AUSTRALIAN WOMEN'S HEALTH NETWORK

HEALTH AND THE PRIMARY PREVENTION OF VIOLENCE AGAINST WOMEN

Position Paper 2014

Australian Women's Health Network

Health and the Primary Prevention of Violence against Women

A publication of the Australian Women's Health Network, based on a commissioned paper from **Dr Sue Dyson**, with support from the AWHN Publication Review Panel, April 2014.

This publication may include subsequent alterations/additions which do not necessarily reflect the views of the original commissioned writers.

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Association number: A02383

www.awhn.org.au

ISBN: 978-0-9578645-5-9

Published July 2014

Acknowledgements

The Australian Women's Health Network gratefully acknowledges funding support provided by the Australian Government to develop this resource through the Health Systems Capacity Development Fund, Commonwealth Department of Health.

AWHN would like to thank Dr Sue Dyson and the AWHN Publication Review Panel (Patty Kinnersly, Liz Murphy, Marion Hale and Kelly Banister) and the design team at Gasoline.

About AWHN

The Australian Women's Health Network is an advocacy organisation that provides a national voice on women's health, based on informed consultation with members. Through the application of a social view of health, it provides a woman-centred analysis of all models of health and medical care and research. It maintains that women's health is a key social and political issue and must be allocated adequate resources to make a real difference.

It aims to foster the development not only of women's health services but of stronger community-based primary health care services generally, which it sees as essential to improve population health outcomes. It advocates collaboration and partnership between relevant agencies on all issues affecting health. To this end, AWHN coordinates the sharing of information, skills and resources to empower members and maximise their effectiveness. The coalition of groups that comprises the organisation aims to promote equity within the health system and equitable access to services for all women, in particular those women disadvantaged by race, class, education, age, poverty, sexuality, disability, geographical location, cultural isolation and language.

This position paper is available for free download at: www.awhn.org.au

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Definitions

Domestic violence (also family violence, intimate partner violence) may be physical and involve actual physical harm, threatened harm against a person, or someone/something they care for. It may be emotional, and may involve belittling, name calling, and intimidation. It may also take the form of limiting a woman's freedom. For example financially, by keeping a woman dependent on a partner to the extent that it is necessary to ask for money and justify all expenditure; or socially, such as being insulted or bullied in front of others; or being isolated from friends or family or controlling where she can go or who she can see. It does not have to occur in the home to be classified as domestic violence and can take a number of forms, including stalking and cyber-stalking.

Equality: The Oxford English dictionary defines equality as the state of being equal, especially in status, rights, or opportunities. **Gender equality:** suggests that women and men should receive equal treatment and not experience disadvantage on the basis of their gender. This principle is enshrined in the United Nations Universal Declaration of Human Rights.

Equity: Equity is a term which describes fairness and justice in outcomes. It is not about the equal delivery of services or distribution of resources; it is about recognising diversity and disadvantage to ensure equal outcomes for all.

Family or intimate partner violence refers to violence that occurs between people in relationships, including current or past marriages, domestic partnerships, familial relations, or people who share accommodation such as flat mates and boarders. It can affect people of any age, and from any background, race, religion or culture.

Gender: Although these terms 'sex' and 'gender' are often used interchangeably, they have very different meanings. 'Sex' refers to the biological and physical characteristics that define maleness and femaleness. 'Gender' refers to the socially constructed roles, behaviours, activities, and attributes that any given society considers appropriate for men and women; gender defines masculinity and femininity (World Health Organisation, 2014).

Gender-based violence, or violence perpetrated by men against women, takes many forms. In addition to physical violence by intimate partners, known assailants or strangers, the definition of gender-based violence includes violence that results from unequal power relations based on gender differences.

Health: is defined as '…a complete state of physical, mental and social well-being, not merely the absence of disease or infirmity' (World Health Organisation, 2013).

Sexism: is discrimination based on gender and the attitudes, stereotypes, and the cultural elements that promote this discrimination. Given the historical and continued imbalance of power, where men as a class are privileged over women as a class, an important, but often overlooked component of sexism is that it involves prejudice plus power.

Sexual violence can occur between intimate partners, relations, acquaintances or between strangers. It takes many forms including sexual harassment, verbal abuse, leering, threats or indecent exposure.

Sexual harassment is any unwanted or unwelcome sexual behaviour, which makes a person feel offended, humiliated or intimidated. It is not interaction, flirtation or friendship which is mutual or consensual. Sexual harassment is a type of sex discrimination which disproportionately affects women. Despite being outlawed for over 25 years, sexual harassment remains a problem in Australia.

Violence against women is a term that encompasses all forms of gender-based violence.

Background

The rates of physical violence experienced by men and women since the age of 15 are comparable. For both, the perpetrator is far more likely to be male, however the contextual settings strongly differ[1]. Violence against men more often occurs in public while violence against women more frequently occurs in the home.

The Australian Bureau of Statistics (2012) found that men aged 18 years and over were more likely to have experienced violence by a stranger (36% of all men) compared to men who had experienced violence by a known person (27% of all men). The most likely type of known perpetrator was an acquaintance or neighbour (10%).

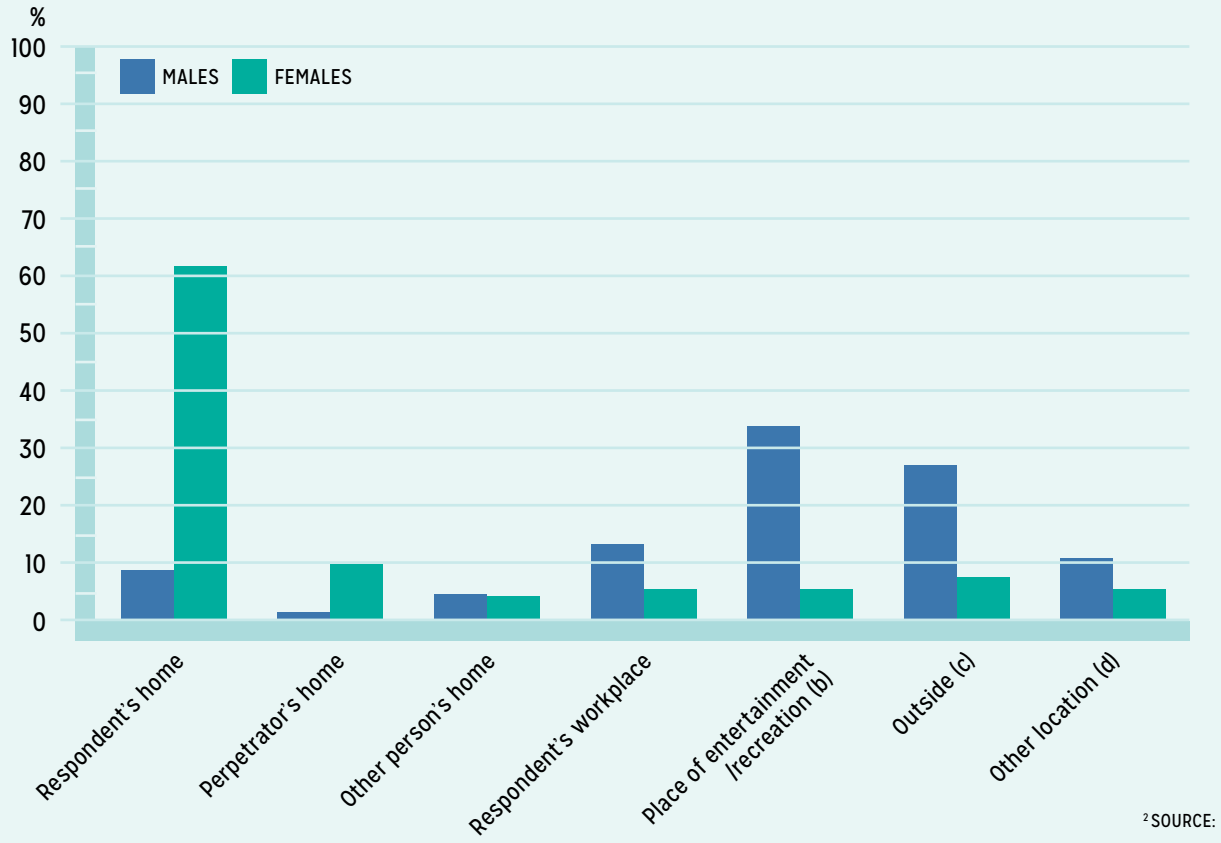
In contrast, women aged 18 years and over were more likely to have experienced violence by a known person (36% of all women) compared to women who had experienced violence by a stranger (12% of all women).

The most likely type of known perpetrator was a previous partner (15% of all women). Almost every week, a woman in Australia is killed by a partner or ex-partner (Mouzos & Makkai, 2004).

The differing contexts and perpetrators of violence against women and men often leads to the violence against women being considered a private issue. There is a failure to interrogate the reasons why some men see violence against their partners or ex-partners as an appropriate response or form of engagement.

This is why, according to the United Nations Population Fund (UNFPA), gender based violence is 'The most pervasive, yet least recognized human rights abuse in the world'

OF MEN AND WOMEN WHO EXPERIENCED PHYSICAL ASSAULT BY A MALE (a), Location of the most recent incident



[2] SOURCE:

[1] Australian Bureau of Statistics (2006) Personal Safety, Australia. www.abs.gov.au/ausstats/abs@nsf/Lookup/4102.0main+features30Jun+2010
[2] Australian Bureau of Statistics (2012) PersonalSafety, Australia. www.abs.gov.au/ausstats/abs@nsf/Lookup/4906.0Chapter3002012

Executive summary

This position paper focuses on the primary prevention of violence perpetrated by men against women. It develops a position on primary prevention (as distinct from secondary and tertiary interventions). It also identifies examples of good practice across settings, and factors for success for primary prevention programs. The paper has been developed as a resource for public education, debate and community activities related to the primary prevention of violence against women.

Intimate partner violence is prevalent, serious and preventable; it is also a crime. Among the poor health outcomes for women who experience intimate partner violence are premature death and injury, poor mental health, habits which are harmful to health such as smoking, misuse of alcohol and non-prescription drugs, use of tranquilisers, sleeping pills and anti-depressants and reproductive health problems.

The cost of violence against women to individuals, communities and the whole of society is staggering and unacceptable. Every week in Australia at least one woman is killed by her current or former partner, and since the age of 15, one in three women has experienced physical violence and one in five has experienced sexual violence. The annual financial cost to the community of violence against women was calculated by Access Economics in 2002/3 to be $8.1 billion (Victorian Health Promotion Foundation, 2004), a figure which is likely to increase unless the incidence of violence against women can be reduced and ultimately eliminated.

Gender based Violence

> ***Gender-based violence**, or violence perpetrated by men against women, takes many forms. In addition to physical violence by intimate partners, known assailants or strangers, the definition of gender-based violence includes violence that results from unequal power relations based on gender differences.*

The term gender based violence encompasses a range of abuses that result in, or are likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, whether they occur in public or private life (United Nations, 1993). Research has established that rather than being a few isolated acts, violence against women is a pattern of behaviour that violates the human rights of women and girls, limits their participation in society and damages their health and well-being (García-Moreno et al., 2013).

Gender-based violence is a complex social problem with serious health consequences. Recognition of the social nature of violence against women is central to efforts to eliminate it. A strong link has been established between gender based violence and the systemic inequalities rooted in structural power imbalances between men and women (United Nations General Assembly, 2006). The terms gender based violence and violence against women will be used interchangeably in this paper. When referring specifically to domestic violence the terms intimate partner violence and family violence may also be used.

In Australia nearly one in three women over the age of 15 years reports being subjected to violence at some time and one in five has experienced sexual violence. Intimate partner violence contributes to 9% of the total burden of disease for women aged 15 to 44 years (Victorian Health Promotion Foundation, 2004).

The social determinants of health are the conditions in which people are born, grow, live, work and age. These are shaped by the distribution of money, abuses of power and the distribution of resources at global, national and local levels, as well as by gender (Australian Women's Health Network, 2012).

Prevention

There is a strong association between sexist peer norms, low status of women and violence against women (Dyson and Flood, 2008, Flood, 2011, UN Division for the advancement of women, 2008, Victorian Health Promotion Foundation, 2010). Violence supportive attitudes and behaviour can be found almost anywhere, and recognised as: lack of support for gender equality; belief in the inferior status of women in relation to men; sexual harassment and coercion; bullying, abusive or controlling behaviours, or group disrespect (demonstrated by rude, aggressive behaviour, consumption of pornography, sexualising women, group consumption of alcohol, and rape supportive attitudes). The goal of prevention is to make these attitudes and behaviours visible and change them through the promotion of equal and respectful relationships.

Primary prevention is a public health approach that aims to prevent violence from occurring in the first place. It is advocated as an effective means of working towards the elimination of all forms of violence against women. Primary prevention must focus on changing the culture/s that operate to make gender based violence acceptable. This is sometimes referred to as culture, or cultural change.

Primary prevention programs can be carried out in 'settings', or the places where people in communities live, work, play and age (Peersman, 2001). A settings approach makes it possible to target specific groups with appropriate programs – in (among others) sports clubs, schools, workplaces and faith settings, as well with specific population groups including children, young people, and people with physical and intellectual disabilities, Indigenous and culturally and linguistically diverse people. Some examples of settings approaches are further explicated in this position paper.

A social/ecological model has been proposed for both understanding gendered violence and for prevention activities. The Victorian Health Promotion Foundation (VicHealth) has a model which suggests that rather than being a simple phenomenon, violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors. The model works at three levels which are interdependent with each other: individual/relationship, community/ organisational and societal (Victorian Health Promotion Foundation, 2007).

Rather than focus on negatives, primary prevention must take a positive, community building, or strengths based approach. A strengths-based approach calls for programs to be positive, inclusive and enabling. Such an approach makes visible and values the skills, knowledge, connections and potential in a community. It promotes capacity, connectedness and social capital (Glasgow Centre for Population Health, 2011). This approach has the potential to engage men and women in the community as partners in bringing about the changes needed to eliminate violence against women. Many small and medium sized primary prevention programs using this approach are currently in progress in communities across Australia. See, for example, a report on programs from the Victorian Health Promotion Foundation (2012). As greater numbers of ordinary people become involved in prevention programs the combined effect has the potential to create a groundswell of momentum that will lead to the kind of long term cultural change that is required to create a society in which all people are equal, and respectful relationships and behaviours are the norm.

Policy Context

Australia has Commonwealth, State and Territory plans that focus on both responding to and preventing violence against women. All states and territories are signatory to the Commonwealth plan to Prevent Violence against Women and their Children, yet not all of the individual plans align with the Commonwealth in terms of primary prevention. There is a lack of transparency and clarity about how the different plans are being implemented and progressing. The Commonwealth has funded a number of community based programs since 2009 yet no effective knowledge transfer[3] about the learnings that have come out of these programs has taken place to inform practice.

[3] Australian Knowledge transfer and exchange is the process of sharing useful, evidence based learnings, expertise and skills with others. It involves a broad range of activities which are mutually beneficial to a range of stakeholders, including in this case researchers, practitioners and policy makers

Recommendations

To Federal, State and Territory Governments

Based on the findings of this position paper the Australian Women's Health Network recommends that Governments:

1. Recognise that no single initiative will prevent violence against women. Dedicated funding must be provided to the primary prevention sector to ensure activities can be delivered across the range of settings where people live, work and play to continue and expand the work of preventing and eliminating all forms of violence against women.
2. Continue to provide specific funding for the tertiary response sector at a level to ensure women who are subjected to intimate partner violence and sexual assault have adequate and appropriate services available to provide them with safety and support.

This position paper has highlighted the importance of a collaborative, coordinated integrated approach to address violence against women. We believe that a national body is required to ensure the successful implementation of the recommendations contained on this paper. We therefore recommend that:

3. Responses to violence against women be guided by a national advisory structure of all relevant stakeholders. This would include governments, the Foundation, ANROWS, AWAVA, women's health and other community organisations. The national advisory body would be responsible for developing a collaborative multi-year workplan between member stakeholders.

Further, we recommend that:

4. All community projects funded by the Commonwealth Government are evaluated (using either an external evaluation approach or a capacity building internal evaluation approach as discussed on page 29 of this position paper) and that reports of these evaluations are made freely available to the primary prevention sector to build the evidence base and to ensure ongoing learning. The multi year workplan discussed in Recommendation 3 should also be accompanied by an appropriately funded, substantive meta-evaluation of whole of population change.

It is the role of government to ensure gender equity is enshrined in all Commonwealth and State laws, policies and practices. We therefore recommend:

5. All government policies should be reviewed regularly using a gender lens and when necessary updated to ensure that gender equality is enshrined in all its practices.
6. A communication strategy should be undertaken to promote gender equality laws and policies to ensure they are understood and adhered to by government, business and non-government sector organisations.
7. Governments and political parties at all levels should comply with and model gender equality in all appointments and committees.

It is commendable that Australia has a long term prevention plan in place; however, preventing violence against women is both an urgent and long term task that should not be subject to changes of government. The AWHN therefore recommends:

8. That Governments should publish regular updates on the progress of Commonwealth, state and territory prevention of violence against women plans. Reports from community programs funded under these plans should also be made available to ensure effective knowledge exchange occurs to inform ongoing practice.

There is a considerable focus on educating young people in equal and respectful relationships in the Commonwealth plan to prevent violence against women. The AWHN therefore recommends:

9. Respectful relationships education programs be incorporated into all schools' curricula from kindergarten through year 12.
10. All school programs are developed using the good practice principles detailed on page 24 of this position paper, using a whole school (health promoting) approach.
11. Long term funding be provided to continue improving and expanding primary prevention approaches across settings. This should include a long term commitment to evaluation.

To the Foundation to Prevent Violence against Women and their Children

Based on the published roles and functions of the Foundation detailed on pages 34 & 35 of this position paper, the AWHN recommends:

12. Awareness raising programs developed and conducted by the Foundation should be evidence based, and draw on the good practice principles for community programs identified on page 24 of this position paper.

13. The Foundation develops a nationally agreed framework (including detailed definition of, and principles for primary prevention) to guide program development and implementation. This should be used to assess applications at all levels for funding primary prevention programs. Criteria for assessing primary prevention are suggested on page 24 of this position paper.

The media can play an important role in the primary prevention of violence against women. The EVAs[4] in Victoria has established that collaborations between NGO and media representatives can be productive. We therefore further recommend:

14. The Foundation works collaboratively with media outlets regardless of the platform to develop voluntary standards for reporting and advertising that reflects gender equality and respectful representations of women and men.

To Primary Prevention Practitioners

Two key bodies stand out as having the knowledge and experience in both the social determinants of health and primary prevention, VicHealth and the women's health sector Australia wide. VicHealth has provided the evidence base upon which programs can be developed and the women's health sector has well developed skills in health promotion and primary prevention. The AWHN therefore recommends:

15. At a minimum, primary prevention programs should promote gender equality and respectful relationships, as well as challenging violence supportive behaviours, environments and structures that are the social determinants of violence against women.

16. Primary prevention programs be planned using the good practice principles identified in section 2.6 of this position paper.

17. Because gender inequality and the social determinants of health are critical factors underpinning violence against women, a gendered lens should be applied to the planning of primary prevention programs to ensure the underlying factors of gender and power are incorporated into all program plans.

[4] The Eliminating Violence Against Women Media Awards

HEALTH AND THE PRIMARY PREVENTION OF VIOLENCE AGAINST WOMEN

1. Introduction

Australia has a strong, independent and thriving women's health sector with skills and experience in health promotion and primary prevention. This position paper articulates the Australian Women's Health Network (AWHN) position on the primary prevention of violence against women for their improved health and well-being. The paper:

- proposes a position on primary prevention (as distinct from secondary and tertiary interventions).
- identifies good practice principles primary prevention programs and factors for success for programs, based on practice across different settings.
- provides a review and analysis of the implications of the Commonwealth, State and Territory Plans to prevent violence against women;
- presents a resource for public education, debate and community consultation activities related to primary prevention.

The position paper draws on Australian and international peer reviewed work based on empirical evidence, however, because prevention of violence against women is a relatively new field of research, it also draws on the extensive grey literature on the topic.[5] The paper starts with a discussion of gender, the social nature of violence against women and the kinds of behaviour and attitudes that support, foster or condone gender based violence. In section two, it focuses on prevention of violence against women, in particular the public health approach, including primary prevention and the ecological model. Section three discusses evaluation approaches and identifies good practice principles for primary prevention. Section four examines the policy context for preventing violence against women in Australia, analyses the national, state and territory prevention plans, and discusses two recent initiatives, the Foundation and the Centre for Excellence to Prevent Violence against Women. Finally it draws on the findings to make recommendations for primary prevention policy and practice in Australia.

1.1 Gender and power

Although these terms 'sex' and 'gender' are often used interchangeably, they have very different meanings. 'Sex' refers to the biological and physical characteristics that define maleness and femaleness. 'Gender' refers to the socially constructed roles, behaviours, activities, and attributes that any given society considers appropriate for men and women; gender defines masculinity and femininity (World Health Organisation, 2014). Gender can be conceived as a system of social power relations which permeates the structures, processes and practices of all aspects of public and private life (Australian Women's Health Network, 2012).

Mainstream social and cultural practices within societies strengthen notions that gender roles for women and men are natural biologically determined differences. Gender is deeply embedded in the legal, religious and cultural structures and norms that are taken-for-granted in the everyday arrangements of people's lives. Gender relations are multi-dimensional, interweaving relationships of power, economic arrangements, emotional relationships, systems of communication and meaning (Connell, 2003).

Power can be conceived in two main ways: as power-over and power-to. A power-over model is characterised by three main features: that power is possessed, flows from above to below, and is primarily repressive (Sawicki, 1991). In this model, those who possess power oppress those who do not have it, and there are few options for the oppressed to remedy their oppression other than revolution. Another model of power is that it is not a possession, but as something that circulates in networks between individuals (Foucault, 1980). In this model, power is neither positive nor negative, but simply exists. This understanding of power does not suggest that it cannot be used to oppress, but recognises the possibility of resistance, and of agency – the capacity for individuals to take action and bring about change – that is not present in hierarchical notions of power.

From this standpoint, power can be seen as operating between individuals and groups who share a common understanding about unspoken social 'rules' for the conduct of gender relations and it may be used to enforce as well as to resist violence. The elimination of violence against women is predicated on the the idea that deeply held cultural norms and values can be changed.

[5] Grey literature is all that material which is not subject to peer review, i.e. peer reviewed journals and books (Alberani, Peitrangeli & Mazza, 1990). This may include reports, newsletters, pamphlets, web sites and other print and digital media sources.

1.2 Violence against women

Gender-based violence is a complex social problem which grows from deeply-held beliefs, value systems, stereotypes and power relationships. In addition to the physical, emotional and social harms resulting from gender based violence, there are also multiple, serious, complex sequalae for its victims.

Globally, 30% of women have experienced physical and or sexual intimate partner violence and 7% have been sexually assaulted by someone other than a partner (García-Moreno et al., 2013). In Australia nearly one in three women over the age of 15 years report being subjected to violence at some time and one in five have experienced sexual violence (National Council to Reduce Violence Against Women and their Children, 2009).

Gender based violence is not a new phenomenon; recognition of the extent of the problem is, however, relatively new. It is only in recent decades that meaningful measures have been developed to understand the true scope and impact of intimate partner violence (Australian Women's Health Network, 2013). For example, evidence of the scope, impact and human costs of violence against women was not established until 2004 when VicHealth published its report *The health costs of violence: Measuring the burden of disease caused by intimate partner violence. The study that led to this report established that in Australia intimate partner violence* contributed to 9% of the total burden of disease for women aged 15 to 44 years (Victorian Health Promotion Foundation, 2004). The availability of measures to understand the health implications of violence against women, and the subsequent actions to address the problem through improved services and the development of prevention programs, represents a quantum leap in knowledge and understanding about violence against women as a serious health issue and demonstrates that 'what gets measured gets done' (Australian Women's Health Network, 2013). It is this knowledge and understanding that underpins the current groundswell of primary prevention activity.

The evidence has demonstrates that, rather than being a few isolated acts, violence against women is a pattern of behaviour that violates the human rights of women and girls, limits their participation in society and damages their health and well-being (García-Moreno et al., 2013). The complexity of the problem means that both the response system and prevention efforts must be multi-sectoral and inter-disciplinary, and must operate in all the structures of government, community and interpersonal relations.

Despite a desire to explain the phenomenon by seeking a cause, no single cause adequately accounts for violence against women; it cannot be attributed solely to individual psychological factors or socioeconomic conditions (United Nations General Assembly, 2006). Explanations for violence that focus primarily on individual behaviours and personal histories, such as alcohol abuse or a history of exposure to violence, overlook the broader impact of systemic gender inequality and women's subordination (UN Women, 2012).

Although violence against women is a centuries old phenomenon, it was not until 1993 that the issue of violence against women was accepted as a human rights violation at the Vienna World Conference on Human Rights and defined 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 (United Nations, 1993).*

Gender equality between women and men is recognised as a principle in international law, articulated in many United Nations documents from the 1948 Universal Declaration of Human Rights onwards. They are also enshrined in Australian law. Recognition of the social nature of violence against women is central to efforts to eliminate it.

1.3 The impact of violence against women

Violence against women has serious health and social consequences, and the figures concerning this are stark. Since the age of 15 years 40% of all Australian women have experience some form of gender based violence. Twenty one percent of women have experience physical assault and 17% have experienced sexual assault. One in six women have experienced violence by a current

or former partner at some time in her life. In addition, since the age of 15 years one third of all Australian women have experienced sexual harassment in the form of inappropriate comments about their body or sex life, one quarter have experienced unwanted sexual touching and one in five have been stalked (Australian Bureau of Statistics, 2006).

The direct health consequences of gender based violence (GBV) to women, include depression, anxiety and phobias, suicidal behaviours, physical injury, a range of somatic disorders and a variety of reproductive health problems (Victorian Health Promotion Foundation, 2008). Women who have been exposed to violence report poorer overall physical health than those who have not, and there is evidence that the health impact of violence can persist long after the abuse has stopped (Victorian Health Promotion Foundation, 2004, García-Moreno et al., 2013).

In addition to the immediate physical and mental health harm experienced by women there are also long-term effects. According to VicHealth:

> *Domestic violence has a long-term impact on its victims and survivors, including their income and financial stability, housing security, and parenting, and on their children's safety during contact with abusive ex-partners (Walsh (2008) cited in Victorian Health Promotion Foundation, 2008)*

Intimate partner homicide also accounts for one fifth of all homicides in Australia. Female deaths account for four out of five of these homicides, typically these women are killed in the context of a long history of domestic violence (Victorian Health Promotion Foundation, 2010). There are also serious consequences for children, families and the wider community. The experience of growing up in a violent home can be devastating and increases children's risk of mental health, behavioural and learning difficulties. Boys who witness domestic violence are at a greater risk of becoming perpetrators as adults (Victorian Health Promotion Foundation, 2008).

In addition to the serious human costs of violence against women the financial cost to the community are enormous. This takes into account the cost of public and private services to victims, perpetrators and children, the costs in terms of lost productivity (including sick leave, 'presenteeism'[6], access to employment support services, replacing staff and lost unpaid work) (Victorian Health Promotion Foundation, 2008). Other costs include counselling, changing schools, child protection services, increased use of government services, and juvenile and adult crime (Victorian Health Promotion Foundation, 2004).

1.4 What is violence supportive behaviour?

As discussed above, gender based violence is a complex social phenomenon that is supported and maintained in society as a result of a range of overt and covert actions that are normalised to the point where they are taken for granted and often pass unnoticed. The strong association between sexist peer norms, low status of women and violence against women must be addressed in any violence prevention project, and to do this, the attitudes and behaviours that foster or maintain the practice must be made visible and changed.

Research with male perpetrators has identified a range of particular predisposing attitudes and behaviours. These include a general approval of interpersonal violence by men, acceptance of rape myths, belief that relations between men and women are adversarial, and generalised hostility towards women. This may include distorted ideas about social situations, such as taking a woman's lack of interest in sex as a personal insult, thinking that women dress deliberately to tease men, or that women actually enjoy rape once they are forced to submit (Hagemann-White et al., 2010). Adherence to any of these beliefs or values by a person of any gender contributes to a violence supportive environment.

Certain settings[7] appear to support sexual violence, for example, studies in university fraternities, military institutions and sporting organisations[8] suggest that attitudes that position men as needing to dominate in sexual relations, link masculinity with extreme forms of heterosexual performance, sexist, heterosexist and homophobic attitudes, use of pornography, and general norms of women's subordinate status all support a climate of violence against women (Boswell and Spade, 1996, Sanday, 1996, Dyson and Flood, 2008). For example, in sport, Rosen (2003) reported an association between 'group disrespect' (the presence of rude and

[6] This term has been coined to describe distraction, lack of concentration and underperformance at work. In other words being physically present at work but in all other ways absent.

[7] The term 'setting' is used in health promotion practice to describe the places where people live, work and play. A settings approach will be discussed in more detail below.

[8] The majority of this research has occurred in the USA.

aggressive behaviour, pornography consumption, sexualised discussion, and encouragement of group drinking) and the perpetration of intimate partner violence, at both individual and group levels.

Other factors in these settings that have been associated with some men becoming abusive or violent include:

- Male bonding: The codes of mateship and loyalty in tightly knit male groups may intensify sexism and encourage individuals to allow group loyalties to override their personal integrity.
- Settings which encourage male aggression: for example, contact sports that naturalise and glorify violence through teaching athletes physical aggression and dominance, extreme competitiveness, physical toughness and insensitivity to others' pain.
- Sexualisation and subordination of women: some critics point to women's roles in sports, either as sexualised props for men's performance (for example, as cheerleaders or carers), or as supporters and carers, as being implicated in sexist norms.
- Celebrity status and entitlement: the high-profile status and celebrity treatment of professional athletes has been seen to potentially feed a sense of entitlement and lack of accountability for actions off the field.
- Drug abuse: excessive consumption of performance enhancing and illicit drugs and alcohol has been identified as a potential risk factor for sexual assault.
- 'Groupie' culture: players' sexual involvement with women who seek out their sexual company, combined with a status of entitlement, may shape athletes' assumptions about women, sexuality, and consent (Dyson and Flood, 2008, Benedict, 1998, Melnick, 1992).

These attitudes and behaviours can be seen in a wide range of other male dominated settings.

Context-specific mechanisms further shape the prevalence of violence-supportive attitudes and violent behaviour among men. One is *group socialisation*: in joining particular groups such as sporting teams, the military or fraternities men are actively inducted into the existing norms and values of these contexts. Another mechanism is *self-selection*: men with pre-existing violence-supportive attitudes and behaviours and an orientation towards behaviours such as heavy drinking may join groups with similar norms (Dyson and Flood, 2008).

Research with men in US college settings has shown that they tend to overestimate the amount of sex their male peers have, and the degree to which their peers support coercive behaviour with women. At the same time they underestimate the importance of consensual sex to their friends (Casey and Lindhorst, 2009, Berkowitz, 2002). In another study Berkowitz (2003) argues that a small but vocal minority of men who endorse rape supportive attitudes create the perception that sexual objectification and coercion of women are normal in male peer networks and create a climate of disrespect for women. Fabiano et al. (2003) also found that most men reported privately that they placed high value on consent in sexual activity. This may suggest that the majority of men (or women) do not adhere privately to sexist or other violence supportive attitudes, however, their silence condones and therefore supports violence against women.

Other settings normalise violence supportive attitudes and behaviours in different ways. For example, faith based communities may be sites where gender based violence is inadvertently fostered or condoned. This may be based on custom and tradition rather than the teaching of a particular religion. For example, by emphasising women's subordinate status in comparison with that of men, or blaming a woman for her husband's abusive behaviour because she is not suitably submissive. The report of a primary prevention program in faith based communities in Melbourne argues that it is important for leaders in these communities to speak out against violence and promote equal and respectful gender relationships as part of their pastoral role (Holmes, 2012). The UN expert meeting on the role of faith based communities in prevention acknowledged the sensitivity, complexity and diversity of engaging faith communities in prevention (Grape, 2012).

Workplaces are also sites where women may experience violence, or where violence supportive attitudes prevail, and gender hostility and sexual harassment in workplaces may be normalised. In an Australian study, over 60% of women surveyed reported experiencing some form of violence and 75% reported experiencing unwanted or unwelcome sexual behaviour at work (Chung et al., 2012). This may involve explicitly sexual

verbal and non-verbal behaviours, insulting behaviours that are based on gender, unwanted sexual attention and sexual coercion. In the workplace employers and managers have a responsibility to ensure the workplace is safe and non-discriminatory; those who do not do this are displaying violence supportive attitudes and behaviours (Chung et al., 2012). There is also ongoing evidence that women in Australia experience gender based discrimination in the workplace, as demonstrated by the gap in women's pay relative to men's and under-representation in positions of decision making and seniority (Chung et al., 2012). Workplaces that do not address this differential are exercising violence supportive practices.

Schools are yet another site where violence supportive attitudes and behaviours may thrive. In 2008 the *National Survey of Secondary Students and Sexual Health* reported that 38% of young women in years 10, 11 and 12 had experienced unwanted sex, a 10% increase since the previous survey in 2002. Students cited being too drunk, or pressure from their partner, as the most common reasons for having unwanted sex (Smith et al., 2009).

Adolescence and young adulthood are times when young men are testing ways of enacting their masculinity, which can be highly contingent and situational depending on peer groups and role models. Blye (2003) described this as a process of young men jostling between competing forms of masculinity. For example, men may use sexist jokes as a kind of bonding exercise; it is through joking friendships that men are able to negotiate the tension they feel over a need for intimate friendships with other men. This phenomenon was also observed by Corboz, Flood & Dyson (forthcoming) in research with elite Australian football players. Sometimes these confused performances of masculinity described by Blye above can lead to overt sexism and consequently be violence supportive.

In summary, violence supportive attitudes and behaviour can be found in any setting, and recognised as lack of support for gender equality, belief in the inferior status of women in relation to men, sexual harassment and coercion, bullying, abusive or controlling behaviours, group disrespect (demonstrated by rude, aggressive behaviour, consumption of pornography, sexualising women, group consumption of alcohol, and rape supportive attitudes). While many of the attitudes and behaviours discussed in this section have been identified by researchers in specific settings, they also occur in other settings so should not only be limited to the setting in which they are discussed.

Violence supportive attitudes and norms are also shaped by other social influences including popular media. A wide range of studies have documented relationships between tolerance for physical or sexual violence and exposure to particular imagery in pornography, television, film, advertising and electronic games (Flood & Pease, 2006).[9]

[9] www.awe.asn.au/drupal/sites/default/files/Why_Violence_Against_Women_and_Girls_Happens.pdf

2. Prevention of gender based violence

2.1 A public health model for prevention

Public Health has been defined as an organised response to the protection and promotion of human health (Peersman, 2001). It is concerned with the health of entire populations, which may be a local neighbourhood or an entire country. Public health programs are delivered through education, promoting health lifestyles, and disease and injury prevention. This is in contrast to the medical approach to health which focuses on treating individuals after they become sick or injured. Public Health embraces a definition of health which has been recognised since 1958 as '…a complete state of physical, mental and social well-being, not merely the absence of disease or infirmity' (World Health Organisation, 2013).

Public Health has developed a three level model of prevention to address a range of health issues that affect both populations and individuals. In this model, *Tertiary prevention* aims to work with people who are already affected by disease to improve function and minimize the impact of the disease and delay complications and repeat events associated with it. *Secondary prevention* aims to reduce the progression of disease through early detection, such as screening and pre-symptomatic stages, early detection and early intervention associated with the onset of disease.

Primary prevention aims to limit the incidence of disease by addressing the causes or determinants of potential ill-health. This may be by reducing exposure to risk factors as well as by promoting protective factors, such as the emergence of pre-disposing social or environmental conditions that can cause disease (National Public Health Partnership, 2006). In the disease prevention model described here there is some overlap between secondary and primary prevention, for example, when the cause of the problem cannot be eliminated the focus turns to modifying behaviour using a combined approach.

The public health model for prevention has been adapted for preventing violence against women. Thus, primary prevention is explained as preventing violence from occurring in the first place; secondary prevention as providing early intervention, for example, with perpetrators; and tertiary prevention as providing safety and support for victims after violence has occurred (World Health Organisation, 2002, Dyson and Flood, 2008, Martin et al., 2009, Flood, 2011).

2.2 The Social Determinants of Health

An understanding of the social determinants of health is critical for primary prevention programs. These are the conditions in which people are born, grow, live, work and age (World Health Organisation, 2013) that are shaped by the distribution of money, power and resources at global, national and local levels as well as by gender and accompanying abuses of these. This is also sometimes also known as the 'social hierarchy' (Australian Women's Health Network, 2012).

The Ottawa Charter identifies the fundamental conditions and resources for health as including peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity (World Health Organisation, 1986). The social conditions that influence violence against women include: the ways in which gender roles and relationships are constructed and defined; how power and material resources are distributed; social norms about violence and violence against women; and access to resources and systems of support (Women's Health West, 2012).

Well-being describes a concept of health in which equity, freedom from violence and discrimination, and access to the resources necessary to live a full and satisfying life are paramount (World Health Organisation, 1948). Women who experience intimate partner violence also experience inequalities on a range of social health measures. For example, as a result of violence they may experience lack of access to secure housing, as well as insecure work and income support. Thus, violence against women not only affects health but also well-being.

There is a strong link between violence against women and the systemic inequalities rooted in structural power imbalances between men and women (United Nations General Assembly, 2006). A gendered analysis can expose the ways in which the social determinants of health affect women and men differently (including those from marginalised or disadvantaged communities). Such an analysis must form the basis of primary prevention programs to eliminate gender-based violence.

2.3 Primary Prevention of Violence against Women

The work of primary prevention of violence against women is about changing the attitudes and behaviours that lead to some men abusing power by socially, emotionally or physically controlling or being violent against women. These are the factors that give rise to, or create the conditions that lead to gender based violence and abuse. These conditions include the structural barriers of gender inequality and gender role socialisation, and the social norms that ignore, condone or support violence against women (Quadara and Wall, 2012).

According to the report from the UN Expert Group meeting in 2012, primary prevention remains a poorly understood concept across sectors and between stakeholders. It is often conflated with early intervention or the response to existing violence, or else limited to awareness raising or social marketing campaigns (UN Women, 2012). Education programs or sessions are frequently used in primary prevention, however, short, one-off education programs that are not linked with a comprehensive program do not meet the criteria for being primary prevention.

Health promotion is a public health discipline which strives to address the social, political and economic determinants of health in order to achieve a complete state of physical, mental and social well-being for individuals and communities, and to empower people to take charge of their own health. It provides an alternative to medicalised understandings of health, and goes beyond addressing individual lifestyle strategies (Peersman, 2001). For health promotion, health is seen as a resource for everyday life, not the objective of living, it is a positive concept which emphases social and personal resources, as well as physical capacities (World Health Organisation, 1986).

Culture has been described as a way of making sense of the world through shared understandings and constructed meanings – about the cultivated stories, myths, symbols and rituals that make sense of what groups have done, are doing and will do (Giddens, 1979). Because culture is continually emergent, negotiated and in play, change is possible. The strategies that are used to bring about culture change may include education, community mobilisation, social marketing, events (such as White Ribbon day or International Women's Day breakfasts and other community events), structural and policy changes and a myriad of other approaches. It is important to note that any one of these strategies implemented on a stand-alone basis do not meet the criteria for being primary prevention.

To be defined as primary prevention the strategies must challenge the attitudes and behaviours that are violence supportive whilst changing the structural supports that maintain gender inequality. Education programs, awareness raising and community mobilisation are all important, but alone do not constitute primary prevention; a comprehensive, multi-level, integrated approach is needed for primary prevention. Primary prevention should actively address multiple and intersecting forms of discrimination and disadvantage that place women and girls at risk of violence (UN Women, 2012). Primary prevention of gender based violence must focus on changing the culture/s that operate to make gender based violence acceptable and is sometimes referred to as culture or cultural change.

Primary prevention programs can be carried out in 'settings', or the places where people in communities live, work, play and age (Peersman, 2001). A settings approach makes it possible to target specific groups with appropriate programs – in (among others) sports clubs, schools, workplaces and faith settings, as well with specific population groups including children, young people, and people with physical and intellectual disabilities, Indigenous and culturally and linguistically diverse people.

VicHealth has led the way in piloting prevention programs across a range of settings. In 2012, *The Respect, Responsibility and Equality program: A summary report on five projects that build new knowledge to prevent violence against women* was published which provided an overview of five settings based programs that built capacity to promote equal and respectful relationships in various settings. These included:

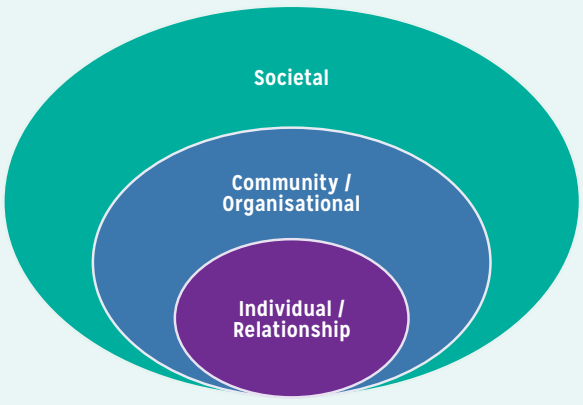
- Workplace setting: *Working Together Against Violence*, a Women's Health Victoria program in a male dominated corporate workplace.

- Maternal and child health: *Baby Makes 3*, Whitehorse Community Health Service program for parents in their transition to first time parenthood.
- Faith based communities: *Northern Interfaith Respectful Relationships* program, led by Darebin City Council to build capacity among faith leaders to foster respectful and violence free relationships between men and women.
- Youth sector: *Partners in Prevention*, led by the Domestic Violence Resource Centre Victoria to build capacity of practitioners to promote equal and respectful relationships.
- Local government sector: *Respect and Equity*, a program in one local government to address the underlying causes of violence against women from planning and policy to service provision.

2.4 The Ecological Model

To implement a primary prevention approach the use of a social/ecological model for change has been advocated. The social/ecological[10] model has been proposed for both understanding violence and for prevention activities.[11] The model suggests that rather than being a simple phenomenon, violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors. The model works at three levels: individual/relationship, community/organisational and societal, each of which is interdependent with the other.

FIGURE 1: AN ECOLOGICAL APPROACH TO UNDERSTANDING VIOLENCE AGAINST WOMEN
SOURCE: VicHealth (2207)



The Ecological Model suggests that the problem of violence against women is essentially one of culture and environment, rather than one of deficits in individuals. Solutions involve changing social norms and behaviours, and require the active involvement of all levels of the community. The premise of this model is that violence is a function of the abuse of power and control, and it aims to bring about social change to create an ethical setting where individuals are not exploited, power is not abused and all members of a community are involved (Maton, 2000). It has been argued that this model has the capacity for social transformation in individual and community values and norms. Change depends on interventions occurring at multiple levels ranging from individuals through to society, and from society down to the individual (Dyson and Flood, 2008). In this model:

- The **societal level** seeks to understand the cultural values and beliefs that shape the other two levels of the social ecology and change institutional and cultural support for, and weak sanctions against, gender equality and rigid gender roles. The role of governments is emphasised in providing an 'enabling' environment through policy and legislative reform to promote gender equality and women's empowerment.
- The **community/organisation level** works on the formal and informal social structures that impact on individuals such as norms concerning gender equality, masculine peer norms and organisational values.
- The **individual/relationship level** focuses on developmental and personal factors that shape responses to stressors in the environment such as rigid gender roles, weak support for gender equality, attitudes of masculine entitlement and superiority, and male dominance and control of wealth in relationships, as well as on promoting respectful relationships (World Health Organisation, 1986, Victorian Health Promotion Foundation, 2007).

[10] Commonly called the ecological model, the term will be simplified and used in this way throughout this paper.

[11] In this paper it will only be discussed in terms of primary prevention.

2.5 VicHealth Framework to guide primary prevention

While primary prevention work is happening across Australia, in the past decade the scope of this work has been strongest in Victoria, led by the Victorian Health Promotion Foundation (VicHealth).[12] VicHealth is one of a very small number of health promotion foundations established internationally, and the only one in Australia, with the explicit purpose of promoting health and well-being. VicHealth works in partnership with government, organisations, communities and individuals, and since the early part of this century has taken the lead in researching and developing programs to prevent violence against women.

VicHealth's *Preventing Violence Before it Occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria* (The Framework) demonstrates that efforts to prevent violence against women should be based on three interrelated themes. Promoting equal and respectful relationships between men and women; promoting non-violent social norms; and reducing the effects of prior exposure to violence and improving access to resources and systems of support (Victorian Health Promotion Foundation, 2007).

As well as mainstream efforts, the VicHealth Framework identifies particular population groups and actions for prevention activities. Population groups include children, young people, women and men, disadvantaged neighbourhoods, Indigenous communities, rural communities, culturally and linguistically diverse communities and women with disabilities. Preventative actions include research, monitoring and evaluation, direct participation programs, organisational and workforce development programs, community strengthening, communications and social marketing, advocacy and legislative and policy reform.

Settings and sectors for action include community services, corporate, faith communities, education, workplaces, cultural institutions and networks, arts, sport and recreation, media and popular culture, local government, health, cyberspace and new technologies, justice, academic and military/like institutions (Victorian Health Promotion Foundation, 2007).

VicHealth also identifies medium term outcomes. For example, at the *individual/relationship* level these may include improved access to support and resources, equitable gender relations and improved skills in non-violent conflict resolution. *Organisational outcomes* might include organisations that model and facilitate equal, respectful and non-violent gender relations. *Community outcomes* could lead to environments that value and support norms which are non-violent, which build connections between people and take action to address violence if it does occur. *Societal outcomes* might include strong legislative and regulatory frameworks for gender equality and healthy relationships between men and women. VicHealth also argues that these outcomes would in turn lead to long term benefits for individuals, communities and society as a whole. (Victorian Health Promotion Foundation, 2007).

VicHealth has developed a guide to primary prevention of violence against women based on the ecological framework (Victorian Health Promotion Foundation, 2007), an extract of which is reproduced below.

2.5.1 Key determinants of violence and theme for action

PROMOTING EQUAL AND RESPECTFUL RELATIONSHIPS BETWEEN MEN AND WOMEN		
Individual determinants	**Community/organisation contributors**	**Societal contributors**
▪ Rigid gender roles/weak support for gender equality ▪ Masculine sense of entitlement ▪ Male dominance and control of wealth in relationships	▪ Masculine peer and organisational cultures ▪ Culturally specific norms regarding gender and sexuality	▪ Institutional and cultural support for, or weak sanctions against gender inequality and rigid gender roles.

[12] VicHealth is a statutory authority with a tripartite governance structure (including government, community and VicHealth representatives) which was established by the Victorian Parliament as part of the Tobacco Act 1987.

2.5.2 Key contributing factors and themes for action

PROMOTING NON-VIOLENT NORMS/REDUCING THE EFFECTS OF PRIOR EXPOSURE TO VIOLENCE		
Individual determinants	**Community/organisation contributors**	**Societal contributors**
▪ Attitudinal support for violence against women ▪ Witnessing or experiencing family violence as a child ▪ Exposure to other forms of interpersonal or collective violence ▪ Use and acceptance of violence as a means of resolving inter-personal disputes	▪ Neighbourhood, peer and organisational cultures which are violence supportive or have weak sanctions against violence ▪ Community and peer violence	▪ Approval of, or weak sanctions against violence or violence against women ▪ Ethos condoning violence as a means of settling interpersonal, civic or political disputes ▪ colonisation
IMPROVING ACCESS TO RESOURCES AND SYSTEMS OF SUPPORT		
Individual determinants	**Community/organisation contributors**	**Societal contributors**
▪ Social isolation and limited access to systems of support ▪ Income, education and occupation ▪ Relative labour force status ▪ Alcohol or illicit drug use ▪ Poor parenting ▪ Poor mental health ▪ Relationship and marital conflict ▪ Divorce/separation	▪ Weak social connections and social cohesion and limited collective activity among women ▪ Strong support for privacy of the family ▪ Neighbourhood characteristics (service infrastructure, unemployment, poverty)	▪ Support for the privacy and autonomy of the family ▪ Unequal distribution of material resources (unemployment, education)

2.6 Good practice in primary prevention

In 2006 the UN Secretary General reported to the General Assembly on the *In-Depth Study on All Forms of Violence against Women*. The report articulated general principles, based on international evidence, for good practice in prevention. These principles can be applied to all programs and are mapped here against the levels of the ecological model:

Societal level: prioritising the prevention of violence against women in all policies and programs; allocating specific resources within all sectors for prevention activities, and seeking political support for sustained, long-term investment in prevention (United National General Assembly, 2006). Community and media programs should also be supported by Government laws and policies that promote gender equality (World Health Organisation, 2009).

Community/Organisation Level: developing prevention strategies that address the root causes of violence against women, particularly the persistence of gender-based stereotypes; outlining clear objectives, defining what prevention strategies are seeking to change and how; and putting in place a process of monitoring and evaluation. Working with a cross-section of stakeholders, including government bodies, NGOs, workers' and employers' organizations and local community leaders, to build inclusive and effective strategies; and promoting women's safety, including by altering physical environments where necessary

Individual/relationship level: engaging men and boys proactively in strategy development and implementation for the prevention of male violence against women; highlighting the fact that violence against women is unacceptable and its elimination is a public responsibility; ensuring that prevention efforts are holistic, take into account multiple discrimination and connect wherever possible with other key issues for women (United Nations General Assembly, 2006).

Prevention programs need to be developed using a consistent, evidence based framework. When planning a prevention initiative it is vital to consider how this work can complement and reinforce similar approaches occurring at other levels. In this way multiple settings and sectors can work coherently to build the necessary momentum to effect long term cultural change. For example, an education program in a sports club or school may have a primary focus on the individual/relationship level of the social ecology, but it can draw upon examples of respect in the wider community by using 'teachable moments'[13] from the media or current affairs to encourage participants to think more broadly than their own immediate lives and relationships.

Many small and medium sized programs are currently in progress in communities across Australia; as these programs develop a growing body of knowledge is emerging from practice. The combined effect of this will create a groundswell of momentum and lead to the kind of long term cultural change that is required for the ultimate elimination of violence against women and the creation of a society in which all people are equal, and respectful relationships and behaviours are the norm.

2.6.1 Principles for community mobilisation

In addition to the comprehensive principles for prevention (discussed above), other sources have articulated principles for community mobilisation and prevention education.

The World Health Organisation (2007) identified principles for conducting community based primary prevention education. These include: the use of participatory methods for effectively engaging participants; fostering an enabling social environment to increase the likelihood that positive behaviour change will be sustained; employing and training facilitators with high quality skills; providing long term follow-up to support and sustain changes brought about by the program; and combining education with wider advocacy and community mobilisation activities.

A community mobilisation approach that reaches each level of the ecology has been advocated by Michau (2005). These include:

A proactive approach: primary prevention assumes that it is not enough to provide services for women experiencing violence, or to promote prevention without challenging communities to examine the assumptions which perpetuate it. The root causes of violence against women must be addressed through gender based analysis of why violence occurs – such as the imbalance of power between women and men and rigid gender roles.

A holistic approach: violence prevention should be relevant and recognise the multifaceted and interconnected relationships between individuals and institutions. The complex histories, cultures and relationships that shape a community must be acknowledged and accommodated. To generate momentum for change a wide cross section of community members must be engaged, not just women or one sector, such as police or the health care system.

A process of social change: changing attitudes, values and norms is a process, not a one off event. Projects should be based on an understanding about a systematic process of change, implemented by skilled facilitators who can guide a community on a journey of change.

Repeated exposure to ideas: individuals should be exposed to regular reinforcing messages from a range of sources over a sustained period of time. This means a co-ordinated approach across sectors with faith, school, sports, and arts communities, the media, and workplaces all communicating the same messages about violence against women being unacceptable under any circumstances, and respect and equality being desirable in relationships.

Community ownership: organisations can play a role in facilitating change, but it is in the hearts and minds of the individuals and groups in a community where change must occur. Therefore, it is those individuals and groups who must engage with and lead change.

2.6.2 Principles for prevention education

Prevention education programs are directed at children, young people and adults in a range of settings. Research in the USA noted a paucity of evidence concerning prevention education programs with young people that demonstrate disrupting sexually violent behaviours.

[13] Teachable moments are those times when a significant event occurs that can be used to 'educate' groups or individuals. For example, incidents of blatant disrespect or of gender inequality in the media or current affairs can be used as the basis for facilitated discussion to focus on what could have been done differently. Teachable moments are suggested as a strategy for Soccer's *Coaching Boy's into Men* program.

Tharp et al. argue that programs have forgone 'the standards of evidence and the principles of prevention to move a program more quickly into practice' (Tharp et al., 2011, p. 3384). To identify principles for prevention, these authors turned to prevention programs in areas such as delinquency, substance abuse, sexual risk and school failure, which they claim have demonstrated effectiveness. The principles identified include that programs should be comprehensive, use varied teaching methods, be theoretically driven, promote positive relationships, be appropriately timed in development, socio-culturally relevant, and employ well trained staff to ensure adequate implementation and are of sufficient 'dosage' to create behaviour change (Tharp et al., 2011).

In Australia work has also been done on developing principles for violence prevention. For example, the Social Justice and Social Change Research Centre at the University of Western Sydney identified six standards for education programs to prevent sexual assault, which extend to both community and school based programs (Carmody et al., 2009). The same year VicHealth also developed principles for respectful relationships education (Flood et al., 2009). Rather than go into detail about each authors' principles, here they are synthesised, as they are remarkably similar. Both reports suggest that programs must:

- be comprehensive
- be theoretically driven and address cultural and developmental concerns
- engage educators who are well trained and skilled in prevention education techniques, and use a positive, enabling approach
- use participatory approaches to effectively engage participants, and
- be subject to rigorous evaluation.

Research has demonstrated that to be effective, programs with school aged students should be part of a whole school approach[14] that promotes an ethos of equality, respect and non-violence throughout the school community, supported by policies (Flood et al., 2009, Dyson, 2008, Dyson et al., 2011). School programs should also be supported by community interventions that work to effect change in individuals and whole communities by addressing gender norms, and media interventions such as public awareness campaigns that challenge gender norms and attitudes through awareness raising activities.

Didactic approaches are unlikely to be effective in education programs. A number of alternative approaches to education shift the power focus away from the educator towards empowering learners. Critical pedagogy, founded by Paolo Friere, is concerned with the idea of a just society in which people have economic, political and cultural control over their lives (Aliakbari and Faraji, 2011). According to Freire (2005) traditional education works on a model that assumes information can be 'banked' by educators who hold 'knowledge' into students who are empty vessels and recipients of information; in this model, teachers are authorities and students (regardless of their age) are obedient to their authority (Friere, 2005). Individual learning styles differ, and varied approaches are appropriate to maximise learning in any group. Much learning is non-formal and essentially a social process. 'Learning is not just a psychological process, but is intimately related to the world and affected by it. People take on the knowledge, values, beliefs and attitudes of the society in which we live' (Jarvis, 1987, p. 11). Action learning is one form of critical pedagogy that is about learning from concrete experience and critical reflection, through group discussion, trial and error, discovery and learning from one another. It is a process by which groups of people work towards change on real issues or problems (Zuber-Skerritt, 2001).

Based on the principles for primary prevention programs identified above for community, and education programs, the following questions are proposed to guide practitioners planning a program to assess whether it meets the criteria for being primary prevention:

- Does it address sexist norms and promote gender equality?
- Is it comprehensive, contextualised and relevant to the setting and the individuals in it?
- Does it focus on structural as well as individual contributors to the problem?
- Does it have a clear program logic that is theoretically and empirically informed?
- Does it emphasise a positive, strengths based developmental process?
- Is it (or will it be) evaluated?

[14] A whole school approach is advocated as part of health promoting schools. This involves not only working with students and on the curriculum, but also addressing the health issue in school policies, the overall ethos and environment in the school and by engaging the wider school community including staff members, parents, students and relevant local community agencies.

2.6.3 Principles for awareness raising campaigns

Awareness raising campaigns are an important component of a comprehensive primary prevention approach. They should aim to change attitudes, behaviours and beliefs that normalise and tolerate gender based violence. Awareness-raising campaigns are recognised as the efficient and effective means of communicating information to the general public. Awareness raising should take a top down, bottom up approach, fostering communication and information exchange in order to improve mutual understanding as well as mobilising communities and the whole society to bring about the necessary change in attitudes and behaviour (European Institute for Gender Equality, 2013). They should have a strong basis in human rights and gender analysis; clear, appropriate, comprehensive definitions of violence; take a women/victim-centred approach; hold men/perpetrators accountable for the violence they inflict; emphasise equality and anti-discriminatory practice and recognise the diversity of women and men.

In Australia, VicHealth undertook a review of awareness raising campaigns and identified a number of principles for implementing such programs. These include:

- Pretesting, and 'on the ground' activities to avoid undesirable and unintended consequences of awareness campaigns (e.g. normalising abuse). Preparation for increased awareness also needs to include interagency responses and referral networks, so that responses to the campaign can be appropriately addressed.
- Need for a campaign to be based on social marketing and health promotion theory and for it to be developed using formative research with thorough pretesting.
- Developed from a theoretical base and/or had been developed using research or pre-testing. The authors also noted that few campaigns had been evaluated (Donovan and Vlais, 2005).

2.6.4 A Strengths Based approach

A strength based approach calls for programs to be positive, inclusive and enabling. Health promotion theory suggests that to be effective, programs must be 'salutogenic' (Antonovsky, 1996). Traditional, disease focused approaches to health use a 'pathogenic' model sit at one end of a continuum of approaches to health and well-being while salutogenesis sits are the other. Salutogenesis argues that health can be an asset held by individuals and groups which can promote positive well-being (Glasgow Centre for Population Health, 2011). In the salutogenic, or asset based approach, one type of intervention aims to strengthen resources such as self-management, community networks, and another aims to create meaning – interventions to increase perceptions of control (Harrop et al., 2006). An asset based approach makes visible and values the skills, knowledge, connections and potential in a community. It promotes capacity, connectedness and social capital (Glasgow Centre for Population Health, 2011). In primary prevention programs, it is important that it is positive, strengths based and that participants are engaged as partners in the change process, not as potential victims or perpetrators. This means not focussing too much on the negative aspects of abuse and disrespect, but focusing on promoting equal and respectful relations between women and men. It also means recruiting women and men as partners in prevention so that they take responsibility for identifying changes and making them happen.

2.6.5 Challenges to Primary Prevention

It is important to recognise that primary prevention in the field of preventing violence against women is a new and emerging field and practitioners may face challenges as they learn from experience.

One of these challenges is to maintain a focus on primary prevention rather than be drawn into tertiary, secondary prevention. Because tertiary work is more visible and tangible, funding bodies may try to combine response and prevention in one program. The response sector has historically struggled to provide safety and support for women who are victims of violence and it is vital that resources should not be taken from these services, and that they should not have to compete with for limited funding with the primary prevention sector.

Prevention requires specific skills which are different to those required for crisis response, and it is important that the workforce for each has a clear understanding of its roles and responsibilities and works together co-operatively. While the reason for running primary prevention programs is to eliminate violence against women, the focus of programs must be on the underlying causes. That is, the power imbalance, gender inequality between men and women and associated cultures of disrespect and abuse. These are the factors that give rise to, or create the conditions that lead to gender based violence. These conditions include the structural barriers of gender inequality and gender role socialisation, and the social norms that ignore, condone or support violence against women.

To achieve the goal of preventing and eliminating violence against women it is imperative that funding for evidence based primary prevention programs and research is not only maintained, but also expanded as new knowledge and understanding emerges.

3. Evaluating primary prevention programs

In the context of social programs, evaluation is a means of documenting what has happened, identifying what worked, what didn't work, assessing short and medium term outcomes and longer term impact. Process evaluation tells the 'story' behind the program as it develops. Outcome evaluation focuses on the effects of the program; the extent to which its goals and objectives were met, and any unexpected outcomes. Impact evaluation reports on the long term results of a program, analysing, for example, the long-term maintenance of change resulting from a program.

The work of primary prevention is not an exact science and evaluating the effectiveness of prevention programs can be difficult. Criteria for effectiveness depends on the findings of a well conducted, rigorous evaluation which focuses on outcomes in terms of not only knowledge and attitudes, but also on sustained behaviour change. The kind of high level measures that are often identified for primary prevention, for example, changes in community attitudes, are almost impossible to link to particular programs. Few studies have had the capacity to follow participants in a program longitudinally to understand what changes and which programs work (World Health Organisation, 2002, Quadara and Wall, 2012, Casey and Lindhorst, 2009).

Evaluation is a developing science and the increased demand for evidence based programs has increased pressure on the community sector to include evaluation as part of program plans; which rarely includes adequate funding for external evaluation. Earlier generations of evaluation focused on the evaluator as 'objective scientist' who stands outside of a program to judge its worth, or describe strengths or weaknesses. VicHealth has developed a capacity building approach to the evaluation of primary prevention programs. This will support community organisations to include internal evaluation, see, for example, Kwok (2013) and Flood (2013).

Evaluation capacity building has been defined as efforts to equip community sector practitioners with the skills to conduct evaluations and to integrate evaluation findings into practice (Flood, 2013). This approach was used in the five projects of the *Respect, Responsibility and Equality* programs funded by VicHealth between 2008 and 2011. According to Kwok (2013) primary prevention practice effects change incrementally and evaluation of programs should also be incremental. She identifies three key points which have emerged from the capacity building approach to evaluation:

- **First**, primary prevention evaluations must be *process* oriented – based on the understanding that the work is aimed at determinants level change. Primary prevention is about a means not an end and evaluations must be means directed.
- **Second**, evaluations must be prepared to explain the link between the program initiatives and the potential to influence determinants level change (that is, gender equality and respectful behaviours). They should be able to demonstrate that changes have occurred through realistic and measurable indicators.
- **Third**, evaluations are about practice that holds promise for longer term change. Promising practice is not necessarily practice that achieves a reduction in the problem, rather it is practice that is shown to potentially influence the root causes of the problem, in this case, the social norms that make violence against women acceptable in the first place (Kwok, 2013).

3.1 Knowledge transfer and exchange

Knowledge transfer and exchange is a process which brings together researchers and the individuals, groups and communities which have a stake in participating in, or using research or evaluation findings to exchange ideas, evidence and expertise. In other words, research informs (evidence based) practice and practice in turn informs research to ensure a continuous cycle. It is a critical part of the research process and can take the form of:

- building links to ensure that research informs and is informed by policy and practice.
- developing and maintaining relationships between researchers and those who have a stake in informing or using the results of the research.

- disseminating research outcomes in ways that are accessible and comprehensible to the relevant stakeholders.

Anecdotally there are many other projects in progress and completed, but almost no academic literature that analyses or reports on outcomes[15]. Added to this there are limited community reports that add to learning from empirical experience. Although a plethora of prevention programs have been funded over the past decade the lack of effective knowledge transfer and exchange is a major flaw that must be addressed. It is hoped that the Centre for Excellence and Foundation for the Prevention of Violence against Women (see below) established in 2013 may go some way to addressing this gap in knowledge

[14] What 'counts' as evidence is often limited to peer reviewed publications. There is a time delay – often of years – between the completion of research or evaluation, writing up results, submitting them to academic journals, peer review and final publication.

4. Policy Context

4.1 National, State and Territory Plans

The National, State and Territory Plans to address violence against women are summarised below. The plans all focus to some extent on the three levels of prevention (discussed on pages 16 and 17 of the paper). Response, service co-ordination and integration take a central position in most of the plans. Each plan has been analysed to understand the extent to which they address primary prevention and the three levels of the social ecology discussed on page 27. Although the various plans contain detailed strategies or action plans, the main focus of the summary here is on the extent to which the plans meet the criteria for primary prevention.

Plans were sourced from web searches, some were readily available on the relevant Government Department's web site, others were harder to find. In 2012 a progress report on the National Plan was submitted to the Australian Women against Violence Alliance (AWAVA). The report outlined primary prevention measures that had been implemented, including The Line social marketing campaign, respectful relationships programs in schools and community settings targeting young people, especially boys and community based in sporting organisations.

No other evaluation or update on the progress of the National Plan was found in searches of the Australian Government web site, of the departments responsible for implementation and co-ordination of the plan, or of the internet. In 2013 there were two significant developments related to the National Plan, the announcement of a Foundation for the prevention of violence against women and the National Centre for Excellence. The progress report to AWAVA also notes that the National Centre of Excellence (NCE) as a key strategy to deliver the Plan's goal of improving the evidence base and its application towards enhancing policy, programs and practice (FaHCSIA, 2012).

4.2 Summary of National and State Government Plans

Policy	Time frame	Goals/outcomes	Analysis
National Plan to Prevent Violence against Women and their Children	2010 – 2022	1. Communities are safe and free from violence 2. Relationships are respectful 3. Indigenous communities are strengthened 4. Services meet the needs of women and their children experiencing violence 5. Justice responses are effective 6. Perpetrators stop their violence and are held to account.	▪ Outcomes one & two meet the criteria for primary prevention. ▪ Outcome one addresses all levels of the social ecology. ▪ Outcome two emphasises the importance of working in schools with young people. ▪ Community programs have been funded as part of the plan but no evidence is yet available. ▪ In 2013 it was planned to include respectful relationships education in the national curriculum, identify primary prevention benchmarks and to work with the media to shape the broader conversation about violence against women.

Policy	Time frame	Goals/outcomes	Analysis
Queensland state plan: *For our sons and our daughters*	2009 - 2014	▪ All people, regardless of gender, age, sexual orientation or personal circumstance, are safe to live free from domestic and family violence in Queensland.	▪ No mention of primary prevention, the focus is on tertiary strategies. ▪ Schools program Social and Emotional Learning in Queensland to 'support children to develop positive behaviour and constructive social relationships' mooted but no details available. ▪ Although Queensland is a signatory to the National Plan and is active in a range of secondary and tertiary programs, a search of the Queensland Government web site revealed no annual reports for the current strategy, which expires in 2014.

Policy	Time frame	Goals/outcomes	Analysis
ACT Strategy: *Our Responsibility: Ending Violence against Women and Children*	2011-2017	▪ Women and children are safe because an anti-violence culture exists in the ACT ▪ Increase safety and security for women and children in public spaces ▪ Promote and support public discussions about violence against women and children ▪ Build respectful relationships initiatives, identify gaps and new target groups for education.	▪ Meets the criteria for primary prevention. ▪ Recognises violence against women as a human rights issue and an impediment to equality. ▪ Addresses all levels of the social ecology

Policy	Time frame	Goals/outcomes	Analysis
New South Wales: *Stop the Violence, End the Silence: NSW domestic and family violence action plan*	2010 (no end date)	Prevention goals: ▪ Increase community awareness that such violence is not acceptable ▪ Sustained, evaluated prevention strategies targeting the whole community and particular 'at risk' communities ▪ Mainstreaming preventative strategies across key government agencies.	▪ Primary prevention embedded in the plan. ▪ Stresses an integrated approach. ▪ Has immediate, medium and long term goals. ▪ Alludes to the ecological model

Policy	Time frame	Goals/outcomes	Analysis
Victoria: *Action plan to address violence against women & children: everyone has a responsibility to act*	2012 – 2015	▪ Addresses prevention, early intervention and response through an integrated system ▪ Educating to change attitudes and behaviours and to promote respectful non-violent relationships and engaging organisations and communities to promote gender equity and stop violence ▪ Fostering relationships, organisations, communities and cultures that are gender equitable and non-violent.	▪ Contains a clear definition of primary prevention and acknowledgement of the ecological model. ▪ Anecdotally an evaluation of the plan is planned, however evidence of this this was not found on the DHS web site. ▪ A strong primary prevention plan.

Policy	Time frame	Goals/outcomes	Analysis
South Australia: *A Right to Safety: the next phase of South Australia's Women's Safety strategy*	2011 – 2022	Prevention section has three main areas of focus: ▪ Promoting communities not to tolerate violence against women ▪ Promoting respectful relationships ▪ Promoting gender equality.	▪ Uses the VicHealth *Framework for primary prevention* and meets the criteria for primary prevention. ▪ Ecological approach not specified, however, the three outcomes address the individual, relationship, community and societal levels of the ecology.

Policy	Time frame	Goals/outcomes	Analysis
Western Australia: *Family and domestic violence prevention strategy to 2022*	2013-2022	▪ *Prevention and early intervention* states 'individual attitudes and behaviours within the community reflect that family and domestic violence in any form is not acceptable' ▪ Encourage schools and other educational institutions to implement Respectful Relationships Education Programs through integration into the mainstream curriculum ▪ Continue to raise awareness and support attitudinal change towards family and domestic violence through a range of social marketing campaigns targeted at diverse communities ▪ Build capacity and engagement with media outlets to promote appropriate and respectful reporting of family and domestic violence (Government of Western Australia, 2012).	▪ This strategy does not specify the use of, or define primary prevention or the ecological model; it has no mention of gender equality, and therefore, does not address the root causes of violence against women. ▪ Because it lacks these qualities, this plan, whist it addresses some components does not for the purposes of this paper meet the criteria for primary prevention.

Policy	Time frame	Goals/outcomes	Analysis
Tasmania: *Primary Prevention Strategy to Reduce Violence against Women and Children*	2012 – 2022	▪ Strongly aligned with the national plan ▪ Rejects outcomes 5 and 6 from the National Plan as being secondary and tertiary responses that should be addressed through the criminal justice system ▪ The implementation plan states that it will address social norms and practices relating to violence, gender roles and relations and access to resources and systems of support, and provides actions, and indicators for change for each stated action ▪ Each of the actions in the implementation plan address the broader factors that underpin the phenomenon of gender-based violence.	▪ Clearly defines primary prevention and the ecological model ▪ No evidence that it is being applied in practice.

Policy	Time frame	Goals/outcomes	Analysis
Northern Territory		No specific plan, links with the National Plan and VicHealth resources and AWHN National Women's Health Strategy.	

4.3 National Centre for Excellence

The National Centre for Excellence (NCE) was established in mid-2013, represents a key commitment under the National Plan and a specific component of the first three year plan 2010 – 2013. The main function of the NCE is to build the evidence concerning domestic violence and sexual assault, and it has responsibility for developing a national research agenda and program.

Prior to 2013 the Commonwealth Government funded two gender based violence clearinghouses to disseminate research and inform practice: the Australian Domestic Violence Clearinghouse and the Australian Centre for the Study of Sexual Assault. With the creation of the National Centre for Excellence (NCE) two key bodies responsible for research and knowledge transfer in the national plan are now defunded. According to the NCE web site the core functions of the two clearinghouses will continue under its aegis, and a phased approach to the transition will see the existing clearinghouses continue to provide certain functions and services while the NCE prepares for a transition late in 2014.

The NCE is located in Sydney; its functions are specified in the 2012 National Implementation Plan (discussed above) as being to:

- Lead national efforts to enhance the research base in the areas of domestic [and family] violence and sexual assault across research, education and service delivery organisations to support the National Plan;
- Focus on translating evidence into information to support ongoing improvement in the work of practitioners;
- Help inform policy development and service delivery responses; and
- Prioritise, coordinate and focus research efforts across the different outcomes of the National Plan, as well as taking account of priorities identified in other national research agendas.

Late in 2013 the NCE undertook a stakeholder engagement process to inform the development of a national research agenda and identification of research priorities for perpetrator intervention programs. The report of the stakeholder engagement process states that primary prevention remains an under researched area in relation to domestic and family violence, with the main research focus being on interventions (or tertiary prevention).

Initial funding of $1 million was provide to establish the NCE; from mid-2013 the Centre will receiving annual funding of $3 million, with the Australian Government providing $1.5 million annually and the remaining

$1.5 million being provided by state and territory governments on a cost shared basis (Department of Social Services, 2013).

In May 2014 the Federal Government re-launched the NCE under a new name, as Australia's National Research Organisation for Women's Safety (ANROWS).

4.4 Foundation for the Prevention of Violence against Women.

In July 2013 the Foundation to Prevent Violence against Women and their Children (the Foundation) was launched by the Commonwealth and Victorian Governments. The Foundation is a national, independent, not for profit, awareness-raising non-government organisation (NGO). It will engage the community in action to prevent violence against women and their children. The purpose of the Foundation is to harness community energy to reject inequality and violence against women, and drive a change in attitudes and behaviour (West et al., 2013). The role of the Foundation is to build on the National Plan, particularly in relation to primary prevention. Its objectives are to:

- Raise awareness and engage the community in taking action to prevent violence against women and their children;
- Drive a broad-based change in attitudes that condone or excuse violence against women and their children, and promote respect between women and men, including young people and children;
- Work with communities in which women and their children can be especially vulnerable to violence. This includes indigenous communities, culturally and linguistically diverse (CALD) communities and women and children with disabilities;
- Protect children through preventing violence against women, recognising the linkages between violence against women and child safety and well-being;
- Build a platform to bring together and support existing best practice primary prevention and other community organisations to collaborate in reducing violence against women and their children; and
- Establish an innovative and sustainable agency.

During the last half of 2013 community consultations were carried out around Australia with a range of stakeholders. The consultant's report on the national consultation process proposes that the Foundation should:

- Develop a national awareness raising strategy/ campaign to increase understanding across the country of the nature, dimensions, contributors and impacts of violence against women and their children, including a media/communications strategy;
- Develop a national primary prevention plan with implementation guidelines linked to the National Plan, National Framework for Protecting Australia's Children 2009-2020 and other relevant strategies/ frameworks; and
- Map key legislative and other systemic factors and develop a priority action plan to guide the changes required to assist in the prevention of violence.

At the time of writing this paper it was announced that the Foundation and the Victorian health Promotion Foundation (VicHealth) had formed a partnership to build, at the national level, on existing work to prevent violence against women. The first priority of the partnership is the development of national framework to provide a shared understanding of what needs to be done and ANROWS will be an equal partner in the frameworks development. (VicHealth, 2014).

5. Recommendations for a way forward

A sound foundation has been laid for the future development of primary prevention of violence against women in Australia. VicHealth has developed the evidence base and frameworks upon which to build primary prevention programs and the women's health sector across Australia has well developed skills for delivering such programs. This is not to suggest that all the answers are available and there is a great deal more to learn. With the backing of governments and the new non-government structures of the Foundation and Centre for Excellence, the stage is set for the work to continue and for ongoing improvement in knowledge and skills to occur. Based on the findings of this position paper, the Australian Women's Health Network (AWHN) proposes the following recommendations for a way forward in Australia to work towards the goal of eliminating violence against women.

To Federal, State and Territory Governments

Based on the findings of this position paper the Australian Women's Health Network recommends that Governments:

1. Recognise that no single initiative will prevent violence against women. Dedicated funding must be provided to the primary prevention sector to ensure activities can be delivered across the range of settings where people live, work and play to continue and expand the work of preventing and eliminating all forms of violence against women.
2. Continue to provide specific funding for the tertiary response sector at a level to ensure women who are subjected to intimate partner violence and sexual assault have adequate and appropriate services available to provide them with safety and support.

This position paper has highlighted the importance of a collaborative, coordinated integrated approach to address violence against women. We believe that a national body is required to ensure the successful implementation of the recommendations contained on this paper. We therefore recommend that:

3. Responses to violence against women be guided by a national advisory structure of all relevant stakeholders. This would include governments, the Foundation, ANROWS, AWAVA, women's health and other community organisations. The national advisory body would be responsible for developing a collaborative multi-year workplan between member stakeholders.

Further, we recommend that:

4. All community projects funded by the Commonwealth Government are evaluated (using either an external evaluation approach or a capacity building internal evaluation approach as discussed on page 29 of this position paper) and that reports of these evaluations are made freely available to the primary prevention sector to build the evidence base and to ensure ongoing learning. The multi year workplan discussed in Recommendation 3 should also be accompanied by an appropriately funded, substantive meta-evaluation of whole of population change.

It is the role of government to ensure gender equity is enshrined in all Commonwealth and State laws, policies and practices. We therefore recommend:

5. All government policies should be reviewed regularly using a gender lens and when necessary updated to ensure that gender equality is enshrined in all its practices.
6. A communication strategy should be undertaken to promote gender equality laws and policies to ensure they are understood and adhered to by government, business and non-government sector organisations.
7. Governments and political parties at all levels should comply with and model gender equality in all appointments and committees.

It is commendable that Australia has a long term prevention plan in place; however, preventing violence against women is both an urgent and long term task that should not be subject to changes of government. The AWHN therefore recommends:

8. That Governments should publish regular updates on the progress of Commonwealth, state and territory prevention of violence against women plans. Reports from community programs funded under these plans should also be made available to ensure effective knowledge exchange occurs to inform ongoing practice.

There is a considerable focus on educating young people in equal and respectful relationships in the Commonwealth plan to prevent violence against women. The AWHN therefore recommends:

9. Respectful relationships education programs be incorporated into all schools' curricula from kindergarten through year 12.
10. All school programs are developed using the good practice principles detailed on page 24 of this position paper, using a whole school (health promoting) approach.
11. Long term funding be provided to continue improving and expanding primary prevention approaches across settings. This should include a long term commitment to evaluation.

To the Foundation to Prevent Violence against Women and their Children

Based on the published roles and functions of the Foundation detailed on pages 34 & 35 of this position paper, the AWHN recommends:

12. Awareness raising programs developed and conducted by the Foundation should be evidence based, and draw on the good practice principles for community programs identified on page 24 of this position paper.
13. The Foundation develops a nationally agreed framework (including detailed definition of, and principles for primary prevention) to guide program development and implementation. This should be used to assess applications at all levels for funding primary prevention programs. Criteria for assessing primary prevention are suggested on page 24 of this position paper.

The media can play an important role in the primary prevention of violence against women. The EVAs[16] in Victoria has established that collaborations between NGO and media representatives can be productive. We therefore further recommend:

14. The Foundation works collaboratively with media outlets regardless of the platform to develop voluntary standards for reporting and advertising that reflects gender equality and respectful representations of women and men.

To Primary Prevention Practitioners

Two key bodies stand out as having the knowledge and experience in both the social determinants of health and primary prevention, VicHealth and the women's health sector Australia wide. VicHealth has provided the evidence base upon which programs can be developed and the women's health sector has well developed skills in health promotion and primary prevention. The AWHN therefore recommends:

15. At a minimum, primary prevention programs should promote gender equality and respectful relationships, as well as challenging violence supportive behaviours, environments and structures that are the social determinants of violence against women.
16. Primary prevention programs be planned using the good practice principles identified in section 2.6 of this position paper.
17. Because gender inequality and the social determinants of health are critical factors underpinning violence against women, a gendered lens should be applied to the planning of primary prevention programs to ensure the underlying factors of gender and power are incorporated into all program plans.

[16] The Eliminating Violence Against Women Media Awards.

References

ABRAMSKY, T., WATTS, C. H., GARCIA-MORENO, C., DEVRIES, K., KISS, L., ELLSBERG, M., JANSEN, H. A. & HEISE, L. 2011. What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women's health and domestic violence. Biomed Central Public Health 11, 17 pages.

ALIAKBARI, M. & FARAJI, E. 2011 Basic Principles of Critical Pedagogy. International Proceedings of Economics Development and Research 17

ANTONOVSKY, A. 1996. The salutogenic model as a theory to guide health promotion. Health Promotion International, 11, 11-18.

AUSTRALIAN BUREAU OF STATISTICS 2006. Personal Safety Survey, Australia. Canberra: Commonwealth of Australia.

AUSTRALIAN WOMEN'S HEALTH NETWORK 2012. Women and Health and Well-being. Drysdale, Victoria.

AUSTRALIAN WOMEN'S HEALTH NETWORK 2013. Women Health: Meaningful measures for population health planning. Drysdale, Victoria.

BENEDICT, J. R. 1998. Athletes and Acquaintance Rape, Thousand Oaks CA, Sage.

BERKOWITZ, A. 2002. Fostering Men's Responsibility for Preventing Sexual Assault. In: SCHEWE, P. (ed.) Preventing Violence in Relationships: Interventions Across the Life Span. Washington DC: American Psychological Association.

BERKOWITZ, A. 2003. Applications of Social Norms Theory to Other Health and Social Justice Issues. In: H. WESLEY PERKINS, E. (ed.) The Social Norms Approach to Preventing School and College Age Substance Abuse. Jossey Bass.

BLYE, F., MICHAEL, K., TRUDY, L. & KEVIN, D. 2003. A Tangle of Trouble: boys, masculinity and schooling-future directions. Educational Review, 55.

BOGGS, C. 1976. Gramsci's Marxism, London, Pluto Press.

BOSWELL, A. A. & SPADE, J. Z. 1996. Fraternities and College Rape Culture Gender & Society, 10, 133-147.

CARMODY, M., EVANS, S., KROGH, C., FLOOD, M., HEENAN, M. & OVENDEN, G. 2009. Framing Best Practice: National standards for the primary prevention of sexual assault. Sydney: National Sexual Assault Prevention Education Project for The National Association of Services Against Sexual Violence. .

CASEY, E. A. & LINDHORST, T. P. 2009. Toward a Multi-Level, Ecological Approach to the Primary Prevention of Sexual Assault: Prevention in Peer and Community Contexts. Trauma, Violence, & Abuse, 10, 91-114.

CHUNG, D., ZUFFEREY, C. & POWELL, A. 2012. Preventing violence against women in the workplace (An evidence review: full report). . Melbourne, Australia: Victorian Health Promotion Foundation.

COKER, A. L. 2004. Primary Prevention of Intimate Partner Violence for Women's Health: A Response to Plichta. J Interpers Violence, 19, 1324-1334.

CONNELL, R. 2003. The Role of Men and Boys in Achieving Gender Equality [Online]. United Nations Division for the Advancement of Women

CORBOZ, J., FLOOD, M. & DYSON, S. forthcoming. Challenges of Bystander Intervention in Elite Sport: Lessons from the Australian Football League. Violence Against Women.

DEPARTMENT OF SOCIAL SERVICES. 2013. National Centre for Excellence [Online]. Canberra: Commonwealth of Australia. Available: http://www.dss.gov.au/our-responsibilities/women/programs-services/reducing-violence/the-national-centre-of-excellence [Accessed January 21st 2014].

DONOVAN, R. & VLAIS, R. 2005. Review of Communication Components of Social Marketing/Public Education Campaigns Focusing on Violence Against Women. Melbourne: Victorian Health Promotion Foundation.

DYSON, S. 2008. Catching On Everywhere: Evaluation of a whole school sexuality education project in 50 Victorian schools [Online]. Melbourne: Victorian Government Department of Education. Available: http://www.eduweb.vic.gov.au/edulibrary/public/teachlearn/student/coeverywherept1.pdf [Accessed February 24th 2009].

DYSON, S., BARRETT, C. & PLATT, M. 2011. 'The school's a calmer place': Promoting cultures of respect in schools. . Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University.

DYSON, S. & FLOOD, M. 2008. Building Cultures of Respect and Non-Violence. Melbourne: Australian Football League and VicHealth.

EUROPEAN INSTITUTE FOR GENDER EQUALITY 2013. Study on 'Collection of methods, tools and good practices in the field of domestic violence (area D of Beijing Platform for Action)': Awareness raising. Croatia: European Institute for Gender Equality.

FABIANO, P., PERKINS, W., BERKOWITZ, A., LINKENBACK, J. & STARK, C. 2003. Engaging Men as Social Justice Allies in Ending Violence Against Women: Evidence for a Social Norms Approach. Journal of American College Health, 52, 105-112.

FAHCSIA. 2012 Update to NPIP – Progress on National Priorities August 2012 [Online]. Available: http://awava.org.au/wp-content/uploads/2012/08/Update-to-NPIP-August-2012.pdf [Accessed January 16th 2014].

FLOOD, M. 2011. Involving Men in Efforts to End Violence Against Women. Men and Masculinities, 14, 358-377.

FLOOD, M. 2013. Trends in Evaluation: Preventing Violence against women. Paper 1. VicHealth.

FLOOD, M., FERGUS, L. & HEENAN, M. 2009. Respectful Relationships Education: Violence prevention and respectful relationships education in Victorian secondary schools. Melbourne: Victorian Health Promotion Foundation.

FOUCAULT, M. 1980. Power/ Knowledge, New York, Harvester Press.

FREIRE, P. 2005. Education for critical consciousness, New York, Continuum International Publishing Group.

GARCÍA-MORENO, C., PALLITTO, C., DEVRIES, K., STÖCKL, H., WATTS, C. & ABRAHAMS, N. 2013. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Switzerland: World Health Organization

GIDDENS, A. 1979. Central Problems in Social Theory: Action, Structure and Contradictions in Social Analysis, University of California Press.

GLASGOW CENTRE FOR POPULATION HEALTH 2011. Asset based approaches for health improvement: redressing the balance. Glasgow Centre for Population Health.

GOVERNMENT OF WESTERN AUSTRALIA 2012. Western Australia's Family and Domestic Violence Prevention Strategy to 2022.

GRAPE, M. 2012 The Role of Faith Based Organisations in a Strategy to Eliminate Violence Against Women and Girls Bangkok, Thailand UN Women in cooperation with ESCAP, UNDP, UNFPA, UNICEF and WHO

HAGEMANN-WHITE, C., KAVEMANN, B., KINDLER, H., MEYSEN, T. & PUCHERT, R. 2010. Review of Research on Factors at Play in Perpetration. Osnabruk, Germany: University of Osnabruk.

HALL SMITH, P., WHITE, J. & MORACCO, K. 2009. Becoming Who We Are: A theoretical explanation of gendered social structures and social networks that shape adolescent interpersonal aggression. Psychology of Women Quarterly, 33, 25-29.

HARROP, E., ADDIS, S., ELLIOTT, E. & WILLIAMS, G. 2006. Resilience, Coping and Salutogenic Approaches To Maintaining And Generating Health: A Review. Cardiff University.

HOLMES, S. 2012. Promoting Equal and Respectful Relationships in Faith Communities: a Manual and Tool Kit working together to prevent violence against women before it occurs. Darebin, Victoria: Darebin City Council & The Victorian Health Promotion Foundation (VicHealth).

JARVIS, P. 1987. Adult Learning in the Social Context, Indianapolis, MacMillan Publishing.

KWOK, W. L. 2013. Trends in Evaluation: Preventing violence against women. Paper 2. VicHealth.

MARTIN, S. L., COYNE-BEASLEY, T., HOEHN, M., MATHEW, M., RUNYAN, C. W., ORTON, S. & ROYSTER, L.-A. 2009. Primary Prevention of Violence Against Women: Training Needs of Violence Practitioners. Violence Against Women, 15, 44-56.

MATON, K. I. 2000. Making a Difference: The Social Ecology of Social Transformation Journal American Journal of Community Psychology 28, 25-57.

MELNICK, M. 1992. Male athletes and sexual assault. Journal of physical education, recreation and dance, 63, 32 – 35.

MICHAU, L. 2005. Violence against women: Good Practice in designing a community-based approach to prevent domestic violence. Vienna, Austria: UN Division for the Advancement of Women in collaboration with UN office on Drugs and Crime.

NATIONAL COUNCIL TO REDUCE VIOLENCE AGAINST WOMEN AND THEIR CHILDREN 2009. Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009 – 2021. Canberra: Commonwealth of Australia.

NATIONAL PUBLIC HEALTH PARTNERSHIP 2006. The Language of Prevention. Melbourne: NPHP.

PEERSMAN, G. 2001. Promoting health: principles of practice and evaluation. In: OLIVER, S. & PEERSMAN, G. (eds.) Using Research for Effective health Promotion. Buckingham: Open University Press.

QUADARA, A. & WALL, L. 2012. What is effective primary prevention in sexual assault? Translating the evidence for action. ACSSA Wrap, 11.

ROSEN, L. N., KAMINSKI, R., MOORE PARMLEY, A., KNUDSON, K. & FANCHER, P. 2003. The Effects of Peer Group Climate on Intimate Partner Violence Among Married Male U.S. Army Soldiers. . Violence Against Women, 9, 1045-1071

SANDAY, P. R. 1996. Affirmative Consent. A Woman Scorned: Acquaintance Rape on Trial. . New York: Doubleday.

SAWICKI, J. 1991. Disciplining Foucault: Feminism, Power, and the Body, New York, Routledge.

THARP, A., DEGUE, S., LANG, K., VALLE, L., MASSETTI, G., HOLT, M. & MATJASKO, J. 2011. Commentary on Foubert, Godin and Tatum (2010): The evolution of sexual violence prevention and the urgency for effectiveness. Journal Of Interpersonal Violence, 26.

UN DIVISION FOR THE ADVANCEMENT OF WOMEN 2008. Women 2000 and beyond: the role of men and boys in achieving gender equality. United Nations Department of Economic and Social Affairs.

UN WOMEN 2012. Report of the Expert Group Meeting on Prevention of Violence against Women and Girls In: FERGUS, L. (ed.). Bangkok, Thailand 17-20 September 2012 UN Women in cooperation with ESCAP, UNDP, UNFPA, UNICEF and WHO.

UNITED NATIONAL GENERAL ASSEMBLY 2006. Convention on the Elimination of All Forms of Discrimination against Women. In: NATIONS, U. (ed.) Resolution A/60/503. Dag Hammarskjöld Library United Nations

UNITED NATIONS 1993. Declaration on the Elimination of Violence against Women. Geneva: United Nations.

UNITED NATIONS GENERAL ASSEMBLY 2006. In-Depth Study on All Forms of Violence against Women: Report of the Secretary General.

VICTORIAN HEALTH PROMOTION FOUNDATION 2004. The health costs of violence -Measuring the burden of disease caused by intimate partner violence. Melbourne Victorian Health Promotion Foundation.

VICTORIAN HEALTH PROMOTION FOUNDATION 2007. Preventing Violence Before it Occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria. Melbourne: VicHealth.

VICTORIAN HEALTH PROMOTION FOUNDATION 2008. Violence Against Women in Australia As a Determinant of Health. Research Paper 4. Melbourne.

VICTORIAN HEALTH PROMOTION FOUNDATION 2010. National Survey on Community Attitudes to Violence Against Women 2009: Changing cultures, changing attitudes – preventing violence against women. A Summary of Findings. Melbourne: Victorian Health Promotion Foundation.

VICTORIAN HEALTH PROMOTION FOUNDATION 2012. The Respect , Responsibility and Equality program. A summary report on five projects that build new knowledge to prevent violence against women. Melbourne, Australia: Victorian Health Promotion Foundation.

VICTORIAN HEALTH PROMOTION FOUNDATION 2014. New partnership delivers national focus on violence prevention 10.04.14 Partner Media Release Available: http://www.vichealth.vic.gov.au/Media-Centre/Partner-media-releases/New-partnership-delivers-national-focus-on-violence-prevention.aspx

WEST, R., PLANT, A. & SCOTT, M. 2013. The Foundation to Prevent Violence against Women and their Children Report of the National Consultations. Balmain, NSW: WestWood Spice.

WORLD HEALTH ORGANISATION. 1986. Ottawa Charter for Health Promotion [Online]. WHO. Available: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/ [Accessed January 23rd. 2014].

WORLD HEALTH ORGANISATION. 1948. Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19 June – 22 July, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organisation, no 2, p 100) and entered into force on 7 April, 1948 (Vol 2003) [Online]. Geneva: WHO. Available: http://www.who.int/3by5/partners/NGOguidingprinciples.pdf.

WORLD HEALTH ORGANISATION. 1986. Ottawa Charter for Health Promotion [Online]. WHO. Available: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/ [Accessed January 23rd. 2014].

WORLD HEALTH ORGANISATION 2002. World report on violence and health. Geneva: WHO.

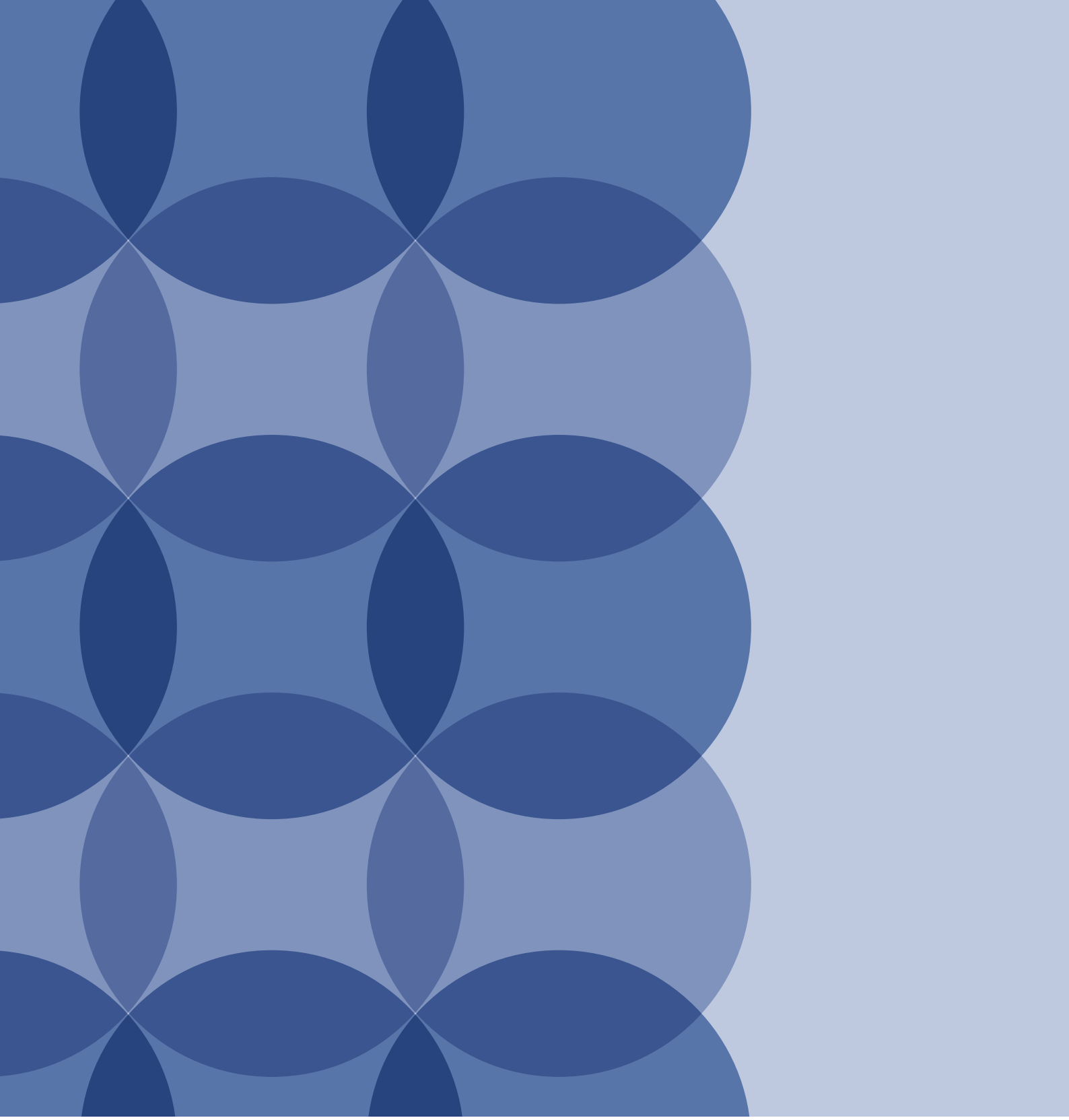
WORLD HEALTH ORGANISATION 2007. Primary prevention of intimate partner violence and sexual violence: Background paper for WHO expert meeting May 2-3 2007.

WORLD HEALTH ORGANISATION 2009. Promoting gender equality to prevent violence against women. Geneva, Switzerland: World Health Organization.

WORLD HEALTH ORGANISATION. 2013. What are social determinants of health? [Online]. World Health Organisation,. Available: http://www.who.int/social_determinants/sdh_definition/en/index.html [Accessed January 5th. 2014].

WORLD HEALTH ORGANISATION. 2014. What do we mean by “sex” and “gender”? [Online]. Available: http://www.who.int/gender/whatisgender/en/ [Accessed January 9th 2014].

ZUBER-SKERRITT, O. 2001. Action Learning and Action Research: paradigm, praxis and programs. In: SANKARA, S., DICK, B. & PASSFIELD, R. (eds.) Effective Change Management Through Action Research and Action Learning: Concepts, Perspectives, Processes and Applications Lismore: Southern Cross University Press.



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