Web Page: http://www.awhn.org.au/

Submission to the National Council to Reduce Violence against Women and Children.

A Response to Inform the Development of the National Plan to Reduce Violence against Women and Children.

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"The roots of violence against women lie in historically unequal power relations between men and women and pervasive discrimination against women in both the public and private spheres. Patriarchal disparities of power, discriminatory cultural norms and economic inequalities serve to deny women's human rights and perpetuate violence".[1]

The Australian Women's Health Network commends the Rudd Commonwealth government on its commitment to develop a National Plan to Reduce Violence against Women and Children (NPoA) and congratulates it on the establishment of the National Council. A Concerted national effort, spearheaded by the Commonwealth and operating across all areas of public policy, is needed to achieve a reduction in gender inequality. Because gender inequality forms the societal basis for violence against women and to some extent against children, its reduction is an essential precondition for achieving a decline in the incidence of violence.

Promoting gender equality is part of the core business of the Australian Women's Health Network (AWHN). The organisation is community-based, non-profit and consultative and provides a national voice on women's health issues. Established in 1986, it is linked to women's health networks and service provision agencies in all States and Territories. Each jurisdiction is represented on the management committee, as well as Aboriginal women, who have established an Aboriginal Women's Caucus. AWHN cuts across political, economic, social and ethnic barriers and works with a wide cross section of Australian women. It operates as a women's health advocacy and information organisation, working with government policy makers, where appropriate, and other agencies to improve the health and well-being of Australian women. The organisation is funded from membership fees and does not receive government funding.

This submission does not address the four suggested questions, since there is abundant published information on each of the issues. See, for example, material on the March 2008 Edition of Women's Health Victoria's Clearinghouse Connector, which focuses on violence against women at http://www.whv.org.au/clearinghouse-connector/cc-violence2.htm,

[1] United Nations (2006) *Violence against Women*, Secretary-General's Study On All Forms of Violence against Women, at http://www.un.org/womenwatch/daw/vaw/

the Australian Domestic and Family Violence Clearinghouse website at http://www.austdvclearinghouse.unsw.edu.au/ and Canada's National Clearinghouse on Family Violence at http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/ao_e.html AWHN's submission concentrates, instead, on the impact of violence on women's health and the health of children. A large literature has accumulated which elaborates on the close connections between violence against women and children and poor health outcomes.

Introduction.

While the causes of violence are complex, there is wide agreement that intimate violence is firmly embedded in gender inequality. As The World Health Organisation (WHO) has argued, the unequal distribution of power and resources between men and women is a significant factor underpinning violence against women.[2] Therefore, a reduction in violence against women and, to some extent, against children as well, requires a reduction in gender inequality across the board.

Violence can take many forms, both direct and structural. While many definitions are possible, WHO has chosen the following:

> the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation[3]

This definition recognises that intimidation and the use of power are key components of violence and that, while violence may result in injury and death, its impact can be more or less invisible, manifesting in psychological and social problems that are not necessarily readily apparent. Some consequences may be latent and may remain for many years after violence has ended. Violence may also be structural. In Australia, the lack of appropriate services for women escaping violence, can be put into this category. The persistent overrepresentation of women amongst those who are poor can also be seen as a form of structural violence.

To be effective, therefore, campaigns to reduce violence against women and children must operate across the full range of public policy areas, addressing the wide and varied factors, the social determinants, that cumulatively produce gender inequality. The Australian Women's Health Network recommends that the National Plan of Action take a broad and comprehensive approach to the reduction of gender inequality. Such an approach is necessary to set down a stronger foundation on which to build violence reduction programmes and projects.

Gender Inequality and Poor Health Outcomes.

Gender inequality is one of the social determinants that produce negative health outcomes for women and children. AWHN, following the World Health Organisation, views health from a social determinants perspective in its broad social context, recognising that health outcomes are influenced by a range of social,

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[2] WHO (2002) *World Report on Violence and Health*, Geneva, quoted in VicHealth (2004) *The Health Costs of Violence*, Carlton South, p 10.
[3] Krug, Etienne et al (2002) *World Report on Violence and Health*, WHO, Geneva, p 5.

environmental, economic, gender and biological factors and that differences in health status are linked to sex, age, socioeconomic status, ethnicity, disability, location and environment[4]. Thus discrimination against women, economic insecurity, the unequal burden of unpaid work and access barriers to appropriate, publicly funded services all impact heavily on negative health outcomes for women and often for the people for whom they care. As Dr Robert Hall has argued recently, "gender relations are present at every part of the health and disease pathway and so gender needs to be considered at every stage of health promotion, disease prevention, health care and palliative care".[5]

As the Canadian Centre for Policy Alternatives has argued, "poverty is a form of structural violence against women".[6] As elsewhere in the world, women continue to experience economic disadvantage at higher rates than men. In Australia, only 58 per cent of women were in the paid labour force compared with 72 per cent of men in 2006. In the same year, the ratio of female to male full-time earnings showed a gender pay gap of 16 per cent, with women's full-time earnings at $941 compared with $1125 for men. Women vastly outnumber men as receivers of income support payments, 83 per cent of one parent families are headed by women and women have much lower superannuation entitlements than men across all age groups.[7] One of the direct consequences of low income and poverty on women's vulnerability to violence is that they often find themselves in exposed situations, for example, waiting on bus stops at night and in rental housing in less safe areas of cities. Studies have shown that young women, in particular, in lower socio-economic areas are more likely to experience violence than those from high income areas[8]

Workplace conditions, too, may give rise, directly and indirectly, to poor health outcomes. Discrimination and/or harassment of women in the workplace, for example, may lead , not only to anxiety, depression and other mental health problems, but may also result in economic insecurity, which is closely associated with reduced life chances and poorer health. Where ever studies have been undertaken around the world, close links have been found between low socio-economic status and higher rates of morbidity and mortality.

Australia's gender pay gap operates throughout women's life spans. It contributes to economic insecurity for low income families, especially women headed families, and therefore has a negative impact on the health of children as well as women. It also contributes to a serious lack of financial independence for women in retirement. One of the ways that income insecurity impacts directly on health in Australia is by reducing the use of necessary medical services. A recent international study shows that 17 per cent of Australians did not access recommended medical care because of cost in 2006. This study, which unfortunately does not provide sex disaggregated

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[4]Australian Women's Health Network (2008) *Women's Health: the New National Agenda*, Position Paper, March, p 8-9. Available at http://www.awhn.org.au/).

[5] Quoted in Australian Women's Health Network (2008), p 13.

[6] Canadian Centre for Policy Alternatives (2007) "Ending Violence against Women: Understanding the Connections between Direct and Structural Violence", December 20, at http://www.policyalternatives.ca/documents/Manitoba_Pubs/2007/FastFacts_Dec_20_Ending_Violence_Against_Women.pdf

[7] Australian Women's Health Network (2008), pp 10-11.

[8] Mouzos, Jenny and Makkai, Toni (2004) *Women's Experiences of Male Violence*, Australian Institute of Criminology, Research and Public Policy Series, Number 56, p 28.

data, also shows that 13 per cent of Australians did not get their prescriptions filled or skipped doses in order to make their medications last longer.[9] We know that most of these people are women because of their overrepresentation in low income and older age groups.

Examples of gender inequality are part of Australian experience on a daily basis. These examples operate to produce a "demonstration effect". Consciously or unconsciously, citizens are routinely reminded of the unequal status of women, with associated connotations of lower worth and value. The culture of inferior standing forms a societal foundation for violence against women.

Violence against Women and Poor Health Outcomes.

Violence against women is both embedded in gender inequality and serves, in turn, to reinforce and perpetuate that inequality. It may take many forms including physical, emotional, psychological, sexual, verbal, environmental, social, financial and religious/spiritual abuse and it has been found that physical abuse and sexual and psychological abuse often take place together.[10] The International Violence Against Women Survey (IVAWS) showed that 57 per cent of Australian women had experienced at least one incident of violence in their lives.[11] All violence statistics, of course, must be viewed in the context of the significant underreporting of physical and sexual assault that has been revealed in studies worldwide.[12]

The Australian women's health movement has recognised violence as one of the key determinants of negative health outcomes for women since its mobilisation in the early 1970s. Currently, AWHN has selected violence as one of the five priority areas which need to be addressed in the proposed new National Women's Health Policy. [13] The identification of violence as a priority arises from consultations around Australia with women and from the work and experience of women in specialised women's health services in all States and Territories.

Violence is enormously detrimental to women's health. A major World Health Organisation study of violence and health in 2002[14] found that violence had a negative impact on women's physical, sexual, reproductive, psychological and behavioural health, as well as having fatal consequences in cases of AIDS related mortality, maternal mortality, homicide and suicide. Women with a history of exposure to violence suffered higher rates of depression, more suicide attempts, more chronic pain, more psychosomatic disorders, more physical injuries, gastrointestinal disorders and negative reproductive health outcomes. Post-traumatic stress disorder has also been found to be prevalent. Neurological disorders result from head injuries and strangulation, sexually transmitted and urinary tract infections are more common,

[9] Schoen, Cathy, Osborn, Robin, Doty, Michelle, Bishop, Meghan, Peugh, Jordon and Murukutla, Nandita (2007) "Towards Higher- Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007" in *Health Affairs*, Web Exclusive, pp W717-W734.
[10] Institute of Health Economics (2008), *Spousal Violence against Women: Preventing Recurrence*, Edmonton, p 1.
[11] Mouzos and Makkai, op. cit., p2.
[12] Institute of Health Economics, op. cit., P3.
[13] Australian Women's Health Network (2008), p 15; 21-22.
[14] Krug, op. cit.

along with migraine headaches and chronic pain.[15] Violence against women has been found to have seriously negative reproductive health outcomes in Australia.[16] Moreover, it has been found that the consequences of abuse could persist for many years after the abuse had stopped and that the more severe the abuse, the greater the detrimental effect on health, with multiple episodes having a cumulative impact.

Astonishingly, perhaps, intimate partner violence was the leading contributor to death, disability and illness for Victorian women aged between 15 and 44 years in 2004, ahead of well recognised risk factors, such as high blood pressure, smoking and obesity. The Victorian study found that intimate partner violence had contributed 9 per cent to the total disease burden for Victorian women aged between 15 and 44 years and 3 per cent for all Victorian women in that year. An Access Economics study, undertaken for the Commonwealth government, estimated that, in 2002-3, the total cost of family violence was approximately $8 billion. The Report noted, however, that "less tangible costs", including fear, mental anguish, loss of leisure and physical pain and disability were probably more important to those experiencing violence than productivity costs.[17]

Australian attitudes towards physical and sexual violence have shown a high level of acceptance of aggression, along with a trivialisation of research findings and reports. 40 per cent of Victorians believe that rape results from men not being able to control their sexual urges, 15 per cent believe that women often say no when they really want sex, a quarter of people are prepared to excuse domestic violence if it is the result of temporary loss of control which the perpetrator later regrets and a quarter disagreed with the statement that *women rarely make false claims of being raped*. Despite evidence that perpetrators of violence are overwhelmingly male, 20 per cent of Victorians believe that women and men are equally likely to commit family violence and this number has increased since 1995 when it was only9 per cent.[18] Clearly, primary prevention strategies need to be put in place to impact upon societal attitudes.

Violence, then, has a serious undermining impact on women's health and on the health of the communities they live in. As a recent Canadian study concluded, "Male-to-female spousal violence is a significant public health problem because of the associated physical, psychological, and financial costs to victims, their families, communities, and society in general".[19]

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[15] Coker, Ann (2005) "Opportunities for Prevention: Addressing IPV in the Health Care Setting", *Family Violence Prevention and Health Practice*, volume 1, January, p 1.

[16] Taft, Angela, Watson, Lyn and Lee, Christina (2003) "Health and Experience of Violence amongst Young Australian Women", *The Australian Longitudinal Study on Women's Health* at www.newcastle.edu.a new/centre/wha

[17] Commonwealth of Australia (2004) *The Cost of Domestic Violence to the Australian Economy: Part* 1, pp 19-35.

[18] VicHealth (2007 *Two Steps Forward, One Step Back: Community Attitudes to Violence against Women*, available at www.vichealth.vic.gov.au/cas

[19] Institute of Health Economics (2004) *Spousal Violence against Women: Preventing Recurrence*, January, p. 26.

Violence against Children and Poor Health Outcomes.

Children's health is also profoundly affected by living in households where violence is prevalent [20]. An Australian Bureau of Statistics study shows that 61 per cent of women (822,500) who had experienced violence from a previous partner and 49 per cent of those (111,700) who were experiencing violence by a present partner, had children in their care.[21] The IVAWS showed that 29 per cent of the women surveyed reported having experienced physical and or sexual violence before the age of 16 years. Sexual abuse by a nonparent relative or another male was reported by 16 per cent of women. Those who had experienced childhood abuse were 1 1/2 times more likely to experience violence in their adult lives.[22]

Children who witness violence against their mothers have been found to be at greater risk of a wide range of serious emotional and behavioural problems, along with poor school performance and physical health complaints.[23] They experienced anxiety, depression, low self esteem, nightmares and physical health problems. North American studies show that children who witness spousal violence exhibit many of the same problems as children who are directly abused.[24] Other research suggests that violence causes higher child mortality. The children of women who were physically and sexually abused by a partner were six times more likely to die before the age of five years.[25] A recent Canadian study documents in detail the multitude of deleterious effects that witnessing violence may have on babies, children and young people[26]. Exposed children between the ages of 3 and 5 years have been found to have lower verbal skills and behavioural problems[27], research shows that children and their mothers are often injured when trying to protect each other[28] and a high proportion of young people brought before the juvenile justice system in Canada have been either direct or indirect victims or perpetrators of domestic violence[29].

In Australia, it is estimated that one quarter of children and young people have been witnesses to violent acts against their mothers or stepmothers. Research also shows that family violence and direct child abuse frequently coexist. Researchers have estimated that between 30 per cent and 60 per cent of children who witness family violence also experienced some form of abuse. There is evidence that witnessing

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[20] A review of recent literature can be found in Humphreys, C. (2006) "Relevant Evidence for Practice" in Stanley, N (Ed) *Domestic Violence and Child Protection: Directions for Good Practice*, Jessica Kingsley Publishers, London, pp 19-35.
[21] ABS (2006) *Personal Safety Survey, Australia*, ABS catalogue No 4906.055.003, Canberra. At http://www.abs.gov.au/ausstats/abs@nsf/cat/4906.0
[22] Mouzos and Makkai, op. cit., p 4.
[23] Krug, op. cit., pp 100-103.
[24] WHO, op. cit., p 103.
[25] Ibid
[26] Cunning ham, Alison and Baker, Linda (2007) *little eyes, little ears*, Centre for Children and Families in the Justice System, London, Ontario.
[27] Ybarra, Gabriel et al (2007), "The influence of domestic violence on preschooler behaviour and functioning", *Journal of family violence*, volume 22, number 1, January, pp 33-42.
[28] Mbilinyi,Lyungai et al (2007) "What happens to children when a mother is a battered?", *Journal of family violence*, volume 22, number 5, July, pp 309-317.
[29] Baker, Linda and Jaffe, Peter (2007) "Youth exposed to domestic violence", Centre for Children and Families in the Justice System, London, Ontario.

family violence as a child is likely to perpetuate gendered patterns of violence in future generations. [30]

Violence against Particular Groups of Women -- and Poor Health Outcomes.

Certain groups of women and children are at greater risk of experiencing violence than others. In particular, Aboriginal women, women with disabilities and young women are all in the high risk category. The IVAWS showed that Aboriginal women and women aged 18 to 24 years were the two groups most likely to experience physical and sexual assault. The rate of family violence for Aboriginal women has been reported in one study to be almost 40 times higher than that for non Aboriginal women. Rates of sexual violence are also higher. Whereas Aboriginal women represent around 2 per cent of the Australian population, they comprise 15 per cent of homicide victims. A study of regional Australia showed that very remote regions experienced the highest rates of family violence.[31] These findings that are consistent with a Northern Territory Department of Justice study which showed Aboriginal women, who mostly live in remote locations in that jurisdiction, to be nine times more likely to experience violence than non Aboriginal women.[32] These statistics should be treated with caution because of methodological and other difficulties. However, the authors of the IVAWS argue that the evidence is robust enough to demonstrate a "disproportionate occurrence" of violence and traumatic impact among Aboriginal Australians.[33]

Approximately 2 million Australian women or 20.1 per cent of all Australian women and girls experience disability, with more than half of this number experiencing "moderate to profound core-activity limitation". However, despite the enormous size of this group, there is an extreme shortage of Australian research information on health and well-being experiences, especially in relation to violence. One researcher identified six themes in relation to women with disabilities: invisibility; imaged as asexual; vulnerability to abuse and exploitation; inadequate or inappropriate medical services; poverty, with commensurate educational and occupational disadvantage; poor access to technology and rehabilitation services.[34] As Salthouse and Frohmader[35] argue, the conditions of the lives of women with disabilities, coupled with political sidelining, have "relegated them to a position of extreme marginalisation and consequently, to increased risks and experiences of violence".

Women with disabilities are less likely than their male counterparts to have secondary or tertiary education. Fifty one per cent of this group earned less than $200 per week

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[30] State of Victoria, Department of Justice (2006) *Victorian Family Violence Database: Five-Year Report.*

[31] Department of Transport and Regional Services, *(2006) About Australia's Regions, Bureau of Transport and Regional Economics*, Canberra. At http://www.btre.gov.au/statistics/regional/regstats06/Is Australias_ Regions_06.pdf

[32] Northern Territory Crime Prevention Presentation (2006), *Rates of Assault in the Northern Territory*, Northern Territory office of crime prevention, Department of Justice, Darwin.

[33] Mouzos and Makkai op. cit., p 2; 28-30.

[34] Victorian Government Department of Human Services (2006) *Women's Health and Well-Being Strategy*, Background Paper, Melbourne, Victoria, pp 24-26.

[35] Salthouse, Sue and Frohmader, Carolyn (2004), "Double the Odds-Domestic Violence and Women with Disabilities", paper presented to the "Home Truths" Conference, Sheraton Towers, Southgate, Melbourne, 15-17 September. At http://www.wwda.org.au/odds.htm

in 2004 and only 16 per cent earned more than $400 a week, compared with 33 per cent of men with a disability. Women with disabilities had lower workforce participation rates than men with disabilities across all levels and types of disability, and lower than the population as a whole, they are less likely to own their own homes and are overrepresented in public housing. Salthouse and Frohmader conclude that women with disabilities in Australia experience "discrimination on several levels, each of which restricts their options and opportunities for equal participation in the economic, social, and political life of society. They are disadvantaged attitudinally, economically, politically, psychologically and socially". [36] The social determinants of health are all moving in the wrong direction for women with disabilities!

In relation to violence, women with disabilities experience higher levels and that experience is likely to be dramatically amplified by the other negative circumstances of these women's lives. In Australia, however, there is very little data on the incidence of violence and what data there is, tends to focus on sexual abuse in relation to women with intellectual disabilities. Statistics suggest that 90 per cent of women with intellectual disabilities have been sexually abused and that 60 per cent of these women will have been subjected to sexual abuse before the age of 18 years. There is also evidence that women with disabilities have fewer pathways to safety, tend to be subjected to violence for significantly longer periods and experience more diverse types of violence at the hands of a greater number of perpetrators.[37] Studies in other countries have found that women with disabilities, regardless of age, race, ethnicity and so on, are assaulted, raped and abused at least twice the rate of nondisabled women. In a study of Canadian women with disabilities, 40 per cent had experienced abuse and 12 per cent had been raped. According to another study, 33 per cent of women with disabilities had been assaulted in Ontario, mostly by their husbands, compared with a rate of 22 per cent for women without disabilities. Salthouse and Frohmader express particular concern about the apparent Australian tolerance for widespread abuse against women with disabilities and they note that almost all the research literature identifies a failure to provide care and protection, to believe the victim, to notice violence, to protect from future violence or to take legal action against perpetrators.[38]

According to the IVAWS, women from culturally and linguistically diverse (CALD) backgrounds are less likely than women from English-speaking backgrounds to suffer physical violence, whether recent or measured over the lifetime. The two groups suffered similar levels of sexual violence in the year prior to the survey. Again, the statistics should be treated cautiously since perceptions of what constitutes violence may differ between the two groups and there is some evidence that women from CALD backgrounds are less comfortable about disclosing and openly discussing sensitive information with interviewers.[39] Moreover, it should be remembered that women from CALD backgrounds are overrepresented in lower socio-economic categories and that they experience language and cultural barriers, especially in the access of health services. They suffer from higher levels of mental ill-health,

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[36] ibid

[37] Jennings, Chris (2007) "Access and Equity Equals Best Practice", *Australian Domestic and Family Violence Clearinghouse Newsletter*, 29. No earlier low no if no

[38] ibid

[39] Mouzos and Makkai, op. cit., p 31-32.

occupational related illnesses and injuries and reproductive health problems.[40] [41] The result of these cumulative marginalising forces is that the negative impact of violence is likely to be amplified, with intensification of the negative influence on health.

Violence against Women and Children: An Aboriginal Woman's Perspective.

In some Aboriginal families and communities, violence against women and children is commonplace. Too many Aboriginal women and children do not know what it is to live in a safe, secure and supportive environment. Violence in all its forms, physical, verbal and sexual, continues to ravage communities and, in many instances, the violence is intergenerational. Many factors such as racism, unemployment, alcoholism, spiritual loss, displacement, loss of community elders due to high early mortality and morbidity rates and a breakdown of social capital, impact negatively to perpetuate cycles of violence. Intergenerational grief due to the Stolen Generation policy is also a factor.

Protecting women and children from cycles of violence is often exacerbated by the extended family system. Many Aboriginal women and children live in fear or hide from their extended families for fear of reprisal, especially if their partners are incarcerated as a result of reporting and conviction for family violence or abuse.

The key issue, from an Aboriginal perspective, is that it is the women and children who are regularly uprooted from their family homes and placed in community refuges and safe houses. This has a negative result on family life and may result in children regularly having to move to different areas, experiencing a fractured home and school life.

Recommendations as a Response to Violence in Aboriginal Communities.

- Policies should be developed to ensure that men are removed from the home and put into safe houses where they can receive ongoing support and counselling to address their issues.
- Management plans should be developed which ensure that men address issues such as alcoholism, drug misuse and anger management to a specified level before they are reconnected with their families.
- Social capital and safe home models should be developed within Aboriginal communities. Programs should be developed and continued to promote Strong Women networks. These models will promote a community approach to protecting women and children from all forms of violence, including sexual abuse.

General Recommendations.

- The NPoA should take a comprehensive approach to the reduction of gender inequality in Australia. Research shows that gender inequality is the foundation of violence against women and children. Projects and programmes

[40] Victorian Government Department of Human Services, op. cit. (2006), pp 22-24.
[41] Messimeri-Kiandis, Voula, "Policy differentiation in CALD women's health", presentation to Victorian Women's Health Forum, at http://www.health.gov.au/vwhp/well-being/policy.htm

to achieve a reduced incidence of violence will have limited success while levels of gender inequality remain high.

- An intersectoral approach, combining government and non-government agencies, shown to be necessary but rarely implemented, should be put in place, with plans for expansion as experience and resources allow. All Australian jurisdictions should be formally linked to the NPoA. Comprehensive, integrated and appropriately funded services for women and children experiencing or escaping violence should be developed as a matter of urgency. Agreed standards and benchmarks should be developed to be applied across the country.

- The NPoA should recognise that violence against women is commonly understood to be a manifestation of power, control and domination and its proposed policy responses should be fashioned accordingly.

- The NPoA should be embedded in a human rights framework, recognising that it is a fundamental right of all human beings, including women and children, to live safely and free from violence.

- The NPoA should be properly resourced.

- Utmost priority should be given to the development of programs, in close consultation with members, to meet the needs of the groups who are most at risk of experiencing violence, especially Aboriginal women and their children, women with disabilities and their children and young women and, where applicable, their children. Research projects should be put in place to find out more about the incidence and experience of violence for women with disabilities and women from CALD backgrounds.

- A much more comprehensive approach needs to be taken towards the prevention and treatment of sexual violence. Extensive programs need to be developed to address the reality that vast majority of sexual offences are not reported to police and that a great many "ordinary" men, as opposed to "deviant men", are perpetrators of sexual violence in its many forms.

- Primary prevention programs are necessary and should operate alongside comprehensive strategies to reduce gender inequality. Primary prevention must include programs to change social norms that foster hostility or violence towards women and to support men as involved co-parents, sons, partners and husbands. Programs can be put in place to make environments safer for women and children. Controlling behaviours and male roles that promote aggression and a culture of disrespect for women should be questioned publicly, in conjunction with mass media efforts to raise awareness of violence in all its manifestations.

- Secondary prevention programs are necessary to support women and children who have experienced violence in order to prevent further violent experiences and to treat and prevent present and future negative health outcomes. A major component of these programs is mandatory specialised training about violence

for all health professionals. Fee-for-service medicine, with typically short appointments, is not conducive to the disclosure or detection of the effects of violence. Specialist training should be also available for workers in education and those with caring responsibilities, such as child-care workers. Therapeutic intervention programs for perpetrators should form part of secondary prevention strategies.

- A national data collection system should be put in place as a matter of urgency. National data is necessary to provide a clearer picture of the incidence of violence, especially in relation to the experience of the most at risk groups. It is also necessary as a tool to evaluate and compare the efficacy of interventions conducted in different jurisdictions.

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