Violence against women in Australia

An overview of research and approaches to primary prevention

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About VicHealth

The Victorian Health Promotion Foundation (VicHealth) aims to promote good health and prevent chronic disease for all Victorians. As part of the vision to promote better mental health and wellbeing, over the last decade VicHealth has undertaken extensive research, programs and policy development to prevent violence against women.

VicHealth's Action Agenda for Health Promotion 2013–23 is a 10-year plan for health promotion in Victoria and includes a focus on five strategic imperatives:

- promoting healthy eating
- encouraging regular physical activity
- preventing tobacco use
- preventing harm from alcohol
- improving mental wellbeing (VicHealth 2013).

As part of our action to improve mental wellbeing, and in alignment with the prevention recommendations of the Royal Commission into Family Violence, VicHealth is integrating our work of preventing violence against women into the Victorian prevention system. That is, we are working closely with policymakers and agencies with specific mandates for delivery of prevention initiatives to embed the knowledge, tools and resources we have developed over the past decade.

This overview presents a synopsis of the latest published research examining violence against women in Australia and its prevention. It is an update of earlier editions of the Preventing violence against women in Australia research summary (VicHealth 2008, 2011a) and includes responses to violence against women and primary prevention actions.

ONLINE RESOURCES

More information about activity to prevent violence against women is available at:

VicHealth www.vichealth.vic.gov.au

Our Watch www.ourwatch.org.au

ANROWS www.anrows.org.au

SNAPSHOT: KEY FACTS AND FIGURES

- In Australia, two in every five women (41%) have experienced violence since the age of 15 years.
  - Around one in three (34%) has experienced physical violence.
  - Almost one in five (19%) has experienced sexual violence (ABS 2013).
- Women are most likely to be victimised by men who are known to them: their current or previous cohabiting intimate partners and/or boyfriends or dates (ABS 2013).
- Violence against women is estimated to cost Australia $21.7 billion a year (PwC et al. 2015).
- In Australia, male intimate partner violence contributes more to the disease burden for women aged 18 to 44 years than any other well-known risk factor like tobacco use, high cholesterol or use of illicit drugs (Webster 2016).
- The majority of Australians have good knowledge about violence against women and do not endorse attitudes that are supportive of violence. However, one in five Australians thinks men should take control in relationships and be the head of the household, and more than one in four Australians thinks women prefer a man to be in charge (VicHealth 2014).
- Factors associated with gender inequality are the most consistent predictors of violence against women, and result in gendered patterns of violence. These factors are known as the gendered 'drivers' of violence against women (Our Watch et al. 2015).
- The drivers of violence against women can be addressed through primary prevention strategies, utilising a range of techniques in everyday settings such as workplaces, schools and sports.

Introduction

Violence against women is widely recognised as a global problem of significant magnitude. It is an often invisible but common form of violence, and an insidious violation of human rights. It has serious impacts on the health and wellbeing of those affected, and exacts significant social and economic costs on communities and nations.

- At the international level, the United Nations has adopted specific targets to end all forms of discrimination and violence against all women and girls everywhere within the global Sustainable Development Goals (United Nations 2015).
- Also at the international level, the World Health Organization (WHO) has given significance to the epidemic rates and severe consequences of violence against women by naming male intimate partner violence a leading public health concern for countries around the world (WHO 2002).
- In Australia, two in every five women (41%) have experienced violence since the age of 15 years.
  - around one in three (34%) has experienced physical violence
  - almost one in five (19%) has experienced sexual violence (ABS 2013).
- Violence against women costs Australia $21.7 billion a year (PwC et al. 2015).
- In Australia, male intimate partner violence contributes more to the disease burden for women aged 18 to 44 years than any other well-known risk factor like tobacco use, high cholesterol or use of illicit drugs (Webster 2016).

Violence against women is prevalent and serious, but it is also preventable. While many factors are said to contribute to violence against women, research in the last decade has found that at the population level the two most significant determinants are:

- the unequal distribution of power and resources between men and women
- an adherence to rigidly defined gender roles, or what it means to be (and live as) masculine or feminine (VicHealth 2007).

More recently, research conducted for Our Watch shows that at the population level, gender inequality in public and private life is the necessary underlying condition for violence against women to occur (Webster & Flood 2015). Based on this research, a shared framework for prevention action in Australia articulates four distinct yet interconnected expressions of gender inequality as the drivers of violence against women:

- the condoning of violence against women
- men's control of decision-making and limits to women's independence in public life and relationships
- rigid gender roles and stereotyped constructions of masculinity and femininity
- male peer relations that emphasise aggression and disrespect towards women (Our Watch et al. 2015).

These gendered drivers arise from discriminatory historical, economic and social structures, norms and practices. This means that they are deeply entrenched, but also that they are modifiable and not inevitable. In other words, violence against women can be prevented from happening in the first place, that is, before it occurs to anyone, through action to address these drivers.

This is known as 'primary prevention', which is the key focus of this overview. For more information about primary prevention see *key concepts and definitions* (page 4) and *spotlight on primary prevention* (page 16).

Key concepts and definitions

Violence is defined in the WHO's *World Report on Violence and Health* as:

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 (WHO 2002).

Violence against women is defined by the United Nations (UN) in the *Declaration on the Elimination of Violence against Women* as:

any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (UN 1993).

The definition of violence against women encompasses all forms of violence experienced by women because of their gender, or that disproportionately affect women. This includes physical, sexual, emotional, cultural/spiritual and financial violence, and a wide range of controlling, coercive and intimidating behaviour.

Specific types of violence against women may be categorised as:

- physical violence: physical abuse and aggression such as slapping, hitting, kicking and beating
- sexual violence: rape, sexual coercion, unwanted sexual advances or harassment, forced prostitution and trafficking for the purposes of sexual exploitation
- psychological abuse: for example, intimidation, belittling, humiliation, and the effects of financial, social and other non-physical forms of abuse
- coercive control: a range of controlling behaviour such as isolating women from their family and friends, monitoring their movements, or restricting their access to information, assistance and other resources
- stalking: repeated following, watching or harassing
- harmful cultural practices: dowry-related violence, female genital mutilation, and other practices harmful to women (WHO 2002; Our Watch 2014a).

Violence against women can take forms that are both criminal and non-criminal in nature. Regardless of the form it takes, violence is most often used by perpetrators as a means to exercise some form of power or control over women (Our Watch 2014a).

Violence against women is a violation of women's rights and freedoms as human beings, especially their entitlements to equality, security, liberty, integrity and dignity in political, economic, social, cultural and civil life. Violence against women is discriminatory towards women. Australia has obligations to eliminate such discrimination as we are party to international human rights treaties, most significantly the UN's Convention on the Elimination of All Forms of Discrimination against Women or CEDAW (United Nations 1979).

Male intimate partner violence is a broad term used to describe violence against women perpetrated by current or previous male partners. The term includes men who are cohabiting or have cohabited with the women concerned, and where violence occurred during and/or after their cohabitation, as well as partners who do not / have not lived with these women (such as boyfriends or dates).

Domestic violence and family violence refers to violence perpetrated within the family or household context. They are most often perpetrated by men against their women partners or ex-partners, however these terms can also refer to elder abuse, some forms of child abuse and adolescent violence against parents (State of Victoria 2016).

For **Victorian Aboriginal communities**, family violence has a broader and more encompassing definition than that used in non-Aboriginal communities. It communicates a wide range of physical, emotional, sexual, social, spiritual, cultural and economic abuses that can occur within intimate relationships, families, extended families, kinship networks and communities (Aboriginal Affairs Victoria 2008; State of Victoria 2016). While this model stresses the dynamics and effects of violence on family, kinship and community as a whole, it is women and children who are the primary victims of family violence in Victorian Aboriginal communities. Victorian Aboriginal women and children experience a disproportionate level of family violence at the hands of men, both Aboriginal and non-Aboriginal, compared to the general population (State of Victoria 2016).

There are three ways in which violence against women can be prevented, and each intervention type has distinct aims and targets. **Primary prevention** refers to whole-of-population initiatives that target the primary (first or underlying) gendered drivers of violence against women with the aim that violence does not happen at all. This can be achieved through a combination of universal strategies as well as tailored actions or strategies for different settings, groups and contexts. Primary prevention is distinguished from **secondary prevention (also called 'early intervention')**, which works in more targeted ways to stop early signs of violence in specific individuals, communities or contexts from escalating, and **tertiary prevention (also called 'response')**, which seeks to stop the recurrence of existing violence and/or minimise its impacts (Our Watch et al. 2015).

The focus of this overview is on the prevalence, impact and preventable nature of male intimate partner violence, and male sexual assault against women, both partner and non-partner. These are the two most common expressions of violence against women in Australia. They are also the forms of violence of most interest to the violence against women and prevention sectors, and for which reliable population prevalence estimates are calculated by the Australian Bureau of Statistics (ABS) (Cox 2015).[1]

In Australia, male intimate partner violence contributes more to the disease burden for women aged 18 to 44 years than any other well-known risk factor like tobacco use, high cholesterol or use of illicit drugs.

[1] The ABS measures the prevalence of interpersonal violence in Australia through the Personal Safety Survey (PSS). The survey focuses on the experiences of physical and sexual violence of women and men aged 18 years and over, since the age of 15 years. Physical violence involves any incidents of physical assault and/or physical threat. Sexual violence involves any incidents of sexual assault and/or sexual threat (ABS 2013).

The gender-specific dynamics of violence against women

There are several characteristics of women's experiences of violence that make it a distinctly gendered problem and different to violence against men.

Women are most likely to be victimised by men who are known to them: their current or previous cohabiting intimate partners and/or boyfriends or dates. Men are most likely to be subjected to violence by other men who are unknown to them. This difference is clearly seen in lifetime prevalence estimates prepared by the ABS, and based on their latest Personal Safety Survey (PSS). Estimates show that since the age of 15 years, and at least at one time in their lives:

- 1.5 million women have experienced violence by male cohabiting partners and almost a million (981,300) women have experienced violence by boyfriends or dates
- 0.9 million women have experienced violence by male perpetrators unknown to them
- 0.4 million men have experienced violence by female cohabiting partners and 0.3 million men have experienced violence by girlfriends or dates
- 3.0 million men have experienced violence by male perpetrators unknown to them (ABS 2013).

Women are also most likely to be physically assaulted in their own homes or other private domains; men are most likely to be physically assaulted in public places such as places of entertainment (ABS 2013).

The PSS is designed to capture Australians' experiences of violence as individual incidents, but not the contextual complexities of victimisation and perpetration. Other studies are needed to nuance the data.

In addition to the asymmetrical prevalence rates, research shows that the impacts and consequences of intimate partner violence are also not symmetrical for women and men. For example, women are more likely than men to be afraid of, hospitalised by, or killed by their intimate partners (Our Watch et al. 2015). There are some very limited indications that women subject their male partners to the same level of severe, terrorising and escalating violence as that which men perpetrate against their female partners; in other words, the patterns are not similar (WHO 2002).

When men use violence against their female partners:

- it is often not a one-off incident but rather the result of ongoing patterns of behaviour involving continuing patterns of coercion and perpetration designed to intimidate, undermine, isolate and create fear and control (State of Victoria 2016)
- it is often severe with multiple and concurrent forms of victimisation used – physical, sexual, psychological, emotional, financial and technology-facilitated violence (State of Victoria 2016)
- it is more likely to have serious and lasting impacts, including hospitalisation, and is more likely lead to death/murder (Our Watch et al. 2015).

Research has established that men can also be victims of intimate partner violence, from female and also same-sex male partners (State of Victoria 2016). Research into women's use of coercive control suggests that it is usually motivated by fear and self-defence in the context of violence that is already being perpetrated against them by their male partners (WHO 2002; Swan et al. 2008).

In Australia, almost one in five women has experienced sexual violence since the age of 15 years.

Violence against women: prevalent and serious

Lifetime prevalence estimates

The WHO estimates that, at least once in their life, over one in three women worldwide (35%) has experienced either intimate physical and/or sexual partner violence or non-partner sexual violence (WHO 2013). UN Women states that these figures make violence against women 'one of the most significant issues to be addressed in our time' (UN Women 2015).

How do the lifetime prevalence estimates for women in Australia compare? Figures based on the latest PSS reveal that for women from the age of 15 years, Australia is no different to the global picture.

- Two in every five women (41%) have experienced violence at least once in their lives:
  - around one in three (34%) has experienced physical violence
  - almost one in five (19%) has experienced sexual violence (ABS 2013).
- 39 per cent of women have experienced physical and/or sexual violence from male perpetrators (ABS 2013).
- One in every three women (34%) has experienced physical and/or sexual violence from a man known to them:
  - almost one in six (17%) by a current or previous cohabiting partner
  - one in nine (11%) by a boyfriend or male date (ABS 2013).
- One in every four women (25%) has experienced violence from male intimate partners, including physical and sexual threats. In addition:
  - one in five women (20%) has experienced physical assault
  - one in eleven women (9%) has experienced sexual assault (Cox 2015).
- One in ten women (10%) has experienced violence from male strangers (ABS 2013).
- Almost one in six women (17%) has been stalked by a man (ABS 2013).

Multiple victimisation, whether in the different forms of violence experienced or the number of violent incidents, is also common for women in Australia:

- almost one in eight (13%) has experienced both physical and sexual violence since the age of 15 years
- in the 12 months leading up to the PSS, 81 per cent of women who experienced violence by a male perpetrator were subjected to more than one incident of the violence (Cox 2015).

When women experience repeated incidents of physical violence, the perpetration is most often by the same man; when women experience repeated incidents of sexual violence, the perpetration can be from different men:

- one in nine women has experienced multiple incidents of physical assault by the same male perpetrator
- one in 17 women has experienced multiple incidents of sexual assault by different male perpetrators (Cox 2015).

Heightened risks and distinct circumstances of violence

Violence can intensify during different life stages or events in women's lives, and different groups of women can also experience violence in ways that are distinct to their circumstances.

Young women are especially vulnerable to sexual assault. The ABS has found that in the 12 months leading up to the PSS, the rate of sexual assault among young women (aged 18–24 years) was higher than the national average (Cox 2015).

Pregnant women may be at increased risk of male intimate partner violence. For some women, the violence can occur for the first time when pregnant, while for women living with violent partners, the violence can be exacerbated during this time. Some experts argue that family violence is linked to the perpetrator feeling that his primacy in the relationship is being undermined (State of Victoria 2016).

According to current population estimates:

- there are 39,100 women in Australia who have experienced violence by a current cohabiting partner while pregnant; of these, 24,000 (61%) were victimised for the first time during their pregnancy
- there are 414,600 women who have experienced violence by a previous cohabiting partner while pregnant; of these, 195,500 (47%) were victimised for the first time during their pregnancy (Cox 2015).

Some studies show that the frequency and severity of male intimate partner violence are higher during pregnancy (Burch & Gallup Jr 2004; Martin et al. 2004). Researchers who recently analysed Victorian hospital data during the period 2009–10 to 2013–14 found that:

- at least 11 per cent of Victorian women who were admitted to hospital for intimate partner violence-related assaults were pregnant at the time
- half of these pregnant women had injuries to the abdomen, lower back and pelvis compared with 15 per cent of non-pregnant women, suggesting that the abdomen-pelvic area was over-involved in assaults by male intimate partners of pregnant women (Cassell & Clapperton 2015).[2]

Women leaving (or attempting to leave) violent relationships are vulnerable to increased violence. Some researchers argue that violent male intimate partners can perceive separation as loss of control and become more aggressive as a result (State of Victoria 2016). For women who have lived with male intimate partner violence, that violence can persist – and even escalate – beyond the final separation. For some women, the violence can end in murder (State of Victoria 2016).

According to current population estimates:

- 731,900 women in Australia have experienced violence by a male previous cohabiting partner
- for almost one-quarter (24%) of the women who experienced violence by a male cohabiting partner they are no longer in a relationship with, the violence increased after their final separation (Cox 2015).

Women with disabilities experience violence at rates that are higher than those of other women, and are particularly vulnerable to sexual assault and/or multiple victimisation. Women with disabilities are at risk of violence from their intimate partners, from those who are their carers and in a position to exert control and power, and also those with whom they share a house or residence. It is common for women with disabilities to experience violence by more than one person in their lifetimes – intimate male partners, personal carers, support staff, service providers, medial and transport staff, and male co-residents – and for their experiences of violence to be both severe and protracted (Salthouse & Frohmader 2004; WWDA 2008; Woodlock et al. 2014; State of Victoria 2016).

Violence experienced by women with disabilities is often specific to the nature of their disability. It may include the denial of mobility and communication devices, the withholding of food or medication, and threats of institutionalisation (Curry et al. 2001). Humiliation, harassment, forced sterilisation, denial of reproductive rights, neglect and restrictions to social networks are other documented forms of abuse directed at women with disabilities (Salthouse & Frohmader 2004; WWDA 2008; State of Victoria 2016).

The enactment and experience of violence against women with disabilities is tied to the intersections of gender-based and disability-based discrimination, and their compounding impacts of structural disadvantage and marginalisation (Healey 2013; State of Victoria 2016).

The ABS estimates that in the 12-month period leading up to the last PSS:

- 92 per cent of women with a disability who had experienced violence by a male perpetrator were subjected to more than one incident of the violence, compared to 74 per cent for women without a disability (Cox 2015).

Women with cognitive disabilities are very vulnerable, experiencing extremely high rates of sexual assault (Victorian Women with Disabilities Network Advocacy Information Service 2007). Women with intellectual disabilities are at considerably heightened risk of sexual assault (Healey 2013). Some studies suggest that up to 90 per cent of women in Australia living with an intellectual disability have been subjected to sexual abuse, while more than two-thirds (68%) are sexually abused before they turn 18 years of age; these rates are consistent with overseas studies (Salthouse & Frohmader 2004; Australian Law Reform Commission 2010).

Indigenous women experience family violence and non-partner sexual assault at rates that are higher than non-Indigenous women and with more serious consequences, including hospitalisation and lethality (Webster & Flood 2015). Intimate partner violence is estimated to make a larger contribution that any other risk factor to the gap in the disease burden between Indigenous and non-Indigenous woman aged 18–44 years (Webster 2016).

The over-representation of Aboriginal and Torres Strait Islander peoples in statistics on interpersonal violence, including family violence, is linked to the impacts of colonisation, including inter-generational trauma, dispossession of land, forced removal of children, interrupted cultural practices that mitigate against interpersonal violence, and economic exclusion (ANROWS 2014).

From a Victorian Aboriginal community perspective, the experience of family violence is understood in the historical context of white settlement and colonisation and their resulting and continuing impacts: cultural dispossession, breakdown of community kinship systems and Aboriginal law, systemic racism and vilification, social and economic exclusion, entrenched poverty, problematic substance use, inherited grief and trauma, and loss of traditional roles and status (Aboriginal Affairs Victoria 2008).

Quantifying the extent of family violence experienced by Indigenous women can be difficult because Indigenous status is not always adequately captured through research, nor do the women concerned always wish to disclose their Indigenous status.

[2] The research found a lack of systematic data collection of the pregnancy status of women presenting to hospital emergency departments, making it difficult to estimate the proportion of pregnant women of intimate partner violence-related assaults in non-hospital admitted cases.

The Australian component of the 2002 International Violence against Women Survey found that in the previous 12 months:

- 20 per cent of Indigenous women experienced physical violence, compared to 7 per cent of non-Indigenous women
- 12 per cent of Indigenous women experienced sexual violence, compared to 4 per cent of non-Indigenous women (Mouzos & Makkai 2004).

State-based studies have found that Indigenous women in remote and regional areas experience rates of family violence up to 45 times higher than other women do. They also experience rates of family violence 1.5 times higher than Indigenous women in metropolitan areas. The rates of sexual assault among Indigenous women are 16 to 25 times higher than other women (Lievore 2003).

It must be noted that when Aboriginal women experience violence at the hands of men, perpetrators can be Aboriginal or non-Aboriginal (Webster & Flood 2015; State of Victoria 2016).

Analysis of national databases reveal that Indigenous women are 35 times more likely to be hospitalised for injuries related to family violence assaults than other women (Al-Yaman et al. 2006; Steering Committee for the Review of Government Services 2009).

Regular studies by the Australian Institute of Criminology (AIC) of its National Homicide Monitoring Program show that from 2010–2011 to 2011–2012, Indigenous females were almost five times more likely to be victims of homicide than non-Indigenous females, at rates of 3.2 per 100,000 compared with 0.7 per 100,000 for their respective populations (Bryant & Cussen 2015).

Meanwhile, data from the National Homicide Monitoring Program dating back to 1989 and extending to 2012 show that:

- 41 per cent of all Indigenous victims of homicide were female, compared to 35 per cent among non-Indigenous victims
- over three-quarters (78%) of all Indigenous female victims of homicide were victims of intimate partner homicide, compared to 64 per cent among non-Indigenous female victims (Cussen & Bryant 2015).

Immigrant and refugee women[3] experience violence in ways that are unique to the socioeconomic consequences of migration to, and settlement in, Australia. Structural factors that contribute to immigrant and refugee women's exposure to violence include the intersecting dynamic of racism and sexism in workplace, education or public settings, and racial and gendered stereotypes perpetuated by the general community (Multicultural Centre for Women's Health 2015; Murdolo & Quiazon 2015). Current migration policy is another critical factor:

- Women on temporary visas, such as international students, can be exposed to physical abuse and sexual harassment during their stay. Research has found that some female international students are offered cheaper rent, higher grades and employment in return for sexual favours, although their experiences remain largely invisible to the mainstream (Polsjki 2011).
- Women who have secondary visas – that is, whose visas are tied to those of their partners – are also vulnerable. Their stay in Australia depends on their relationships with primary visa holders remaining intact. Research shows that male spouses can use their visas as a tool for power and control, in addition to other forms of violence. For many women who have experienced domestic violence, deportation threats keep them in a state of fear and reluctant to leave violent situations (Multicultural Centre for Women's Health 2015; State of Victoria 2016).

Further ways that immigrant and refugee women are victimised include when perpetrators restrict their mobility, take their money, force them to work, or prevent them from working or learning English and other skills. These forms of violence can be used by a single perpetrator or by more than one family member, and they can be long term. Victimised women can also face language or cultural barriers presented by mainstream service provision, resulting in them not accessing support when needed as well as the continuation or escalation of violence in their lives (Multicultural Centre for Women's Health 2015; State of Victoria 2016).

Women are most likely to be victimised by men who are known to them.

[3] This overview uses the term 'immigrant and refugee women' to refer to women who have migrated from overseas. It includes those who are a part of newly emerging and longer established communities, and who have arrived in Australia on either temporary or permanent visas (Multicultural Centre for Women's Health 2015).

Violence against women occurs in all communities and across all cultures. While violence against immigrant and refugee women is enacted and experienced in ways that are distinct, as shown above, and while there might be popularised concerns regarding certain communities or cultures, there is currently no Australian evidence to show that any one immigrant or refugee community or culture is any more violent than any another community, including the general community (Multicultural Centre for Women's Health 2015).

Population-based surveys are not always designed to capture the experiences or rates of victimisation of immigrant and refugee women, and when they do there might be limitations to the data collected.[4] The ABS has, however, offered the following estimates for sexual assault and male intimate partner violence, based on the most recent PSS:

- Since the age of 15 years, 9 per cent of women who were born in countries where English is not the main spoken language have experienced sexual assault, compared to 19 per cent of women born in Australia (ABS 2013).
- In the 12 months prior to the PSS, just under 2 per cent of women who were born in countries where English is not the main spoken language had experienced male intimate partner violence, compared to just over 2 per cent of women born in Australia – however these figures are not statistically significant (ABS 2013).

These figures suggest that women from countries where English is not the main spoken language are less exposed to sexual violence and equally exposed to male intimate partner violence compared to Australian-born women. But important influences are at play to caution against such interpretations, including immigrant and refugee women's perceptions and understandings of violence and/or their unwillingness to have experiences recorded in population-based surveys like the PSS (Mouzos & Makkai 2004; Webster & Flood 2015).

Women living in regional and remote areas are more likely to have experienced violence since the age of 15 years than those living in major cities, according to the latest PSS (Webster & Flood 2015). Other than these figures, which must be interpreted with caution, data on the experiences of women in regional and remote areas remain patchy.[5]

Geographic and/or social isolation, and economic vulnerabilities or dependence, are factors that can add to women's vulnerabilities to violence in regional and remote areas (State of Victoria 2016).

The higher rate of violence experienced by Indigenous women living in regional and remote areas, compared to all other women irrespective of where they live and Indigenous women in metropolitan areas, was noted previously.

Violence against women is estimated to cost Australia $21.7 billion a year.

[4] Responses to the PSS are weighted to reflect the demographic characteristics of the Australian population. While this makes the survey representative, it also means estimates for subgroups in the population can be unreliable. For example, sexual assault estimates for women born in countries where English is not the main spoken language will be less reliable than sexual assault estimates for all women, because individual responses to the PSS will have greater impact on the weighted estimates for smaller subgroups. See Cox 2015 for an explanation of the limitations and strengths of the PSS.

[5] The PSS did not ask respondents where they were living at the time of violence. The survey captured the experiences of those living in regional and remote areas at the time of the survey and who reported having been victimised at least once since the age of 15 years.

The health consequences of violence

Violence against women has health consequences that can be immediate and acute, long-lasting and chronic, and/or fatal (whether from prolonged illness and disability or homicide). The more severe the violence, the greater its impacts on women's health, both physical and mental. Moreover, the non-fatal consequences of violence can be far-reaching due to the length of time that women endure violence before they seek help (if ever). These consequences can also persist long after violent episodes have occurred or ended. Non-fatal consequences of violence include:

- acute or immediate physical consequences include injuries such as bruises, abrasions, lacerations, punctures, burns and bites, as well as fractures and broken bones or teeth
- sexually transmitted infections including HIV, and unintended/unwanted pregnancies
- serious physical injuries can lead to longer-term disabilities, gastrointestinal conditions, gynaecological disorders and other health problems / poor health status, including chronic pain syndromes and premature death
- chronic mental health consequences including depression, sleeping and eating disorders, stress and anxiety disorders (such as post-traumatic stress disorder), poor self-esteem, self-harm and suicide attempts
- behavioural consequences include harmful alcohol and substance use (WHO 2012).

In a recently completed investigation of 43 studies on the links between intimate partner violence and various health consequences, Australia's National Organisation for Women's Safety (ANROWS) found strong evidence of victimised women having an increased risk of depression, pregnancy termination and homicide (Lum On et al. 2016). These findings are consistent with global findings (WHO 2013). ANROWS also found evidence – albeit less strong – of a relationship between intimate partner violence and a number of other conditions, including alcohol and drug use disorders, and pre-term and low birth weight outcomes (Lum On et al. 2016).

On the fatal consequences of violence, the National Homicide Monitoring Program recorded 83 female victims of intimate partner homicide for 2010–2011 to 2011–2012 (Bryant & Cussen 2015). This number reflects 76 per cent of all intimate partner homicide victims in Australia over this time.

Given the gender-specific dynamics of perpetration and victimisation, it must be stressed that for the far smaller number of women in Australia who kill their male intimate partners, their actions are more likely to have occurred in response to existing serious and sustained violence being directed at them by their partners (Victorian Law Reform Commission 2004).

The combined toll of illness, disability and premature death on women due to intimate partner violence is estimated through a rigorous research technique known as a burden of disease methodology. In Australia, intimate partner violence is estimated to contribute 5.1 per cent to the disease burden in women aged 18–44 and 2.2 per cent of the burden in women of all ages (Webster 2016). Intimate partner violence contributes more to the burden of disease for women than any other risk factor in women aged 18–44 years, including well-known risk factors like tobacco use, high cholesterol and use of illicit drugs. Violence is estimated to contribute five times more to the burden of disease among Indigenous than non-Indigenous women in Australia and is also estimated to make a larger contribution than any other risk factor to the gap in the disease burden between Indigenous and non-Indigenous women aged 18–44 years (Webster 2016).

The negative impacts of violence on women's health include poor mental health, in particular anxiety and depression, problems during pregnancy and birth, alcohol and illicit drug use, suicide, injuries and homicide (Ayre et al. 2016; Webster 2016).

Social and economic costs of violence

One of the biggest social costs of violence against women is homelessness, as women and their children flee from the places where most intimate partner violence happens (i.e. their homes). Women who leave situations of family violence can be caught in a cycle of homelessness and violence, returning to their homes – and to perpetrators – because of financial insecurity or limited access to crisis services, before leaving again (National Council 2009b).

- Data collected for 2014–2015 shows that of all clients requesting assistance from government-funded specialist homelessness agencies, 92,000 (36%) were escaping domestic or family violence, including 56,000 women and 31,000 children (people of any gender aged under 18 years).
- Since 2011–12, the total number of clients escaping domestic or family violence has increased by 16 per cent, due predominantly to increases in client numbers in Victoria. That is, services have experienced an average 15 per cent increase in client numbers each year over the last four years (AIHW 2016).

Social isolation, poverty and education and employment-related difficulties are identified as other social costs of violence against women (Ayre et al. 2016).

As for the economic toll, violence against women is currently estimated to cost Australia $21.7 billion each year. The cost of pain, suffering and premature mortality constitutes the largest proportion of the total cost, at 48 per cent or $10.4 billion. Governments bear 36 per cent of the total cost, or $7.8 billion, due to health, justice and service costs and also lost productivity. $3.4 billion is borne by victims or other members of society funding their own services or is due to lost opportunity costs (e.g. lost income from being unable to work) (PwC et al. 2015).

Children exposed to violence against women

Women in violent relationships can have children in their care, and a significant proportion report their children having witnessed the acts of violence being perpetrated against them. According to current population estimates:

- there are 128,500 women in Australia who have experienced violence by a current cohabiting partner and had children in their care during the violence; for 74,300 (58%) of these women, the children in their care witnessed (heard or saw) the violence
- there are 733,900 women in Australia who have experienced violence by a previous cohabiting partner and had children in their care during the violence; for 568,700 (77%) of these women, the children in their care witnessed (heard or saw) the violence (Cox 2015).

As well as witnessing violence, children can also be the direct target of it; for instance, if they intervene in the violence that is occurring or attempt to protect their mothers or female caregivers from it, or are specifically targeted by the perpetrator (Flood & Fergus 2008).

The impacts of violence against women on their children – whether the violence is witnessed or direct – can be profound and lasting. Children exposed to such violence are more likely to have a range of health, developmental and social problems, both during childhood and later in life (Ayre et al. 2016).

Victoria's *Family Violence Protection Act 2008* recognises that children's exposure to family violence is of itself a form of family violence (State of Victoria 2016).

Studies also show an association between exposure to domestic violence as a boy and the risk of perpetrating partner aggression later in life. However:

- not all boys who witness violence in the home become abusive in adult relationships
- a significant proportion of men who are violent towards women have not experienced or witnessed such violence as children (WHO 2002; Flood & Fergus 2008).

A boy's exposure to domestic violence therefore cannot be understood as the sole contributor to perpetration in adulthood. The reasons why men use violence towards women are complex and cannot be attributed to single-factor explanations of personal history. Rather, their risk of perpetrating violence is mediated by a range of social and structural factors (WHO 2002; Flood & Fergus 2008).

Community attitudes towards violence against women

In recent years there has been increasing attention in research and policy on the community attitudes and beliefs relating to violence against women. This follows growing recognition that the community as a whole plays a role in perpetuating violence against women, through its beliefs and responses to violence, and also has a positive role to play in preventing violence (VicHealth 2014). For example, community beliefs can provide a culture of support for violence by justifying or excusing it, trivialising or minimising the problem, or shifting the responsibility for violent behaviour from perpetrators to victims. Attitudes can also reflect broader social norms and cultures, and therefore shifts in attitudes are indicators of progress in addressing violence against women (VicHealth 2014).

In Australia there have been successive waves of community attitudes research. The first national survey of community attitudes to violence against women was conducted in 1995 and led by the Office for the Status of Women (ANOP Research Services 1995); more recently VicHealth has led the conduct of the national survey in 2009 and 2013 (VicHealth 2010, 2014).

Findings from the 2013 National Community Attitudes towards Violence against Women Survey show that the majority of Australians have a good knowledge of violence against women and do not endorse most attitudes supportive of this violence. However, the survey also found that there are significant gaps in community knowledge about violence and concerning trends in community attitudes. For example:

- On the whole, Australians' understanding and attitudes remained stable between 2009 and 2013. However, in relation to particular questions, some areas improved whereas others became worse.
- 51 per cent of Australians think most women would leave a violent relationship if they really wanted to.
- 22 per cent think that domestic violence can be excused if people get so angry they lose control.
- Compared with physical violence and forced sex, Australians are inclined to see non-physical forms of control, intimidation and harassment as less 'serious'.
- Since 1995 there has been a decrease in people who agree that violence is perpetrated mainly by men.
- Between 2009 and 2013 there was a decrease in those who recognise that women are more likely than men to suffer physical harm and fear as a result of this violence (VicHealth 2014).

In addition the survey assessed community attitudes towards gender equality, that is, the extent to which the community supports equality between women and men in the public and private spheres. Most Australians support gender equality in the public arena, such as workplaces, and most acknowledge that women still experience inequality in the workplace.

However, the results are more concerning in relation to equality in the private sphere. One in five Australians thinks men should take control in relationships and be the head of the household, and over one in four Australians thinks women prefer a man to be in charge. However, research shows that inequality in relationships is a key risk factor for violence (Our Watch et al. 2015). This suggests strong potential for initiatives focused on building and promoting equality and respect in relationships to have a positive impact on attitudes towards violence against women, and ultimately impact on the prevalence of violence in relationships (VicHealth 2014).

There were some distinct patterns in attitudes among Aboriginal and Torres Strait Islander respondents and also respondents born in mainly non-English speaking countries, however the differences were small in most areas and most patterns in attitudes among these groups followed similar patterns to that in the general community (Cripps & Webster 2015; Webster & Flood 2015).

The survey also found that strongest predictor of a person's attitude to violence is their knowledge about violence and their attitude toward gender equality. These were stronger predictors than demographic factors such as country of birth, socioeconomic status and language spoken at home. The research suggests that universal initiatives to increase knowledge about violence and to increase community support for gender equality will be more effective in changing attitudes to violence than specific interventions targeted towards particular groups (VicHealth 2014).

Young people's attitudes were identified as an area of concern in the national survey findings. Young people aged 16–24 had somewhat more violence-supportive attitudes than others, especially compared with their parents' generation, and young men in particular were more likely to have a poor knowledge about violence and were less likely to support gender equality (Harris et al. 2015).

Other attitudes research in Australia has been focused on young people and young adults. For example, Cale and Breckenbridge (2015) conducted an online survey to investigate attitudes to domestic violence and dating violence among young Australians aged 16–25. They found that while the majority of respondents disagreed with gender stereotypes and attitudes supportive of violence, males were more likely to agree with gender stereotypes than females, and younger respondents were more likely to agree with attitudes supportive of violence than older respondents. Similarly, survey research commissioned by Our Watch with young people aged 12–24 found that:

- one in three young people don't think that exerting control over someone else is a form of violence
- one in four young people don't think it's serious when guys insult or verbally harass girls in the street
- one in four young people thinks it's pretty normal for guys to pressure girls into sex
- 15 per cent of young people think it's ok for a guy to pressure a girl for sex if they're both drunk (Hall & Partners 2015).

It is worth noting that the research was based on convenience rather than population sampling and was designed to inform campaign development. Similarly, in research to inform the development of a national campaign, the Australian Government found attitudes that blame the victim of violence, minimise violence and value empathy with the male/perpetrator were common among the small sample of 10–17 year olds (Department of Social Services 2015). The research concluded that future campaign activity should focus on primary prevention and on the 'influencers' of children and young people – that is, the adults and authority figures in young people's lives who can intervene early on attitudes and provide role modelling towards more respectful attitudes in the future.

One in five Australians thinks men should take control in relationships and be the head of the household.

Responses to violence against women: policy, community and media

Over the past several decades there has been increasing attention on violence against women as a human rights, health, social policy and justice issue. In Australia there has been significant action at the community and non-government level for several years to increase awareness of violence against women and to improve the service and justice responses to violence, in order to protect the safety of women and their children. More recently this action has aimed to address the drivers of violence and to mobilise the community to act on these drivers. Over the last 10 years there has also been increasing activity in government and academic sectors across Australia to respond to violence against women and to link this to safety and equality for women in all spheres of life (VicHealth 2015a).

In this section some of the key achievements of this response are highlighted as well as the key resources that have been developed to guide responses and prevention activities in the future.

Policy

Over the last several years there has been a significant increase in policy activity at the level of state/territory and federal jurisdictions to respond to and prevent violence against women. At the national level, in 2010 the Council of Australian Governments released the *National Plan to Reduce Violence Against Women and Their Children 2010–2022* (the *National Plan*), which included six action areas and would comprise a series of three-year Action Plans (COAG 2010). The *National Plan* draws on the research and recommendations presented by the National Council to Reduce Violence Against Women and Their Children in *Time for Action: The National Council's Plan for Australia to Reduce Violence Against Women and Their Children, 2009–2021* and companion documents (National Council 2009a) and the Federal Government's immediate response, which supported the direction and focus of *Time for Action* (Commonwealth of Australia 2009).

The *National Plan* outcomes are monitored at a population level through two key mechanisms: (1) the Australian Bureau of Statistics Personal Safety Survey, which measures the prevalence of violence against women (ABS 2013), and (2) the National Survey of Community Attitudes to Violence against Women (VicHealth 2010, 2014), which measures the social climate surrounding violence by gauging community attitudes and responses to violence and to gender equality.

The *National Plan* has led to the establishment of two national leadership organisations with a dedicated focus on violence against women that have varying but complementary roles. ANROWS, or Australia's National Organisation for Women's Safety, was established in 2013 to lead and coordinate national research activity to address violence against women. Our Watch, formerly the National Foundation to Prevent Violence against Women and their Children, was also established in 2013 to lead national efforts to drive change in the culture, behaviour and power imbalances that lead to violence against women and their children (VicHealth 2015a). The *National Plan* also supports the development of other relevant national strategies, including the *Change the Story* national framework for the primary prevention of violence against women and their children (Our Watch et al. 2015) and *National Outcome Standards for Perpetrator Interventions* (COAG 2015).

Following their obligations within the *National Plan,* state and territory governments across Australia have developed strategic plans to respond to and prevent violence against women. For example, the Department of Premier and Cabinet Tasmania has developed a series of Action Plans and Primary Prevention Strategies including *Safe Homes, Safe Families: Tasmania's Family Violence Action Plan 2015–2020* (DPC 2015), and the Western Australia Government has developed *Western Australia's Family and Domestic Violence Prevention Strategy to 2022* (Department for Child Protection and Family Support 2012). In Victoria the Royal Commission into Family Violence was established in 2015 and the Victorian Government is committed to implementing all recommendations in the Royal Commission report (State of Victoria 2016).

At the state and territory level there are also a range of related strategies focused on the promotion of gender equality and women's safety, for example, in 2015 the South Australian Government released *Achieving Women's Equality* (Office for Women 2015) and the Queensland Government has released the Queensland Women's Strategy 2016–2021 (Department of Communities, Child Safety and Disability Services 2016).

Community and bystander action

There is evidence of growing community awareness and concern about violence against women and increasing efforts to mobilise people into action to reduce violence in everyday settings. There are several event-focused initiatives that have been developed and maintained over many years, some of which are community-based, such as Reclaim the Night (RTN Australia 2016), and others that are now auspiced by national organisations such as White Ribbon Australia (White Ribbon Australia 2016).

There have also been spontaneous and new mass participation events held in response to high-profile incidents of violence against women, for example the Safe Steps Family Violence Response Centre's annual candlelight vigil (Safe Steps 2016a) and the community marches held to protest against violence after the rape and murder of Melbourne woman Jill Meagher in 2012 (Zielinski 2013). In addition there are community-based initiatives using social media to highlight the prevalence and impact of violence against women, such as Destroy the Joint's 'Counting dead women' project, which reports on the toll of women's violent deaths across Australia (Destroy the Joint 2016).

Some limited research has been undertaken to identify the links between increased community mobilisation and increased policy-level activity to address violence against women. For example Dyson (2012) highlighted the stages of policy development in relation to primary prevention as influenced by community readiness and mobilisation, and described the strategies required to implement and sustain prevention policies in the future. Other multi-country studies have identified the critical role of feminist mobilisation in driving policy change in relation to violence against women (Weldon & Htun 2013).

Some recent large-scale campaigns have sought to further mobilise the community in response to violence against women. Increasingly these campaigns are moving beyond promoting an awareness of violence in the community and towards building awareness of the drivers of violence, and also increasing community action to address those drivers. At the national level, for example, the Australian Government has led the Stop it at the Start campaign (Commonwealth of Australia 2016) and in partnership with Our Watch has delivered the long-term The Line / Can't Undo Violence campaigns and social marketing strategies with a focus on young people (Our Watch 2016d). There are also many communities and regional authorities leading locally based community campaigns to address violence (State of Victoria 2016). Research shows that campaigns and social marketing initiatives are most effective in driving community action and change when they are delivered alongside other prevention strategies, such as organisational development and direct participation programs (Webster & Flood 2015).

There is increasing interest in the potential of 'bystanders' to play a proactive role in responding to violence against women and its drivers – that is, individuals who are not directly involved in violence or its drivers (such as sexism) but can play an active role in speaking up or acting to prevent or intervene in it.

The *More than Ready* survey in Victoria sought to assess the readiness of individuals to respond to behaviour and attitudes that underpin violence against women (such as sexism and discrimination) and the barriers and enablers to responding. The survey found that:

- one in three respondents had witnessed sexism or discrimination against women in the last 12 months in their workplace, sports club or among friends and family
- of those who had witnessed sexism or discrimination, less than half had said or done anything in response to the behaviour
- the main barriers to action were uncertainty about support from others (e.g. colleagues, peers) and lack of confidence or skills to take action (VicHealth 2012a).

Other research in relation to bystander strategies showed that, while several bystander programs had been developed in a range of settings, few had been formally evaluated and the principles for best practice in this area are currently emerging (VicHealth 2011b). There is also emerging research on the benefits and challenges of bystander interventions in male-dominated environments such as workplaces and sports organisations (see for example Corboz et al. 2016; McDonald et al. 2016).

Media

The media reporting of violence against women incidences and issues has been identified as a key influence on community responses to the issue. While this includes a range of media forms, most research about the nature and impact of media reporting to date has been focused on print and news media.

In their review of print media reporting on violence against women between 1986 and 2008, Morgan and Politoff (2010) identified that while there are aspects of reporting that were accurate and enabled a critical analysis of the issues, there were also many areas where reporting could be improved. For example, most reports relied on commentary from justice and courtroom proceedings without also including commentary from victims or expert agencies. More recently an analysis of reporting across print, television, radio and online news media again identified strengths and weaknesses in media portrayal of violence, and highlighted several strategies for Australian media to more accurately reflect the reality of violence against women and its impact (Sutherland et al. 2016).

A range of initiatives have since commenced to build better practices in media reporting. In the area of resources for journalists and for agencies working in the field, there are frameworks and tip-sheets available (Domestic Violence Victoria 2015) and a series of guidelines for reporters (Our Watch & Women's Centre for Health Matters 2016). There are also dedicated awards programs recognising best practice in media reporting (Domestic Violence Victoria 2013; Our Watch 2016a). In addition there are initiatives to strengthen the role and visibility of victims' voices in media reporting through the provision of media training and advocacy resources (Safe Steps 2016b; Women's Health East 2016).

Primary prevention: actions to address the drivers of violence against women

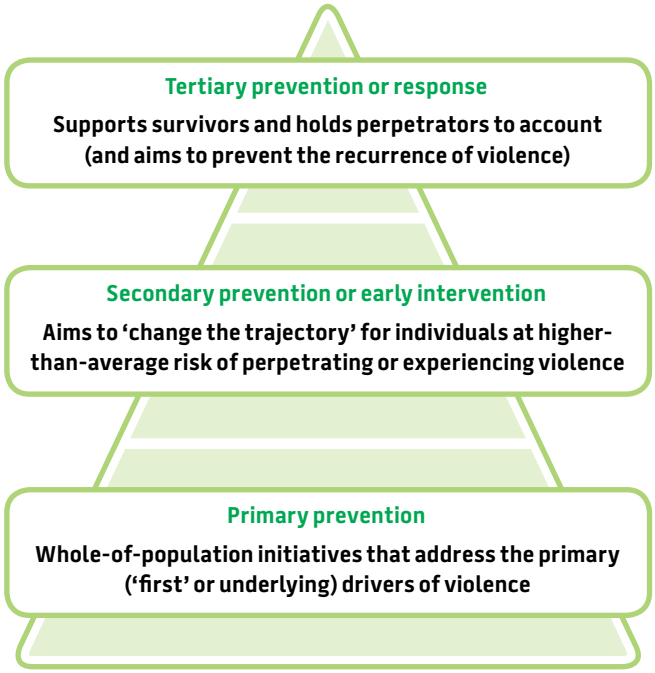
Spotlight on primary prevention

Responses to violence against women can be classified across a prevention spectrum according to their purpose and the population groups they seek to engage. Responses can be described as primary, secondary or tertiary prevention strategies as outlined in Figure 1. This overview is strongly focused on the evidence relating to primary prevention. The evidence relating to secondary and tertiary prevention has been developed and summarised elsewhere (State of Victoria 2016).

Primary prevention is distinct from other prevention strategies in that it aims to stop violence before it starts. Primary prevention approaches work across communities, organisations and society as a whole to address the deep, underlying drivers of violence against women (related to gender inequality), so that violence does not happen at all.

While primary prevention strategies must be developed and delivered alongside secondary prevention and tertiary prevention strategies, they are distinct in that they are universal in application and are focused on the drivers of violence, rather than the symptoms or impacts of violence that has already occurred or the early indications that violence is likely to occur.

Figure 1: The relationship between primary prevention and other work to address violence against women (Our Watch et al. 2015)



Frameworks to explain and address the drivers of violence

A number of frameworks have been developed over time to guide policy, programming and practice in the primary prevention of violence against women.

In 2007 VicHealth released a groundbreaking, world-first model that synthesised the best available evidence on the underlying drivers of violence against women (VicHealth 2007). This framework identified that the key driver of violence against women was unequal access to power and resources between women and men at a range of levels, and that the key strategy to reduce violence is to promote more equal and respectful relationships between women and men. It also identified the key techniques required to support this strategy and secure cross-sector action to stop violence before it starts.

Since then, work by international organisations such as the World Health Organization (WHO & London School of Hygiene and Tropical Medicine 2010) has reinforced and built on that evidence base.

Following these frameworks and guidelines, there was a rapid proliferation of programs and research activity in primary prevention across a range of settings and at the policy level (VicHealth 2015a; State of Victoria 2016).

Continuing international research has lent further weight to the notion of gendered drivers of violence against women and their primacy as targets for prevention action. Numerous studies have found a correlation between the many dimensions of gender inequality in public and private life and the occurrence of violence against women. Examples include:

- a study using population-level data from 44 countries published in the prestigious medical journal *The Lancet* (Heise & Kotsadam 2013)
- reviews prepared by eminent international bodies such as WHO (WHO & London School of Hygiene and Tropical Medicine 2010)
- evidence underpinning the development of the *Change the Story* framework for primary prevention in Australia (Webster & Flood 2015).

In 2015, Our Watch, ANROWS and VicHealth led the development of a new national framework that further collated and synthesised evidence to inform enhanced models for understanding what drives violence against women, and what is needed to prevent it. *Change the Story – A shared national framework for the prevention of violence against women and their children in Australia* draws on the strong growing body of research on the drivers of violence against women and provides further clarity about the particular expressions of gender inequality that drive violence, and how this occurs (Our Watch et al. 2015). Building on the ever-increasing evidence of the links between gender inequality and violence against women, as well as international consensus that gender inequality is the necessary condition for such patterns of violence against women, the framework demonstrates four distinct yet interconnected expressions of gender inequality as the drivers of violence against women:

- the condoning of violence against women
- men's control of decision-making and limits to women's independence in public life and relationships
- rigid gender roles and stereotyped constructions of masculinity and femininity
- male peer relations that emphasise aggression and disrespect towards women (Our Watch et al. 2015).

These drivers of violence against women arise from gender discriminatory, institutional, social and economic structures, social and cultural norms, and organisational, community, family and relationship practices. These norms, structures and practices exist and interact at various levels (individual and relationship, organisational and community, system and institutional and societal), which increase the likelihood of violence against women (Our Watch 2015). A socio-ecological model (as shown in Figure 2) suggests that in order to prevent violence, it is necessary to act across multiple levels of the model at the same time.

Furthermore, the framework presents proven and promising techniques for prevention that draw on the growing body of practice and evaluation about how to target these drivers. The framework also describes the infrastructure needed for sustained and concerted action, such as: mechanisms for coordination and quality assurance; an expert workforce; political, sector-specific and civil society leadership; policy and legislative reform; and shared monitoring, reporting and evaluation frameworks (Our Watch et al. 2015).

At the international level, the United Nations has provided a framework for collaboration across countries and global agencies to address the factors that contribute to violence against women at a population level (UN Women 2015). The elements of the Australian framework, *Change the Story* – including the techniques, settings and infrastructure identified for prevention – are consistent with the international framework.

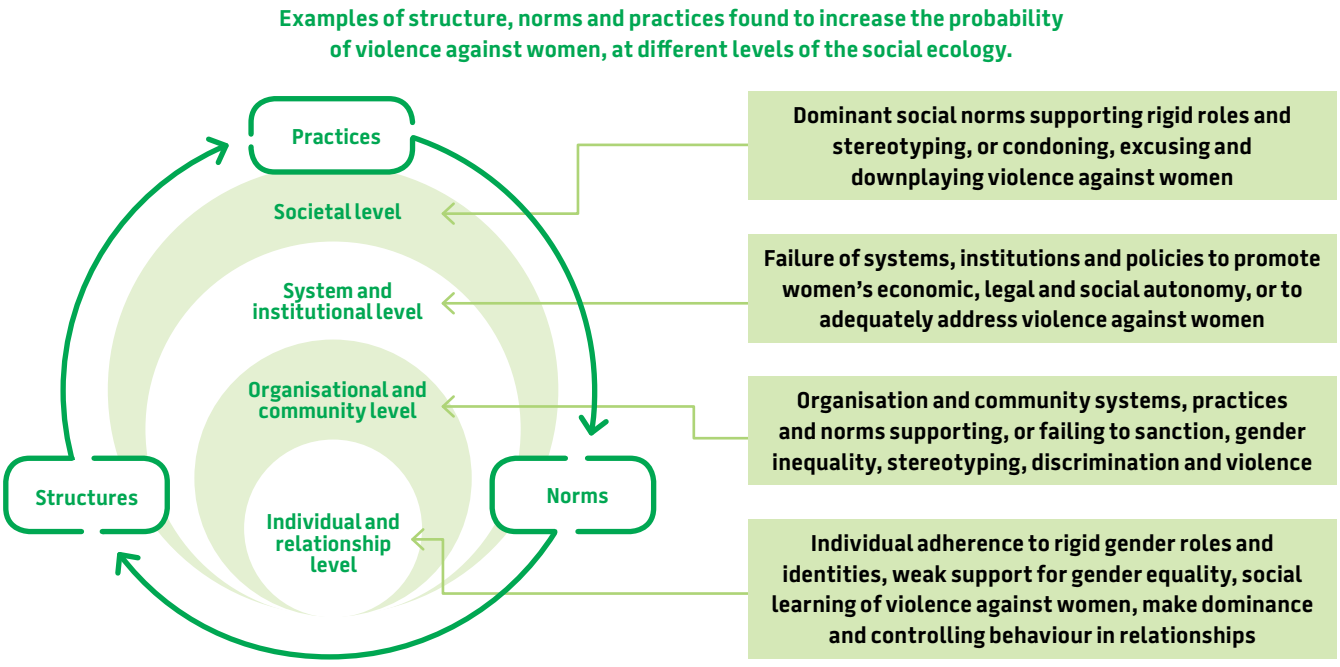
Emerging evidence in prevention programs

Violence against women is preventable and the evidence on proven and promising approaches to prevention is growing.

Australia's national framework to prevent violence against women, *Change the Story*, outlines the characteristics of effective or promising practice, and of less effective or harmful practice (Our Watch et al. 2015), and principles for the effective implementation of prevention techniques (Our Watch et al. 2015). Some of the important features of best practice primary prevention programs are that they:

- target the gendered drivers of violence against women
- are 'gender transformative', in that they move beyond gender-blind or gender-specific approaches and seek to explicitly address and change harmful gender roles, practices and norms
- involve a continuum of interdependent and interlinked strategies
- involve the whole community, including men and boys
- are tailored to, and developed in partnership with, communities who have experienced sustained discrimination and communities from different cultures (Our Watch et al. 2015; State of Victoria 2016).

Figure 2: Socio-ecological model of violence against women (Our Watch et al. 2015)



Essential and supporting actions

The *Change the Story* framework describes the five essential and five supporting actions that are required to address the factors that drive or reinforce violence against women.

Figure 3: Five essential actions required to reduce the gendered drivers of violence against women (Our Watch et al. 2015)

The following actions are considered essential to reduce the gendered drivers of violence against women:

Challenge condoning of violence against women

Promote women's independence and decision-making in public life and relationships

Foster positive personal identities and challenge gender stereotypes and roles

Strengthen positive, equal and respectful relationships between and among women and men, girls and boys

Promote and normalise gender equality in public and private life

The actions in Figure 3 are considered essential in reducing the gendered drivers of violence against women. Within each of these actions, prevention activities should address the norms, structures and practices of gender inequality as described in the framework.

In addition, the following supporting actions address the reinforcing factors that contribute to or exacerbate violence against women, and should be undertaken in concert with the essential actions and in gender-sensitive ways:

- Challenge the normalisation of violence as an expression of masculinity or male dominance.
- Prevent exposure to violence and support those affected to reduce its consequences.
- Address the intersections between social norms relating to alcohol and gender.
- Reduce backlash by engaging men and boys in gender equality, building relationships skills and social connections.
- Promote broader social equality and address structural discrimination and disadvantage (Our Watch et al. 2015).

Settings for action

Primary prevention strategies work best when they are delivered in the places where people live, work, play and learn (VicHealth 2007; State of Victoria 2016). Australia's national framework to prevent violence against women, *Change the Story*, identifies 11 key settings for action to prevent violence against women that represent potential for impact, namely:

- education and care settings for children and young people
- universities, TAFEs and other tertiary education institutions
- workplaces, corporations and employee organisations
- sports, recreation, social and leisure spaces
- the arts
- health, family and community services
- faith-based contexts
- media
- popular culture, advertising and entertainment
- public spaces, transport, infrastructure and facilities
- legal, justice and corrections contexts (Our Watch et al. 2015).

In some of these settings there has been significant and sustained prevention activity, whereas in others there is limited or no activity or practice-based evidence to inform further programming. For example, there has been extensive research and program development in the workplace and education/schools settings, leading to the development of best practice standards and resources (Department of Education and Early Childhood Development 2009; VicHealth 2012b; Our Watch 2015; Powell et al. 2015; Our Watch 2016b; VicHealth 2016a). There has also been a concentration of prevention activity in some universal and service platforms such as local governments and maternal and child health settings in Victoria (MAV & VicHealth 2013), and in media and bystander responses to violence against women as described above.

In addition to single-setting programs and approaches, there is emerging evidence in relation to place-based, regional and site-focused initiatives to prevent violence against women. These approaches are not specific to one setting but span multiple settings in order to achieve a whole-of-community or saturation effect. Evaluation of such programs in Victoria indicates potential for replication and scale-up and points to the broad requirements for multi-setting approaches to be effective, such as cross-sector partnerships, long-term and sustained funding and wide-ranging workforce development activity (Central Victorian Primary Care Partnership 2015; Our Watch 2016c; VicHealth 2016b).

Priority population groups

Preventing violence against women requires an inclusive, universal approach that reaches all Australians, combined with focused effort for those currently experiencing the greatest inequities and violence (Our Watch et al. 2015). Australia's national framework to prevent violence against women, *Change the Story*, recommends specific and intensive effort be focused on those communities or groups affected by multiple forms of disadvantage, or experiencing the cumulative impact of many negative factors. This includes a prioritisation of resources to efforts specifically focused on preventing violence against:

- Aboriginal and Torres Strait Islander women
- women from culturally and linguistically diverse communities
- women with disabilities
- women from rural and remote areas (Our Watch et al. 2015).

Additionally, it is important to work across the life course and target particular life stages that are important transition points or that present particular opportunities to address the drivers of violence against women (Our Watch et al. 2015). This includes during childhood and adolescence, expectant and new parents, during separation and divorce, and older people (Our Watch et al. 2015).

Techniques and methodologies for prevention

Seven key methodologies are identified in public health literature as being effective to create population-level impact. These methodologies are drawn from the actions identified in the Ottawa Charter (WHO 1986) and Jakarta Declaration (WHO 1997) and have proven effective in addressing other significant health and social issues. In the context of preventing violence against women, these methodologies are most likely to be effective if they are executed simultaneously across society and with a sustained base of investment (VicHealth 2007; Our Watch et al. 2015; PwC et al. 2015).

Across the globe, some of these methodologies have been applied in the prevention of violence against women more substantially than others. As a result there is an uneven evidence base and a clear need for further testing and evaluation through policy and further programming (Our Watch et al. 2015; PwC et al. 2015). Table 1 provides an overview of public health methodologies used in the primary prevention of violence against women and the extent to which they are effective.

Guidelines for prevention practice have been developed in relation to particular settings (e.g. schools) and also for program design and implementation overall. For example, *Change the Story in practice – a handbook to prevent violence against women and their children* (Our Watch [forthcoming]a) is a companion to the *Change the Story* framework (Our Watch et al. 2015). It provides guidance, tips and tools to help practitioners plan and implement a range of practical prevention activities and initiatives across different settings and contexts. It also provides guidance for policymakers and funders to support effective funding, planning, coordination and evaluation of prevention practice.

The drivers of violence against women can be addressed through primary prevention strategies, utilising a range of techniques in everyday settings such as workplaces, schools and sports.

Table 1: Public health methodologies to prevent violence against women and evidence of effectiveness

Public health methodology	Purpose	Application to primary prevention of violence against women activity (PwC et al. 2015)	Evidence of effectiveness (by program type) (PwC et al. 2015; Webster & Flood 2015)
Direct participation programs	Facilitate participation and skill development	These programs can be targeted at men, women and children at the individual, relationship or group level to build the knowledge and skills required to establish and sustain equal, respectful, non-violent gender relationships; to build individuals' access to the resources required for such relationships (such as effective early parenting and connections to social networks and institutions); or to prevent or address the impacts of other factors linked to violence against women (for example, child abuse).	Effective Some conflicting evidence across program types (e.g. economic empowerment; group/relationship-level interventions for equitable & respectful relationships; bystander approaches) Successfully implemented but not yet evaluated for impact on violence (peer education; parenting practices; media literacy)
Organisational and workforce development	Create organisational environments that foster good health	This methodology is based on the understanding that organisations and organisational cultures have a powerful role in influencing the behaviour of individuals and groups and so can play a role in violence reduction by modelling non-violent, equitable and respectful gender relations. Workforce development involves building the skills of relevant workforces to implement primary prevention activity either informally and opportunistically or at a more formal level.	Promising (whole-of-school programs) Successfully implemented but not yet evaluated for impact on violence (multi-strategy approaches with media outlets; organisational auditing)
Community strengthening	Strengthen communities and create community environments that foster good health	This methodology mobilises and supports communities to address violence against women and the social norms that make it acceptable. These strategies can also be used to increase community access to the resources required for action and to address broader community-level risk factors for violence against women, such as high rates of early school leaving or localised violent peer cultures.	Effective
Communications and social marketing	Communicate about priority health issues Change behaviour of target audience	These methodologies use a range of communication media to raise awareness of violence against women and address attitudes, behaviour and social norms that contribute to this problem. This includes mainstream television, radio and print media as well as the internet and other social media, community forums, community arts and so on.	Promising (social marketing campaigns plus group education) Ineffective (singular communications campaigns)
Advocacy	Gain political commitment	Advocacy involves building collective activity and mobilisation to raise awareness of the issue of violence against women and to encourage governments, organisations, corporations and communities to take action on structures, policies and systems contributing to the problem.	Successfully implemented but not yet evaluated for impact on violence
Legislative and policy reform	Gain policy/ legislative support	This involves the development of legislation, policies and programs that address the factors underlying or contributing to violence against women.	Successfully implemented but not yet evaluated for impact on violence
Research, monitoring and evaluation	Generate knowledge to guide policy, programs and practice	Research and evaluation underpins activity in the other six areas by informing action, improving the evidence and knowledge base for future planning, and enabling efforts to be both effectively targeted and monitored. Research findings are also important for advocacy and awareness-raising activity.	–

Evaluation and monitoring in prevention

The primary prevention of violence against women is a relatively new area of practice in Victoria (and elsewhere in the world), with innovation characteristic of the field. As a result, high-quality impact evaluations are rare, but there is a strong body of promising and emerging practice (Our Watch 2014b; Webster & Flood 2015). At present there is not yet one overarching framework for the evaluation of primary prevention, however *Change the Story* (Our Watch et al. 2015) notes the need for greater investment in evaluation in the Australian context generally, and for evaluation to form part of any prevention initiative and to be resourced appropriately as a tool for learning and accountability. Population-level indicators and outcomes for prevention are currently being developed for use at program and policy level (Our Watch [forthcoming]b).

A variety of tools and resources have been developed to strengthen and increase evaluation activity – for funders, policymakers and practitioners (VicHealth 2015b; VicHealth 2016b; VicHealth 2016c; VicHealth 2016d; Prevention and Population Health Branch 2010). A range of different evaluation models have been utilised, from participatory/evaluation capacity-building (VicHealth 2016b, VicHealth 2016c) to externally led or independent evaluation (Our Watch 2016c). Evaluation approaches can vary in line with the purpose of the evaluation, the funding requirements and the resources available, however rigorous evaluation methods are possible across the spectrum.

In the context of primary prevention, evaluation should be considered in light of the socio-ecological model, for understanding and acting on drivers of violence (Our Watch et al. 2015; VicHealth 2015b; Flood 2013; Webster & Flood 2015).

Subsequently, different types and levels of evaluation are required depending on the scope of the evaluation. This includes process, impact and outcome evaluation indicators, which measure changes at various time points of a program (Prevention and Population Health Branch 2010; VicHealth 2015b):

- Process – these indicators relate to factors such as the reach, satisfaction and quality of program activities (e.g. number of people who attended a training session, attendee satisfaction with training and overall quality of training)
- Impact – these indicators measure the short- to medium-term changes related to the difference a program has made (e.g. shifts in participants' attitudes, knowledge, skills, behaviour or beliefs around gender and violence, or changes in organisational or institutional policies and practices that are more supportive of gender equality)
- Outcome – these are the longer-term impacts of the program that require more time than a typical two- to three-year project can measure (e.g. achieving an equal and respectful community where all women are free from violence).

Investment in evaluation is crucial to strengthening the knowledge base of what works – and, just as importantly, what does not work – to prevent violence against women (Our Watch 2014b). Given the infancy of the field of primary prevention and limited availability of rigorously evaluated initiatives, there are significant gaps in evidence and continued resourcing of evaluation is essential. Attention should be paid not only to replicating successful techniques, but to testing, adapting and evaluating them in different contexts and settings. In other words, evaluation approaches in prevention can be both evidence-based and also evidence-building (Our Watch 2014b).

Investment in evaluation is crucial to strengthening the knowledge base of what works – and, just as importantly, what does not work – to prevent violence against women.

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