for support of research proposals, development of literature bases, policy options (e.g., programs), and grey literature covering policy options.

Migration has ensured that there are DV researchers and activists in high income countries who migrated from the other countries, included in WDVHP for instance. Immigration and migration have literally and figuratively changed the face of the DV prevention policy community in high income countries. There has been increasingly nuanced and complex discussion of the need for understanding diversity and for cultural competence. In some ways this has benefited the communities of indigenous women, providing lenses for the study of the impacts of migration and increasing debate about what constitutes culture, racism, discrimination, inclusion, integration, and equity. It also raises issues of inclusion and participation in policy communities and dilemmas around representation and power politics.

Towards the Future

In WDVHP, there is a community of people working locally to address DV who are willing to continue to support and facilitate efforts at a global level. Our continued efforts to identify DV prevention policy communities will provide starting points to bring communities to networks. Understanding the current involvement of the health sector more clearly will provide insight into what is needed to engage them in DV prevention as a legitimate health issue in the near future.

I Introduction

Rationale for the Program of Research

DV is a problem of such magnitude that it warrants the concern and attention of health researchers and health care practitioners internationally.[1-7] For many countries, particularly low and middle income countries (LMIC), awareness of the wide-ranging impact of DV is increasing but it has not been widely incorporated into mainstream policy.[7;8] Internationally, there has been inconsistent response to the problem from the health sector.[5;9-14] Little is known as to why the health sector has not had a more effective response.

The foundation for this five country study was the role of policy communities in creating a health sector response. The five countries produced separate reports. In this report we integrate the analyses looking for commonalities and differences. We begin the report with a discussion of domestic violence and the health impacts. This is followed by a description of the conceptual framework of the study, the objectives and methods of the study. Results and discussion point to opportunities for international networks to move the DV prevention policy agenda forward.

Domestic Violence

Violence against women is often referred to as gender-based violence because the violence is directly linked to gender inequality.[15] "Gender-based violence is one of the most widespread human rights abuses and public health problems in the world today, affecting as many as one out of every three women" state Marijke Velzeboer and her colleagues (p. xi).[1] In the case of women, gender-based violence encompasses different acts of violence that include an abuse of power and a desire to control the victim, such as, child sexual abuse, sexual assault, date rape, sexual harassment, and intimate partner violence. Intimate partner violence may include financial control, threats to harm children, name calling, deliberate exposure to danger, physical assault, and sexual assault, to name a few of the experiences that women in abusive intimate relationships have reported over time and in many studies. The focus of this study was intimate partner violence among adults. In this report, we refer to intimate partner violence as domestic violence (DV), a common label that captures the daily and pervasive nature of the women's experiences and the connection to family and home.

DV traverses national borders, race, class, ethnic and religious lines, and educational levels.[2] Research from around the world reveals similar patterns.[3-5] An exception to this is the disproportionate burden carried by Aboriginal peoples in Canada and Australia. In Canada, 25% of Aboriginal women were assaulted, which is three times the rate for non-Aboriginal women. Rates of spousal homicide for Aboriginal women were more than eight times higher than those for non-Aboriginal women.[16] In Australia, Aboriginal and Torres Strait Islander women are over represented in the statistics on interpersonal violence, and those living in rural and remote areas are 45 times more likely to be a victim of DV than non-Indigenous women.[17;18] In both countries, recognized contributors to these higher rates include: economic and social deprivation; alcohol and substance abuse; the intergenerational cycle of violence[16;19]; and a history of colonization.[20;21]

Health and DV

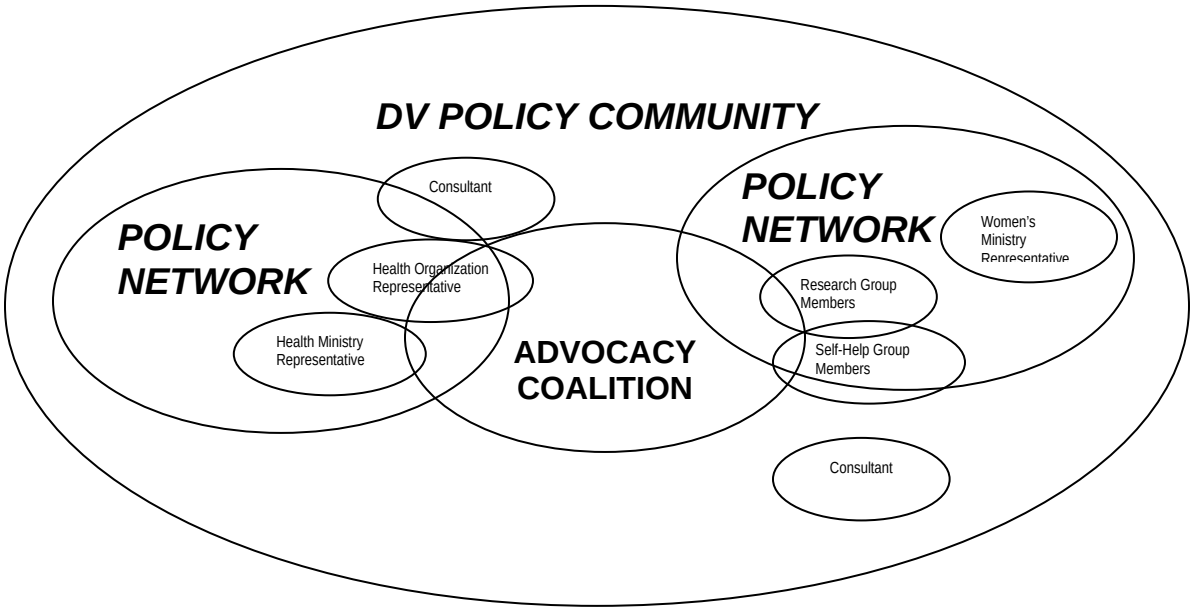
The published literature describes DV as a pervasive population health concern with serious consequences for health status.[22] DV reduces health status and increases health care utilization. In addition to the direct physical and psychological injury of DV, evidence suggests that abused women have more illnesses[23;24]; sexual ill health[25-33]; and chronic health conditions, stress, and substance use[34] than other women. Mental health problems are common among abused women.[35-40] The effects of psychological abuse also have consequences on the long-term health of abused women.[27;41;42] Violence is associated with serious consequences for women's reproductive health.[28] Women who are pregnant are at risk for violence and at risk for increased levels of violence.[43-46] Violence and the fear of violence may intimidate women and prevent them from trying to negotiate safer sex, discussing fidelity with partners, or leaving risky relationships. These problems associated with DV are exacerbated in conflict, post-conflict, and refugee situations where women and girls are subject to high rates of sexual assault and increased vulnerability to prostitution and trafficking.[8] In areas of conflict, differentiating DV from other forms of violence against women may be impractical (e.g., Afghanistan).

Research supports the identification of indigenous women as at particular risk. There continues to be a need at a global level for research to support efforts to address DV in indigenous populations in order to use commonalities and local causality to inform policy and practice aimed at health issues of women subject to DV. Little is known about women in LMIC. Recent work sponsored by the World Health Organization has begun to fill the gaps. From a study of 10 countries (including Bangladesh, Brazil, Peru, Thailand, and the United Republic of Tanzania), Garcia-Moreno et al. reported that between 15% and 71% of women had experienced physical or sexual violence from a partner in their lifetime, and between 3% and 54% had experienced it in the year previous to the study.[15]

Conceptual Framework: Policy, Policy Communities and Policy Making

As noted in Thurston, Scott and Vollman,[47] public policy is defined as that made by governments[48] to distinguish it from the operational or organizational policies made by administrators, managers, or front-line staff within public organizations. Public policy is also separate from private or corporate policy or policies made by non-governmental organizations. That does not mean that there is no interaction among these various locations of policy. Public policy making represents a process that involves policy makers operating within the governmental arena, as well as a diverse set of constituencies that function to pressure the government and to influence the public policy making process.[49] Howlett and Ramesh distinguish the actors in the policy cycle.[50] The actors in a policy subsystem have at least some knowledge of the topic (e.g., DV) and form a Policy Community. Some members of the Policy Community interact on a regular basis and these form Policy Networks. Advocacy Coalitions form yet another subset of the Policy Community. Members of coalitions share a basic set of beliefs (policy goals plus causal and other perceptions) and seek to influence governmental institutions in order to achieve their policy goals.[50] Figure 1 illustrates the types of linkages that can exist in a Policy Community and how there can be gaps; for instance, all members of a self-help group may share a common knowledge of DV and the desire to see DV controlled, but all members may not participate in a specific Policy Network.

Figure 1: Policy Community



Note. Adapted with permission from "Public participation for healthy communities and public policy," by WE Thurston, CM Scott and AR Vollman in *Canadian Community as Partner: Theory and Practice in Nursing,* AR Vollman, ET Anderson and J McFarlane, editors. Philadelphia: Lippincott Williams & Wilkins; 2004. p. 124-56.

DV policy community members seek to influence policies that might prevent DV from ever happening and/or to help women, men, and children survive and heal when DV does happen. Members can have different underlying reasons for their stands but propose the same actions. This is just one of the reasons that DV policy making, like most public policy making, is not a step-by-step, linear, and logical process.[48] Howlett and Ramesh present five aspects of a policy creation cycle that can serve to illustrate the importance of a strong DV policy community: Agenda Setting; Policy Formulation; Decision-making; Policy Implementation; and Policy Evaluation. Public consultation and input from a policy community can take place in any part of the policy cycle.[50] Figure 2 is a representation of how the processes can be viewed to work and how cycles can develop.

Agenda Setting is the process through which DV comes to the attention of government or other officials who are policy makers. The Problem Stream is the process whereby the policy community moves DV to where it is perceived as a problem that public bodies should address or where the understanding of the problem is refined. Decision makers may originally receive feedback from external sources, and they are likely to seek advice from internal sources as well.[50] The strength of the policy network clearly impacts on this feedback process. As many have shown, the way a problem is defined shapes the policy options available.[48;51] Originally in Canada and elsewhere, for instance, DV was defined as a private family matter; therefore, public policy makers claimed no role for public policy.

The Policy Stream, consistent with the stage of Policy Formulation, is the process whereby experts and analysts pose solutions to the problem. A range of solutions to various aspects of the

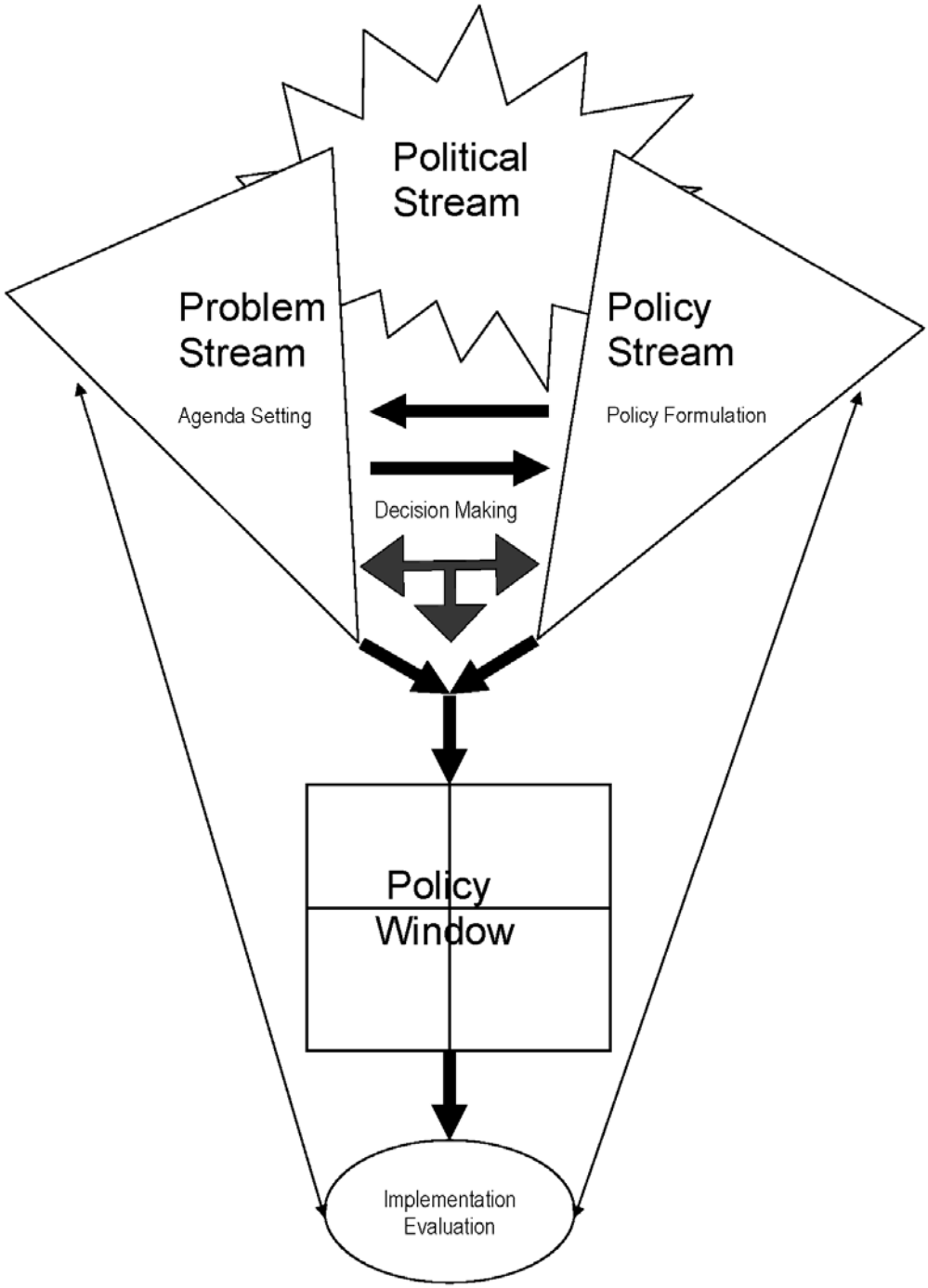
DV problem now exist, for example, and have been tried in a number of locales. As new initiatives are developed and tried, networks can share that information. It is important, therefore, that knowledge of successes and failures makes it to the experts and analysts. Again, if the experts in DV are outside of the policy network where decisions are made, solutions may have a number of problems. It is when solutions become joined to problems and a favourable Political Stream (social and political context) exists that a Policy Window opens (a favourable opening for a public policy).[50]

Even if the work of the Problem and Policy Streams goes well, if the Political Stream is not favourable, for instance, if any public policy is going to attract vociferous opposition, then the Policy Window may never open. For example, when the issue of DV was first raised in Canada's House of Commons in 1981, some members of parliament made jokes and laughed. In general, the public was outraged by the response of some of their elected officials. It was public pressure widely reported in the media prompted the House of Commons' report on domestic violence.

This Canadian example also highlights the influential role of the media[52] in both reflecting and shaping the Political Stream. The media can help create "ideas in good currency", that is, ideas that "sound right to most people" (p. 121).[48] Similarly, Engberg-Pedersen and Webster talk about creating a political space where public policies can be generated.[53] An important aspect of political space is the range and depth of ideas that are circulating in the Political Stream. In Decision Making, policy makers select from among the policy options to choose one that they will support. The policy making process may stop here if resistance is expressed or another topic draws attention. Sometimes, politicians will test public reaction before implementing a decision.

Policy Implementation is the process by which governments put solutions or policies into effect. There can be substantial difference between the broad goals of the stated policy and the actual implementation. Policy Evaluation includes processes of assessing the implementation. Policy community members can have an impact here if they are part of the policy network; however, public participation in public policy development is often quite fragmented.[54-56] This fragmentation is currently the case in DV work.

Figure2: The Policy Process



Note. Adapted with permission from "Public participation for healthy communities and public policy," by WE Thurston, CM Scott and AR Vollman in *Canadian Community as Partner: Theory and Practice in Nursing*, AR Vollman, ET Anderson and J McFarlane, editors. Philadelphia: Lippincott Williams & Wilkins; 2004. p. 124-56.

Objectives of WDVHP

In 2003 the Canadian Institutes for Health Research issued a Request for Proposals through a strategic plan aimed at global health research. This funding competition and its focus presented an ideal opportunity to begin a program of collaborative research with a pilot research project. International contacts and linkages were created that resulted in an Investigative Team from five countries. Team members from Afghanistan, Bangladesh, and Thailand confirm that the governments of their countries have only recently begun to recognize DV and that the health sector has little involvement. Canada and Australia reported that DV has been a public policy issue for decades but that the health sector still played a relatively small role n prevention. Each country has a different type of government and as such they offer a rich resource for investigating the development and implementation of DV health policy. Each country is facing particular challenges that have affected and may continue to affect the development and implementation of DV health policies. Yet it appears that little international exchange occurs in this area. Multi-stakeholder research networks utilizing inexpensive communication mechanisms that encourage the use of global and country specific knowledge to solve local problems, such as this project, are recommended.[57]

The objectives of the Women and Domestic Violence Health Project (WDVHP) pilot study were to:

1. Describe the characteristics of the DV health policy community in 5 participating locales, namely, Calgary and Southern Alberta, Canada; Kabul, Afghanistan; Perth and Western Australia; Dhaka, Bangladesh; and Bangkok, Thailand;
2. Describe the networks and advocacy coalitions of each locale's policy community;
3. Assess utilization of national and international DV policies in the local DV health policy community;
4. Identify future research partners, locally, nationally, and internationally; and
5. Assess the viability of a long-term program of comparative research.

II Methods

Design

The study was designed as a pilot, and resources, in particular funding, dictated the scope; nevertheless, rich data were obtained in each locale. It used comparative case study methodology[58] – each locale was treated as a case – and relied primarily on qualitative data.[58-66] The study involved an iterative process of sampling, recruitment, data collection, and analysis. Although coordinated from Calgary, local coordinators recommended strategies appropriate to their sites. Local teams wrote reports on their data and these were the principle source of data for this comparative report.

Sampling and Data Collection

Data was obtained through individual, face-to-face interviews from three source groups in each locale: 1) members of the formal existing health policy community; 2) members of the DV prevention policy community; and, 3) people affected by the policy but not involved in its

development. An interview guide was developed for each source group and translated in each country as necessary.

The sampling strategy for interviews was purposive, first identifying critical cases, then using snowball sampling techniques to broaden the sample beyond the critical cases.[67] Individual interviews took from a minimum of 20 minutes to a maximum of four hours, with most lasting approximately one hour. Most interviews were audio-recorded and then transcribed.

Canada. Contacts in the community were instrumental in developing a list of key individuals that could speak to Aboriginal issues and/or DV. Agencies throughout Southern Alberta, both on and off reserves and representing urban and rural settings, were contacted. Participants in interviews were also asked to identify other potential participants. Between January and March 2005, 37 interviews were completed that provided a good representation of professionals and agencies.

Afghanistan. In Kabul, 29 formally structured interviews of 20 to 30 minutes each were conducted. The interview participants worked in a variety of governmental, non-governmental, and public sector organizations. Individual interviews were conducted in Pashto and Dari, transcribed, and then translated into English for data analysis.

Australia. Stakeholders in the areas of family and domestic violence and/or health policy were identified in Western Australia. Of the 38 individuals/agencies approached to participate, 5 agencies declined to participate (one gave no reason, an Indigenous service cited a belief that too many studies are undertaken on Indigenous people, and three did not consider that they had any connection to the issue of family and domestic violence and, hence, would not be able to add to the study) and 3 agencies were keen to participate but circumstances were such that it was not possible within the timeframe of data collection. Structured interviews with the 30 participants were completed.

Bangladesh. Individual, face-to-face interviews were conducted with 28 participants, including people from government, non-governmental organizations and women organizations, and women victims of DV. Of an original 30 respondents, 2 were not interviewed: one because an interview could not be arranged and one because the individual later declined to participate. Interviews, lasting between one and four hours, were conducted in Bengali and transcribed, and then translated into English for analysis.

Thailand. For the individual interviews, 30 key informants with experience working on DV issues (ranging from one to five years) were recruited from government departments, non-governmental organizations and universities in Bangkok. They covered four groups including the health sector, social service sectors, legislation sector, and survival groups. Interviews were conducted and transcribed in Thai, with translation into English for data analysis.

Analysis and Writing

Within each locale, data were analyzed and triangulated to develop a thick and detailed description of their existing domestic violence health policy community. The transcribed interviews, reviewed by the interviewer, were entered into QSR N6© or Atlas Ti© (Bangladesh) to aid analysis and interpretation.[68] The research teams in each locale developed their own

coding scheme. For this comparative study, two researchers (WT, JH) compared the reports from the five countries, returning to original data as needed for clarification. A process of connecting and legitimating[69] the findings through reviewing the texts was done in conjunction with revisiting the relevant literature, including other reports and documents from the countries. A draft report was then sent to all research team members for confirmation that the themes represented their data. Additions and clarifications were discussed and the analysis modified. In this way, the local perspectives and the varied disciplinary perspectives of multiple researchers were brought to the interpretation.

Several techniques common to qualitative research were used to ensure that standards of rigor were met for external validity[67;70] and within-project validity.[70-73] In the first case, the qualifications and experience of the research team members combined to ensure that "the researcher as instrument" (p. 168)[74] was prepared for the project. The process of seeking consistency across locales, yet allowing for differences in approaches to be proposed and discussed, allowed for a form of "bracketing" (p. 170)[74] by researchers whereby they had to make their assumptions explicit. In this comparative report, the process of constant comparison across locales forced the researchers to check assumptions and to clarify internal and external validity of claims. As Morse and Richards explain, the process of flexibility in coding, within and between locales, was a source of validity.[74] Rather than force the data into a template or model, each locale developed their own codes, categories, and themes, verifying them as the analysis proceeded. Multiple sources of information (types of people, documents, several locales) and the use of multiple researchers with different disciplinary approaches were sources of triangulation, providing what Creswell referred to as "corroborating evidence" (p. 202).[58]

Verification through reviews and feedback by research team members was another source of validity.[74] This process will continue with peer review of the individual country reports and comparative report by study participants and others involved in the international DV policy community and submission of manuscripts developed from the study to peer reviewed journals.

Ethics

Information regarding the purpose of the study was given to each participant and his/her written consent to participate in the study was obtained prior to the interview commencing. Participants were assured they could withdraw from the study at any time or decline to answer any question asked within the interview that they felt uncomfortable answering. All participants were guaranteed confidentiality but not anonymity. Anonymity was not possible as the policy communities in each locale were small and it could be possible for people to discern who did or did not participate in the study. Every attempt has been made to ensure that the reports do not reveal the speaker.

The research project received approval in each of the locales from appropriate governing bodies. In Canada, the research was approved by the University of Calgary Conjoint Health Research Ethics Board. In Australia, ethical approval was given by the Human Research Ethics Committee of Edith Cowan University. In Bangladesh, government approval was granted and in Thailand approval was received from The Permanent Secretary of the Ministry of Public Health, Thailand. Ethical approval for the research in Afghanistan was received by the Principal Investigator from the University of Calgary Conjoint Health Research Ethics Board.

Strengths and Weakness

The study was limited in scope by the resource available – including funds, time, and security. We did not interview everyone who could be considered a stakeholder in DV prevention. We also did not cover the entirety of countries included in the study, and given the size of each country, there may be significant differences in one area of a country compared to another. The combined years and scope of experience of our research team members lead us to believe that we have an internally and externally valid research project; that is, the reader can be confident that the results represent the locales we studied, and that taking the individual country reports and this comparative study, the reader will agree with our conclusions and will be able to apply our knowledge in her or his setting.

III The Nature of DV Policy Communities

Sectors within Which Members of the DV Policy Communities Reside

Women's Organizations and Shelters

In every country in this study, the perceived leaders around prevention of DV and development of policy and programs were representatives of the civil society sector. Specifically, women in women's advocacy organizations, along with a few academics, have advocated for and developed programs and provide the public voice on viewing DV as a social problem and a public health problem. These women's organizations were developed outside of government to improve the status of women in that society and to provide services and/or advocacy for women's right to equality. Organization boards and members have advocated for similar bodies within government to change the status of women, and this has been supported by international declarations that prioritize improvement of the status of women. As would be expected, the numbers, characteristics, histories, and networking capacities of women-focused organizations differed among countries. Canada and Australia have much in common, for instance, while Afghan women had the distinction of rebuilding after war and the repressive policies of the Taliban and have fewer legislative rights and public services. In community action, however, as represented in the interviews, the stories of trying to prevent DV often sounded very similar.

In Thailand, women's organizations have committed their work to issues related to women's rights, gender equality, women's health, and women's empowerment, as well as trafficking of women and children. Their work covers advocacy, policy formulation, and program implementation. Work related to the area of DV and health and social services for the victims of DV are still limited. For 30 years, there has only been one shelter run by a non-governmental organization that has provided services for the victims of DV, and its services cover several target groups including, for example, women and children who live with HIV and women who have an unplanned pregnancy. The shelters run by government departments are limited in numbers, and their services focus on children more than women.

In Australia and Canada where many shelters provide accommodation and other services for victims of DV, these organizations were singled out in this study as key leaders in DV policy development. They were described as part of the larger women's movement and sometimes as part of a larger women's health movement. The larger women's movement is understood to include organizations that foreground specific issues (e.g., the role of women in self-governance,

micro-financing, sexual assault) and do not necessarily identify as organizations with DV in the mandate. The Women's Health Movement developed as an arm of the women's movement, originating in the 1970s in a self-help clinic in Boston (Boston Women's Health Collective) and developing alongside and sometimes within the mainstream health sector to address issues such as reproductive health, abortion, breast cancer, access to health care and health related information for women, tranquilizer prescribing, and so on.[75-77]

What was evident was an international trend towards specialization within the non-governmental organizations of the DV prevention movement, women's movement, and women's health movement. Shelters and networks of shelters, breast cancer action networks, reproductive rights organizations, and so on, work in seemingly parallel streams. As DV services are established, staff and volunteers become the spokespeople for DV issues. While there is definitely networking and overlap among participants in these movements and networks, the networks are neither always dense nor well-integrated; that is, communication is often lacking and resources and opportunities to exchange information nationally and internationally seem limited.

Human Rights, Discrimination, and Security

In Afghanistan, Thailand, and Bangladesh it was activists around women's rights who were identified as "seeking justice" for victims of DV in a gender-based analysis informed by International Declarations (e.g., Beijing Platform for Action[78]; Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)[79]). In this sense, safety and security issues for women seemed more salient and pronounced in these countries, and these concerns were shared across policy networks. This may be in part because lack of safety actually overtly limits the ability of female members of the women's rights policy community to travel, hold meetings, and carry out their business of protecting women from all types of violence, including DV. Lack of safety for women's rights advocates was most pronounced in Afghanistan, a country still engulfed (as of the writing of this report) in armed conflict and in efforts to create a stable government.

Lack of security was not absent in Canada. In Canada, the discourse around DV characterized it as a field that was not safe for workers; that is, the police feel it is dangerous, and shelter workers operate behind locked doors with security systems. In Australia, there is no real discourse around the safety of workers, yet, they do work behind locked doors. These symbols of dangerousness do not necessarily represent the reality for workers. In both Australia and Canada women and family members fear retaliation from perpetrators of DV who are confronted about their behaviour. In some cases, fear of the negative and retaliatory response from the larger community of men towards women was mentioned in rural areas in Alberta and on First Nations reserves, but the most pronounced discussion around fear was urban women's fear of perpetrators. In fact, killing of women by spouses and other family members occurs in all five countries.

Every country in this study has a Federal or national Ministry or Commission on women's rights that was mandated to raise the status of women in that country by impacting reform in all sectors (e.g., judicial, economic development, education, health). To illustrate the complexity and dynamic nature of policy communities, however, we can look at Canada. Status of Women Canada was a Federal government agency mandated to increase equity through federal policies. In October 2006 a new minority Canadian government closed many Status of Women Canada's

offices around the country,[80] thus further limiting efforts for obtaining equity in policies. Ironically, Canada has a reputation through the Canadian International Development Agency (CIDA) for promoting gender-based analysis abroad. CIDA adopted a policy incorporating gender equality into all of its programs in 1979,[81] but the reports in Canada are that gender-based analysis is not mainstreamed. In reality, Canadian women would benefit now and in the future from more gender-based analysis at all levels of policy development.[12;82] At the next level below federal government, all Canadian provincial governments except one (Alberta) had similar government bodies mandated to improve the status of women.[83] Despite lacking an office focused on the status of women, Alberta did have an Interdepartmental Committee on Family Violence and Bullying that included the ministry of Health and Wellness[a]. However, that Interdepartmental Committee was not mentioned in the interviews as providing leadership. In Western Australia, however, the Family & Domestic Violence Unit (Department for Community Development) was identified as providing leadership.

For Canadian Aboriginal women, the issue of jurisdiction is more complicated than for non-Aboriginal women. They are not directly governed by the government of Canada except through the Indian Act.[84] On reserves, local Band Councils govern, and in Alberta, there are three different treaties covering relationships among Aboriginal people and the government of Canada through the British crown.[85] The federal department responsible for Aboriginal people does have a guide for gender-based analysis[86]; however, local bands and tribal councils may not have any formal body with this mandate.

Justice Sectors

In every country in this study the legal and justice framework prevailed as a proposed mechanism to engage the state in controlling the violent behaviour of husbands and other males by placing it in the domain of criminal behaviour. This is, in part, a response to the human rights issues discussed above, as women have the right to security of the person and to safety in their homes and communities. It is also integral to the desire to move DV from being a private personal matter to being a public policy issue.

One issue that arose in Afghanistan, Bangladesh, and Thailand was the absence of specific laws against DV. In Thailand, the issue of sexual assault or rape was also raised specifically. A man in that country can still legally rape his wife but the national government has, in principle, approved changing the law so that this is illegal. Activists in Thailand and Bangladesh, and now in Afghanistan, are focusing on trying to get police to apply policies concerning criminal behaviour to husbands and other family members.

Addressing the justice sector is complicated by the existence of strong policy communities associated with informal or local “justice” systems (e.g., customary law in Afghanistan or Thailand). In Canada and Australia, addressing the justice sector is not as straightforward as some would assume. Indigenous people are resisting the impact of colonization and forms of community justice are re-emerging, often in collaboration with the government or state systems. The data from Southern Alberta shows that Aboriginal communities are dealing with both

a Other Ministries represented include: Children's Services, Human Resources and Employment, Justice and Attorney General, Community Development, Solicitor General, Education, Seniors, and Aboriginal Affairs and Northern Development

incorporation of *mainstream* police policies and the creation of local models, such as sentencing circles. In Australia some sentencing processes also include traditional law.

The reports from Canada and Australia have also demonstrated that the justice system approach to stranger assault and violence was not, on the whole, helpful to prevention of DV. DV was not addressed in Canada through new laws but through changes in operational policies that set standards for police and court practices to treat DV assault cases as they would treat stranger assault cases. That is, the criminal code for assault was deemed sufficient to cover domestic cases, although it had never been enforced in those circumstances due to the belief that the "private" domain of the home was out of the jurisdiction of police forces. Training of police officers, probation officers, judges, and other workers in the justice sector, therefore, has been widespread since the mid-1970s in both Australia and Canada. In both countries, participants now talked about the need for and development of special courts to address DV, prevent recidivism, and, in some cases, to provide an approach that respects the needs of women for safety and maintaining her family in ways that fit her circumstances. In Western Australia, new legislation, The Acts Amendment (Family & Domestic Violence) Act, was introduced in December 2004, which was after the data collection period for this project. Under this new legislation, Western Australian Police have the power to remove the perpetrator of the violence for a period of 24 or 72 hours without the consent of the victim. Additionally police press charges rather than the woman. In all countries, the need for shelters and sanctuaries for women and children is assumed to coexist with the need for enhanced police and justice sector response. There was also a movement to deal with perpetrators and attempt to get them to change their abusive behaviour through therapy and clinical interventions.

Health Sector

The health sector responses mentioned in the data tended to be limited projects, perhaps representing a tendency to test potential policy options for public acceptability. People generally saw policy responses to injuries as located in emergency departments. In Thailand, One-Stop Crisis Centres were set up by the Ministry of Public Health in 70 general and regional hospitals; however, despite the name, most of the focus is on treatment of the physical consequences of DV, rather than on a holistic service to victims and perpetrators. Bangladesh has also created One-Stop Crisis Centres (two centres serving 14 million people) and these also focus on physical consequences. In Afghanistan, a program by Medicale Mondiale exemplified the provision to women of psychological support and development of personal coping skills. Many of the projects mentioned originated from partnerships with community groups rather than being initiated from within the health sector, once again highlighting the importance of networks.

The results of this study indicate that DV is not represented as a priority in the national, regional, or local government health sectors. There are isolated and bounded responses in some health sectors, for instance, One-Stop Crisis Centres in Thailand just discussed. Separate parts of the health sector may provide services at the operational level (e.g., some health professionals in Southern Alberta ask clients about a history of abuse). In each country in this study, formal bodies were identified that are charged with addressing prevention of DV and including health in the mandate. The National Clearinghouse on Family Violence is located in the Public Health Agency of Canada, Health Promotion Branch.[87] No other national *health* department related to DV was mentioned in the data. The Western Australia Heath Department has a Gender, Child and Community Health Section that operates with a small staff, and is an example at a regional

level. At the local level, the Calgary Health Region in Alberta, Canada includes DV in the mandate of the Community Health Portfolio under Injury Prevention, but no staff were formally designated to lead DV prevention. It did not appear from the data that other regional health authorities covering Southern Alberta had made DV prevention a priority. No local health bodies were identified in the other countries.

International non-governmental organizations with a health focus (e.g., Medicale Mondiale, BRAC) were identified in Afghanistan and Bangladesh to have programs or projects regarding prevention of DV, particularly at the tertiary level in aiding women to overcome the consequences of having been victimized.

Conclusion

When we define the health sector as government departments of health (including Aboriginal band councils) and the services they provide; semi-governmental bodies, such as regional health authorities and the services they provide; private, semi-private and charitable clinics or services that provide medical care, we conclude that the health sector is not well-represented in the DV prevention policy community. Participants in the DV prevention policy community are most likely to reside in non-governmental specialized services for DV victims or perpetrators. In countries where decades of changes and training around DV have occurred in the justice sector (Canada and Australia), special services have been developed and people working in these are active members of the DV prevention policy community. Human rights advocates are also among those active in the DV prevention policy community in LMIC countries, but less so in countries where it is *assumed* by many that women have achieved equality. The non-governmental organization sector, therefore, carries a double load: raising funds for and providing the services to victims; and lobbying governments to change the justice sector response. Human rights advocates share the work in the latter case, as well as trying to improve the general status of women in a country to allow more options for individuals to prevent DV. As is discussed in the next section, the segmentation of the DV prevention policy community and the specialization within sectors leads to some challenges in the process of policy development.

IV The Impact of Competing Discourses on Policy Opportunities

As the policy literature articulates, how people characterize or understand a social problem informs how they believe it can be stopped or prevented. Professionals working in different sectors (e.g., justice, mental health, child welfare, women's shelters) tended to define DV in terms of their area of focus or specialization; for instance, for justice people it was defined by a legal code, and for addictions workers as something stemming from the addiction. These different lenses affect how people believe that DV is manifested in society: it may appear as physical injuries; murder; and/or forced sex and reproductive health problems. Related to this variation in when people "see" DV is a disparity in views about what causes DV. DV is attributed to individual characteristics; for instance, addiction; mental illness; inappropriate behaviour by women (e.g., adultery); or lack of anger management in men. It is attributed to historic factors affecting communities; for example, loss of religious ceremonies or language; processes and outcomes of colonization (e.g., residential schools); or lack of economic

opportunity. Current pressures on communities, such as, war, are also believed to cause DV. DV is also attributed to social institutions, such as, gender norms, lack of constitutional and/or social rights for women, or religious imperatives.

In the countries in this study, we found a focus on tertiary prevention. People principally focused on victims and perpetrators and what could be done to save lives, protect children from exposure, and/or prevent further abuse to women had been subjected to DV. The health discourse, where it existed, largely focused on injury from or mental health impacts of abuse. Thus, the health agenda is defined as tertiary prevention, or intervening in cases, rather than creating an environment or a society where DV is unacceptable. Generally, only among activists was there some talk about the need for social change and change of cultural norms and social institutions so that violence did not happen in the first place.

In conjunction with the focus on tertiary prevention, in each country of this study the justice discourse predominated; that is, people inevitably spoke of the "need" for laws, or the need for police to enforce laws. Lack of enforcement of laws was then construed as a big 'cause' of DV, permitting a lack of legal consequences. The knowledge that DV often leads to murder of women and children drew people to a legal or justice framework for prevention. In addition, failure of the state to take action against perpetrators was widely perceived to be implicit condoning of violence against women, by both the politicians who failed to make and enforce legislation, and the individual police officers and others in the justice system who failed women at an individual level.

The justice sector as a site for solutions is, however, limited. Despite the advances in the justice system responses in Canada and Australia where special DV courts have even been created, the woman may not want to leave the person perpetrating the abuse, become a single parent, or see her partner go to jail. Relying entirely on the justice system to resolve social problems is not an option in societies that wish to avoid a police state. In addition, historically, health professionals have not wanted to become involved with court processes, viewing them as time consuming, ineffective, or outside of their expertise.[88] Health professionals in Canada often ask for justice sector programs (e.g., ways to get legal advice) that do not require "police involvement" so that formal involvement in the system is avoided. In fact, many women experiencing DV also want to avoid the police and courts or seek a limited role for the police (e.g., counselling a man that his behaviour is wrong).

There is a history in the justice system experiences in Canada and Australia that placed greater responsibility on women victims of sexual assault or DV than any other victims of crime. In the first instance, women were actually held accountable for the man's behaviour (e.g., only *perfectly good* women could legitimately be considered victims). Governments of these countries, under pressure from activists, changed regulations and training so that this accounting of victimization was not to occur. However, the legacy still exists, as found in the Alberta data where men are excused on many grounds and women are accused of being complicit in their own victimizations or being of questionable character. In the second instance, Canadian and Australian justice systems held women responsible for pressing charges, providing forensic evidence in an investigation, being a witness in court, and, in essence, being in charge of the case of assault against her. In this study, we saw these same trends developing in Afghanistan, Bangladesh, and Thailand. Women who decline the role of actively bringing charges against

their husbands or who lack skills in presenting forensic evidence are likely to have their situation deemed not to warrant intervention. They may be characterized as wasting the time of the police or not adequately participating in the legal processes. They may subtly or directly be impugned to be of low character, lacking in respect for authority, or of increasing the many demands on the state.

Policy networks and advocacy coalitions within policy communities make strategic choices around how to motivate policy makers and to influence public opinion that may exclude other members of the policy community who cannot find overlap with their priorities or who have ideological differences. In Afghanistan, for instance, lack of women's rights was seen as both a cause and an effect of violence. Literacy and health status were factors seen as both causes and effects, and this is a source of confusion in all countries. Canada and Australia have not taken a "human rights" approach to prevention of DV, and directly questioning patriarchy and oppression of women is no longer an acceptable policy option. This is not necessarily about the ideology of the political party in power (although there are differences on key policies around women's equality). In Canada, it has become more acceptable to talk about the lack of women's rights or equality in other countries than to question whether Canadian women have equality with Canadian men. Many people believe that equality has been achieved at an institutional level, therefore, examples of inequality are assumed to represent individual level problems (e.g., lack of education, low self-esteem, drinking too much) and individual level solutions are then recommended. In 2003-2004, the Alberta Government held a series of "Roundtables" to develop a comprehensive set of recommendations for action on family violence and bullying. The policy agenda around DV was diluted in this process by incorporating it as one of many "family violence" issues and adding the issue of bullying, a type of aggression that is seen primarily to occur among children and youth.[89] In Western Australia the section of the WA Health Department responsible for DV health policy formulation was named Gender, Child and Community Health (emphasis added), highlighting the incorporation of women's health into both child and community health, and thereby diffusing its perceived importance. In Alberta, DV initiatives are under the mandate of the Ministry of Children's Services. Given that all countries in the study were at the table when the Alma Ata Declaration was signed and in which security of the person in participating countries was promised,[90] there nevertheless persists in the early 21st century policy that is not delivering what is needed for women's domestic safety.

In every country in this study, the issue of DV is framed as a "major" social problem. There are various ways that this is reflected (e.g., incidence figures, the costs to governments of interventions, health consequences). As discussed earlier, DV is framed as a dangerous problem for both victims and workers. Shelter workers are engaged in the discourse of dangerousness as they have struggled with the need to triage calls; for example, in Canada workers must decide who is in the most serious situation and in need of immediate shelter, and in Australia workers decide who is in need of shelter and determine if there is available accommodation. In all the countries in this study, most shelters cannot accommodate all women who seek assistance and try to give priority to women with children, believing that women with children have fewer choices and options for escape and that children need protection too. In Western Australia some shelters are funded only to take women and children, and a very small number are funded for lone women.

Since the late 1990s and early 2000s in Canada, safety assessments have become a common part of 'screening' for DV, trying to discern if a woman is at "greater risk" and, if so, has plans in place to escape a threat of harm or even murder. There was a tendency among all professionals to focus on the worst cases of DV, cases of horrible violence, and the very serious cases were the ones profiled as examples. This has the effect of making the experiences of women in less dire situations somehow less urgent or serious. This focus on the most dramatic cases has focused the DV prevention policy community on the extreme end of the spectrum. This frames the DV problem as one only of urgent life saving and an issue of rescuing the most desperately affected. The dilemma here is that the majority of women who are struggling with chronic situations of a less life threatening nature are missing in the focus of the DV prevention policy community. While admittedly the desperate stories are compelling and attract great interest and concern, they convey the perception that these high profile cases are the typical cases, and are what attract attention and raise the issue in the public mind. This may result in little or no awareness or services directed toward the many women living in abusively oppressive marriages or relationships.

In spite of the rhetoric of DV as a "major public problem" in four countries (Australia excluded), the lingering belief persists that DV is a "private" matter, created by the individuals, and seen as a failure to enact *the family* as expected. Therefore, there is shame and disgrace associated with breaking the silence around abuse, especially, but not exclusively, for the abused women. This is related to the notion that practices of physical, sexual, emotional, and financial abuse are so much part of "traditional" norms and beliefs, are so much part of "culture", that women do not even self-identify as abused, and men do not identify their behaviour as abuse. These two themes seem contradictory – on the one hand believing abuse is normal practice and on the other believing that naming it abuse is shameful. They most likely represent common discourses that are circulating, existing together and separately in various parts of the DV prevention policy communities and outside of those communities. In contrast to the human rights for women agenda, one way that the seriousness of DV was framed was its threat to the patriarchal family, although people would use terms such as traditional family, or simply say *the* family. Discourse around the value and importance of family structures were common to all countries in this study, although not as strongly in Australia where "Why does she stay?" tends to dominate. This is also a common discourse in Canada.

Another consequence of the dominance of the justice sector discourse is that this is where the understanding of men as perpetrators of and as solutions to DV resides. The engagement of men in prevention of DV requires a much deeper understanding of their roles. The only network identified that is attempting to grapple with this in collaboration with the larger DV prevention policy community was the Canadian-based White Ribbon Campaign.[91] The White Ribbon Campaign now includes men from over fifty-five countries working to end violence against women. Campaigns focus on educating men and boys, although sometimes a general public education effort is launched.

Conclusion

The different lenses for defining and characterizing and for broad and deep understanding of DV are a major dilemma that was identified in the data from the five countries. The varying (non)ownerships of solutions to issues related to DV and women creates a set of policy networks

within the DV prevention policy community that are loosely connected and often pursuing different agendas. In fact, some sectors may be working at conflicting agendas. The most obvious disjunctions are between activists for women's rights and equality and members of the DV prevention policy community that view DV as resulting from the loss of *traditional* patriarchal norms. The differences of views, however, create more widespread limitation of intersectoral collaboration among non-activists as exemplified by the distance between justice and health sectors. In the Alberta data, it was a justice-oriented mental health program, forensic psychiatry, which played a key role in addressing DV. The continuum of gender-based violence (lack of access to basic human rights, health, education, and economic resources; verbal, emotional, and sexual abuse; physical abuse; acid murders) is contested and dependant upon the sector interviewed and the agenda of the individual policy community member. As women's rights groups begin to talk about the rights end of the continuum, they are most often charged with attempting to *break up* families. Official documents define DV as including all of the possibilities of abuse mentioned above; however, the lack of attention in our data to policy options around this continuum of abuse and the focus on tertiary prevention suggest that the social construction of DV is problematic for development of strong DV prevention policy communities.

V Discussion

The Gap Between International Policies and Local Policies

It would seem that an international human rights agenda is an underused analytic lens for understanding the role of DV and other gender-based violence. Historical patterns are witness to the value of drawing on human rights to force issues into public consciousness, and this is still effective in Afghanistan. Aboriginal women in Canada have employed this strategy to bring attention to the extent of violence they experience.[92] Every country in this study is a signatory to the major UN conventions (e.g., Beijing, CEDAW, Rights of the Child). Neither high income countries nor LMIC, however, have seen significant trends towards eradication of gender-based violence, in particular sexual violence or DV. In each country, some activists question the sincerity of their national governments in signing these declarations. As the policy process described in this report suggests, however, gaining some public knowledge is only one way to get actual changes in policies and programs. Despite years of human rights legislation and public awareness campaigns to eradicate DV and stranger rape, abuse of human rights is not routinely included in definitions of DV or rape in Canada, Afghanistan, Australia, Bangladesh, and Thailand. There seems to be a large gap between signing of international declarations concerning the end to discrimination against women and integration of the understanding of the implications of gender-based violence in policy and practice. International treaties are rarely discussed as relevant to the way that DV is addressed.

One explanation for the gap is the failure to mainstream gender-based analysis and the suggestion that women in high income countries have obtained equality, therefore, DV cannot be related to inequality. In fact, in Alberta the men's rights movement has effectively lobbied government in to deny labelling DV as a women's issue. Another explanation is the lack of connection in the DV prevention policy community between human rights policy community members and gender-based violence policy community members. The World Health Organization (WHO) and UNIFEM were not mentioned by study participants as leaders in the

prevention of DV despite significant work in both international organizations. Similarly, no participants mentioned the Amnesty International Campaign or, in Canada, the Stolen Sisters campaign. Another issue is the separation that governments create in some countries between themselves and DV prevention policy communities, with the consequence that government offices are not often cited as leaders. In Western Australia, however, three government offices were cited as leaders (police, legal aid, and Family & Domestic Violence Unit). It appears that DV prevention policy communities 'think locally, and act locally' which only perpetuates the tendency to avoid a gender-based analysis – the 'big picture' – and to examine the global implications of violence against women.

The differing understandings of what constitutes DV are significant for victims. 'Double binds' are created for the woman who find herself in an abusive intimate relationship and wondering if the experience is individual, "just her." First, if she is not an "appropriate victim", that is, if she breaks gender norms in her society (i.e., is assertive, is loud, drinks heavily, does not have children, to name a few possibilities), some people cannot see her as a possible victim, as someone who could be victimized by an intimate. In addition, if the complaint the woman puts forward is not of a very serious physical abuse (i.e., a serious crime as defined by legislation), then she could be considered to be abusing the resources available and possibly using the justice system inappropriately or for devious reasons (e.g., possibly making false charges to get the man out of the house). In the health sector where injury and mental health are the focus, the appropriate victim is helpless and emotionally damaged. Paradoxically, she is at the same time supposed to be strong, clear, able to articulate her need and seek help, able to take action, manage to become financially independent if the perpetrator is removed from the home, and, as a priority, able to protect her children from experiencing or observing additional violence. In Afghanistan, a woman who brings a complaint of abuse against her husband may be viewed as a disloyal woman and thus her complaint is ignored. In some Aboriginal communities in Canada and Australia, women face similar dilemmas. They are in a community that is unable or unwilling to address DV. However when they go outside of their community for help, they are viewed as being disloyal to the community and complicit with colonialism in that they are unfaithful to cultural heritage and traditional ways of handling conflicts, and possibly putting an Aboriginal man at the mercy of a discriminatory justice system.

Lack of a Population Health Perspective

The tendency to analyze DV from a local perspective is also demonstrated in the lack of a population health analysis. Population health is an approach that aims to improve the health of the entire population rather than focussing on risks and clinical factors related to particular diseases. As such population health increases our understanding of the determinants of health and reaffirms the need for public health professionals to critically examine social inequities and policies that maintain them.[93] The Ottawa Charter for Health Promotion identified many of the same characteristics for health promotion: "Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men."[94]

The dominance of a justice discourse may not be conducive to developing a population health discourse; that is, population health moves away from the individual level attributions to how community level factors affect populations. As Thurston and Vissandjée demonstrate in looking at the determinants of the health of populations of immigrant women, many of these determinants are mediated immediately through individuals (e.g., social support), so that people as well as institutions must shift to promote well-being.[95] Adhering to a justice discourse, however, has precluded a health sector discourse that moves towards other solutions through health policies practiced by doctors, nurses, pediatricians, and so forth.

The population health approach is another set of policy discourses, however, and does not always include the principles of health promotion.[96] Health promotion as outlined in the Ottawa Charter requires attention to justice and equity and has been argued to be a valuable framework for addressing DV when gender-based analysis and feminist theory are included.[11] For instance, people can talk about community participation and engagement without a gender analysis and ignore significant barriers to equal participation by women, the poor, and other groups.[97;98] The theories that people turned to in explaining DV tended to be individual-based theories of socialization and personal adaptation to economic conditions, impromptu marriage, and drug and alcohol use. Few people, for instance, talked about oppression of women as a population.

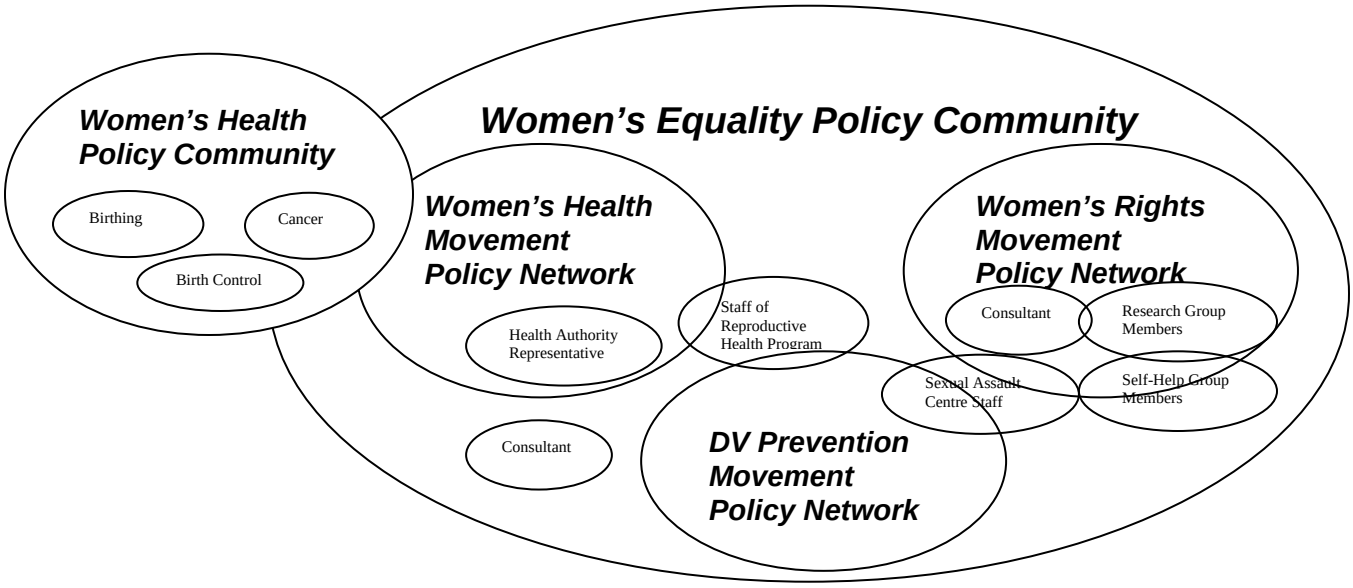
It seems that the focus internationally is on women solving the major social problem of DV one by one. Common policy solutions suggested are for more information and education regarding what abuse is, identifying oneself as abused, and then knowing which services to go to and/or "knowing her rights". The discourse around DV, particularly that which implies there are real or acceptable "victims" (good women) and that men are not responsible for their behaviour, places actual victims and those around them in double binds. Therefore, the individual level solutions proposed are only partially successful and create "gaps in the system" that call for fine-tuning that never addresses the actual dilemmas and roles of social institutions in perpetuating a culture where DV can exist. Even shelters and women's rights advocates are unlikely to discuss the contradictions of being appropriate victims, both because they also define in their intake practices who constitutes an appropriate client for their service, but also because they tend, especially in countries where these services are new (e.g., Afghanistan), to be dealing with women who have experienced horrific abuse. Much research has shown that women experiencing DV tend only to leave or seek intervention from the outside when the violence escalates to life threatening or terrorizing levels, or when the children become direct targets or show extreme reactions to abuse. Given the dilemmas created by the policy community, it is clear why this happens.

Linking Movements

It is beyond the scope of this report to discuss the history and development of the women's movement and women's health movement in each country and internationally. Although she wrote her book almost a decade ago, Lesley Doyal's conclusion that the international women's health movement has had little impact on the national health service of the UK[77] reflects our experience in the five countries included in this study. It seems that specialization has led to a situation where several networks exist, but the overlap in membership, and more importantly in the problem and solution analyses of DV, is weak. As figure three illustrates, people in the three women's equality centred networks (women's health, women's rights, DV prevention) may have

different lenses through which they view DV and may have different ways of understanding the problems and seeing potential solutions. In some countries, networking capacity has decreased due to changes in government funding that have reduced the numbers of civil organizations concerned with women's issues[99] and that can provide liaison among various policy communities. In addition, there is a larger women's health policy community that often does not have an equity or equality concern, and that may have several networks and coalitions that are not connected. Women's health is continuously defined only as reproductive and/or breast health[12] from a biomedical perspective, and that is where the health system resources flow. This reductionist perspective excludes the social and economic determinants of health and comfortably situates DV as outside the health sector in all but those cases that require immediate medical intervention.

Figure 3: An illustration of specialization in the DV prevention, women's, and women's health movements



VI Summary & Implications

Engaging the Health Sector

A number of challenges to engaging the health sector in the DV prevention policy community have been identified. These can also be discussed in terms of opportunities. The opportunity exists to broaden the understanding of DV by discussing it in terms of a threat to the health of populations. International organizations, such as the World Health Organization (WHO), provide a leadership role in bringing DV and other gender-based violence to the policy table. The WHO has conducted a multi-country study highlighting the prevalence of DV and aiming in the process to link researchers and activists within the countries.[15] The networks for the WDVHP research and the WHO research in Thailand and Bangladesh did not overlap at the time of the study, but this illustrates an increase in interest in the health issues of DV and opportunities to form coalitions.

International organizations must keep pressure on national governments to implement the conventions and agreements, such as, Convention on the Elimination of Discrimination Against Women (CEDAW) and other human rights agreements. Countries such as those represented in WDVHP can engage in international work and policy around DV. This will require accessing resources to enable LMIC countries to organize networking opportunities and programs. One advantage of international work is that external advocacy groups can often say things and stand up to speak about DV when it would be impossible for people inside a country to do so. A continuing challenge is for 'outsiders' to work within a country's DV prevention policy community so as not to disrupt or minimize the efforts of in-country leaders. Mobilizing international donors to work in LMIC countries similarly requires a balance of networking and trust building.

Opportunities to share successes and models from both high income and LMIC countries can help build international solidarity.

Individuals affiliated with organizations that have credibility in the health sector may be identified as potential leaders within the DV policy community. These leaders can engage the health sector through building trust and partnerships; for example, large non-governmental organizations such as BRAC in Bangladesh and Medical Mondiale in Afghanistan; government departments, such as the Ministry of Women's Affairs in Afghanistan, or the Department of Health, Ministry of Public Health in Thailand; academic institutions in Canada and Australia; and some women's rights non-governmental organizations. This process can begin by having forums where different perspectives can be shared respectfully. An excellent example of this is the work being done by UNIFEM at a national level in Kabul, Afghanistan. UNIFEM has brought divergent groups interested in DV to the table to share various perspectives on violence against women and to encourage development of policy networks. At a local level, the Calgary (Canada) Mayor's Task Force on Community and Family Violence resulted in sustained funding of the Calgary Domestic Violence Committee and the Action Committee Against Violence that brings stakeholders from non-governmental organizations to one table to discuss coordinated actions and program alternatives in the city. In Western Australia, on-going funding for DV

regional committees that brings representatives from a range of government agencies and non-governmental organizations works to enhance co-ordinated responses.

The common international perception that mental health services for men and women involved in DV need to be improved is a potential opportunity for engaging the health sector. Rather than explaining violence as the outcome of bad mental health, or bad mental health as the outcome of DV, there is growing recognition that violence against women must be linked to the impacts of traumas that require mental health policies, such as, engaging in and surviving war; economic policies around legal and illegal drugs in Afghanistan; alcohol addiction and experiences of residential schools in Alberta; and drugs and alcohol, and trafficking of young girls in Thailand. This opportunity fits with the overall need for interdisciplinary and intersectoral policy communities that can work together to obtain a nuanced understanding of the complex problem of DV.

Working Across Sectors

A challenge for action is to identify solutions that can unite the health sector with parties working in other sectors. Research in the health sector can aid in understanding the language and the priorities expressed by the health sector. In one current project in Calgary (Canada), for instance, the Emergency Room Intervention Project Steering Committee has agreed not to use the word “screening” to refer to an intervention where everyone is asked about DV. In the health sector, the term screening carries certain assumptions and policy requirements that cannot be met in DV.

To engage the health sector in a DV prevention policy community it is necessary to develop mechanisms for the exchange of knowledge, understanding and insights. The health sector relies on professional and academic journals, professional conferences, professional development, and accreditation as major sources of information exchange. An open invitation to health professionals to a conference for police officers or justice officials will not usually result in a large attendance because it is inefficient for people to go outside of their normal professional responsibilities or educational circles. Often, open-ended invitations bring the converted to a meeting, that is, those from the health sector who are already part of an advocacy group for intersectoral collaboration. An open-ended invitation may be seen as a professional education device (i.e., one group letting health professionals know that the workshop or conference is being held). On the other hand, strategically inviting health sector policy representatives to address an audience from another sector may enable them to build credibility and networks. It is also critical to understand that the health sector is not homogenous and that the power politics of health are played out in the divergent nature of the health sector players, from physicians to nurses to administrators.

Education sessions, such as those held for emergency nurses in Calgary (Canada) may also build membership in the DV prevention policy communities if they have this as a sustained and valued aspect of their day-to-day work. Experience has shown that education alone will not make people interested in preventing DV. People in the health sector have also stressed that health professionals should receive training in their professional training. The University of Calgary, Faculty of Medicine has had a specific curriculum for second year medical students for over five years. Faculties of Nursing and Social Work at the same university have not developed similar curricula. In Western Australia, while there is more emphasis on DV in the social work curricula,

it is lacking in nursing programs. An international effort to train all health professionals about gender-based violence, and DV in particular, as a population health issue may help in the long term.

To get to the point of developing an advocacy coalition for DV with health included, it is necessary to identify mutually beneficial goals and outcomes, such as reduction of injury, reduction of use of the health system, improved access to the health system, improved rates of maternal morbidity and mortality, or reduction of transmission of HIV/AIDS, to name a few. Here, the value of a local, national and/or international network that keeps the discussion of causes and consequences of DV broad and encompassing is apparent. For instance, if a local network focuses on DV as injury prevention in order to engage the health sector, a negative consequence could be lasting conceptualization of DV that excludes victims of emotional and sexual abuse.

One way to engage the health sector is to view it not as a huge monolithic bureaucracy, but to strategically engage with specific interest groups within the system. It can be useful to differentiate governance policy and operational policy when trying to change the health sector and move the agenda. People often mistake "starting at the top" with boards and Chief Executive Officers as necessary for change, but Thurston et al. identify the operational policies as more widespread and amenable to engagement.[56] One may find a champion for DV prevention at the level of governance, and this can be strategic when people down the ladder of authority need a sponsor or supporter for their DV policy; however, one may also draw from a larger pool of potential leaders among the managers and directors closer to the front lines of patient care. It may be just as well in some instances to have an Emergency Department nurse or an interested champion from maternity care to begin the process of discussing DV interventions in health. This is apparent in Western Australia where staff from Women's & Children's Health have stronger links to the DV prevention policy community than other sections of the tertiary health sector. This insight can lead to more creative interventions where motivated individuals from the health sector help in understanding that sector. Guidelines for developing successful collaborations or partnerships between the health sector and other sectors can help sustain the work. Once the need for collaboration has been decided, for instance, members work together to clearly state the roles responsibilities, rules and focus of this relationship.

Western Australia's Domestic Violence Advocacy Support Central (DVAS Central) – the "one-stop-shop" created by the co-location of collaborative multi-agency services for victims of DV – is an example of organizations coming together with strong links to sections of the health sector. Divergent groups came together, developed a clear rational for a service where different sectors were represented in one location and could address several of a victim's challenges without sending her to several different offices in the city. As the individuals from different sectors and agencies worked on common goals and with the same women, they further clarified the kind of relationships that were needed to move their agenda forward. As a result, the different sectors are learning about each other, their differences and commonalities, and gaining a better understanding of each others' perspectives and policy agendas. In the case of Australia this approach has resulted in a sustainable collaborative project.

Thailand provides another example of success in working across sectors, including health, legal, social, government departments, non-governmental organizations, and academia, for services,

prevention, advocacy, and policy formulation on DV. For this country, the mechanisms for achieving work across sectors includes stating an intersectoral principle of working with the DV issue in policy and planning at national and local level and implementing the work across sectors at the level of governance, as well as curriculum design for health and legal professional schools which emphasizes the intersectoral work on prevention of DV.

Working Across Genders

A gap in our interviews and discussion so far has been an underlying assumption that the perpetrators of violence against women are always men. An important constituency to be included in the DV prevention policy community is that of activists around the rights of gays, lesbians, bisexuals, trans-gendered, and two-spirited people (GLBT).[100-102] Providing a safe place for open discussion of the issues faced by GLBT can help make clear our assumptions in understandings of gender-based violence and of human rights; for instance, how same sex violence is understood and discussed may or may not be similar to how DV in heterosexual relationships is discussed. Inclusion of men's rights and discussions about how to include men in programs for the prevention of violence against women also has the potential to be helpful.

In each country in this study the need to engage men in prevention efforts was identified. This is another challenge for the health sector where the roles of men and women vary widely and internationally. In Afghanistan, medical training is now open to women again after many years of Taliban rule; however, whether women will have equitable access to medical training remains to be seen. In Canada, for instance, where females have comprised about half of medical trainees for nearly two decades, women still fill only about 20% of academic medical positions. Administrative positions in the health sector and in medical professional associations are predominately held by men. The history of the health sector and the roles of men and women make health organizations gendered in particular ways. Women are implicitly expected to care for children, the sick, and the elderly under most models of health care, for instance, yet the organization of medicine does not accommodate this in medical practitioners.

A Global Response to a Global Epidemic

It is now recognized globally that DV is a threat to the health of populations.[7;15] This study suggests that more needs to be done to enable an analysis of the problem at a global level, while continuing to examine action at the local level. It is obvious in the data from this study that current policies and programs across five divergent countries have failed to make a significant difference in the incidence of DV in the last three decades. On-going analysis and discussion of the problem of DV will support development of innovative and effective solutions.

An effective DV prevention policy community does not require that everyone in the various networks and advocacy coalitions share the same understandings of the problem, but debates are needed to discover underlying frameworks and to ensure that these are not counterproductive. Networks can coalesce around points of agreement and shared understandings while seeking opportunities to influence policy and create programs as policy windows open. The implications of trying to organize a global coordinated response to DV are huge because the spectrum or continuum of definitions is great. One such implication is that coordination would be difficult as agendas differ and sometimes conflict. At a minimum we need the opportunity to learn from each other. Another implication is that politicians and bureaucrats do not want to become

embroiled in controversies. Debates within the DV prevention policy community can become controversial, especially as the topic of the role of family structures is introduced. One of the potential benefits of an international policy community is sharing how to introduce policies so that public opposition is minimized. One benefit of a strongly connected DV prevention policy community is an increased potential for the people involved to strategically prepare their communities (or populations) for a new policy and to identify how to promote a policy in a political constituency. Another benefit may be avoidance of apparent conflicts among advocacy coalitions.

Comparison of experiences and total packages of policies at the local, regional, national, and international level may be very difficult and requires resources to complete, however, it may also be very helpful. It is apparent from comparing experiences from several countries, for instance, that just training the police is not enough, yet the justice system policy representatives may see this as the solution if they do not have the understanding of DV that direct service people can bring to identifying solutions. A similar response has been seen in the health sector, with the assumption that training individual practitioners can overcome the systemic issues that limit their ability to address DV. An issue for debate is under what circumstances training of professionals should take place and what needs to be in place for it to be effective. Another issue is the nature of the training and the role of training in challenging and maintaining institutional discourses and hegemonies.

International comparison can identify the long-term nature of interventions and where to look for unintended consequences, both negative and positive. The issue of marital rape was criminalized in Canada in 1983, for instance, by changing the law to allow spouses to lay charges. Rape laws have been amended in Canada to remove specification that victim and perpetrators were strangers, and now spousal and date rape can be treated under the same act as stranger rape. What has emerged from these "successes" in legislative change, however, is the differential needs of women raped by spouses or dates as compared to those raped by strangers. The implication is that a one-size-fits-all justice system response is not satisfactory.

The World Conference on Family Violence is an excellent example of willingness of government and international organizations to share knowledge and experience. A key role for conferences at the local, regional, national, and international levels is to keep DV on the policy agenda. These can link DV and other gender-based violence in ways that move the development of the policy agenda forward, bringing people from diverse backgrounds to discuss the issues from many perspectives. As discussed earlier, representation from the health sector may have to be carefully nurtured.

Immigration, Migration, and Racism

Globalization of information (all media including the internet), business, and travel has resulted in a greater breadth of knowledge of other countries' cultural norms, foods, practices, and religions. The depth of understanding is less clear. A challenge for the prevention policy community is to address the arguments that traditions are essential to the survival of culture and that questioning patriarchy and dominance are tantamount to colonialization. Feminist scholars of religion, culture, and social change, in particular, are taking on this task, as are activists in some populations. Being in the minority at international meetings and conferences, women from Islamic, Buddhist, or Indigenous religions may be put in the place of feeling the need to defend

the religion, when they would rather discuss strategies to counter religious fundamentalism. The latter seldom arises as a topic of debate in high income countries; however, *FaithLink*, a special project in Calgary (Canada), began in 1998 in recognition that religious communities did not have policies for addressing DV, and that some had policies that were not women friendly.

Immigration and migration have literally and figuratively changed the face of the DV prevention policy community in high income countries. In the last decade in Canada and Australia, for instance, there has been increasingly nuanced and complex discussion of the need for understanding diversity, and for cultural competence among shelter staff and organizations. In Canada, the Calgary Women's Emergency Shelter developed a specific outreach program for immigrant women, and the Brenda Strafford Centre, a second stage shelter, was acknowledged by the United Way of Calgary and Area for its culturally competent programs. In Western Australia organisations such as Ishah and Women's Multicultural Advocacy and Support both run outreach DV programs for 'culturally and linguistically diverse' (CALD) women. In some ways this has benefited the communities of indigenous women, providing lenses for the study of the impacts of migration on family members, and increasing debate about what constitutes culture, racism, discrimination, inclusion, integration, and equity. On the other hand, indigenous people are not migrants and including them under the same umbrella can mask the issues of colonization, treaty rights (in Canada), self-governance, and historic relationships that exist with the state.

Australian and Canadian researchers, both within and between countries, have research partnerships that may benefit Aboriginal health research and DV research globally. People from these countries are working together to address the unique issues facing Aboriginals. In Canada, Aboriginal women have been disproportionately neglected by research, and community politics may preclude women's concerns like DV from getting on the list of priorities. In Australia, however, the situation is the opposite with a call from the Aboriginal community to ensure that research has positive outcomes for Aboriginal people, due to these communities being 'researched-out'. Reports such as the findings of the 2002 Gordon Inquiry into government response to family violence and child abuse in Aboriginal Communities[103] have been instrumental in focussing on the specific issues facing Western Australia's Aboriginal people.

Migration has ensured that there are DV researchers and activists in high income countries who migrated from the other countries included in, for instance, WDVHP. The issues of inclusion and participation in policy communities raises dilemmas around representation and power politics; for example, there could be concerns as to who speaks for the population of Thai people in Calgary and whether there is a Thai "community". Depending on the number of people in a given locale, issues of confidentiality arise in the health sector where programs and policies attempt to be culturally appropriate. English as a second language necessitates translation, and health programs often rely on children or other family members to interpret for a woman. Calling on someone in a hospital who speaks the same first language may result in a member of the cleaning staff interpreting medical jargon. Immigrant women who settle in rural parts of Canada lack access to specialized immigrant serving centres and immigrant advocacy networks that exist in larger centres.

Scholarly Exchange

The opportunity for scholars from high income and LMIC countries to work in other countries and to collaborate on DV research is greater than in any other historical period. There is a growing recognition that "development" is not one way, and scholars and students from high income countries benefit from these exchanges as well as the LMIC scholars. The inequities in access to scholarly literature, such as journals, in funding of universities, and in acceptance of women as scholars continue to challenge the area of DV research.

Countries vary in the extent to which feminist scholarship has been permitted or nurtured; Afghanistan formally lost all scholarship except the study of the Koran, but women's studies has returned to the University of Kabul. In addition, refugees from Afghanistan kept feminist scholarship alive, sometimes at risk to themselves, while they lived in other countries (for example, see the work of Zohra Rasekh).

Globalization has provided the opportunity for women from LMIC countries to obtain advanced education in other countries. This may enable them to return to more powerful positions in their home countries. It also enables them to build an international community of DV scholars upon whom they can call for support of research proposals, development of literature bases, policy options (e.g., programs), and grey literature covering policy options.

Towards the Future

As a team, we look forward to hearing from those who would like to comment on the report. Our project has demonstrated that there is a community of people working locally to address DV who are willing to continue to support and facilitate efforts at a global level. Our continued efforts to identify DV prevention policy communities will provide starting points to bring communities to networks. And finally, understanding the current involvement of the health sector more clearly will provide insight into what is needed to engage them in DV prevention as a legitimate health issue in the near future.

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