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to Reduce Violence against Women & their Children

Compass

Research to policy and practice

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A preventable burden: Measuring and
addressing the prevalence and health impacts
of intimate partner violence in Australian women:
Key findings and future directions

Kim Webster

ANROWS Compass (Research to policy and practice papers) are concise papers that summarise key findings of research on violence against women and their children, including research produced under ANROWS's research program, and provide advice on the implications for policy and practice.

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ANROWS acknowledges the traditional owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander elders past, present and future; and we value Aboriginal and Torres Strait Islander history, culture and knowledge.

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Contents

The study in infographics.....	2
About this Compass.....	5
An overview of the findings.....	7
Key terms.....	8
About burden of disease and the study method.....	10
Prevalence of intimate partner violence.....	12
Study findings: Impacts of intimate partner violence on the health of women	14
Study findings: Disease burden of intimate partner violence	17
Study findings: Prevalence and burden among Indigenous women.....	23
Strengths and limitations of the study.....	31
Preventing the health impacts of intimate partner violence.....	33
Implications for policy, practice and research.....	38
Factors to consider when communicating the findings to others.....	42
References.....	44



Intimate partner violence

An avoidable burden on the health of women and their children



Intimate partner violence is common.



1 in 4 Australian women have experienced physical or sexual violence by an intimate partner since age 15.¹



1 in 3 Australian women have experienced physical or sexual violence and/or emotional abuse by an intimate partner since age 15.²



This includes violence or abuse by a partner they currently or have previously lived with, as well as violence perpetrated by a non-cohabiting partner.

¹ Cox, P. (2015). *Violence against women in Australia: Additional analysis of the Australian Bureau of Statistics Personal Safety Survey, 2012*. Sydney: ANROWS.

² Australian Bureau of Statistics, Personal Safety Survey, Customised Report, 2016. Does not include emotional violence in non-cohabiting relationships since this data is not available.

It has **serious** impacts on women's health.³



This includes injuries and homicide, poor mental health, reproductive health problems and problems with alcohol and drug use.

³ Lum On, M., Ayre, J., Webster, K., & Moon, L. (2016). *Examination of the health outcomes of intimate partner violence against women: State of knowledge paper*. Sydney: ANROWS.



Partner physical and sexual violence in cohabiting and non-cohabiting relationships and emotional abuse in cohabiting relationships

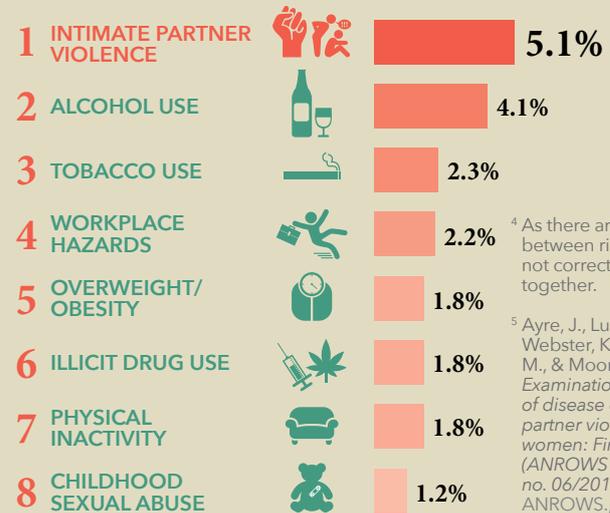
It contributes an estimated **5.1%** of the burden in women aged 18-44 years.⁵

This is more than any other risk factor.



Among all women it contributes an estimated 2.2% to the burden and is the seventh largest risk factor.

Top 8 risk factors contributing to disease burden in Australian women aged 18-44 years⁴ (% estimate)⁵



⁴ As there are interactions between risk factors, it is not correct to add them together.

⁵ Ayre, J., Lum On, M., Webster, K., Gourley, M., & Moon, L. (2016). *Examination of the burden of disease of intimate partner violence against women: Final report (ANROWS Horizons, no. 06/2016)*. Sydney: ANROWS.

Intimate partner violence has other negative consequences.



It violates the human rights of women and their children.



Affects access to housing and employment and increases gender inequality.



Is costly to women and the economy.



Impairs children's health and development now and in future generations.



Increases social and economic inequalities.

Intimate partner violence is preventable.

Preventing it should be a high priority for preventing poor health among Australian women.

The best way to reduce the health burden is to stop violence occurring in the first place.



Many factors contribute to intimate partner violence and we all have a part to play in addressing them. All sectors of society need to work together to create an environment in which women and their children are valued, respected and can live free from violence.

Primary prevention—stopping violence before it starts by tackling root causes

Early intervention with individuals and groups at high risk of perpetrating violence

Response—preventing recurring violence

Supporting recovery

Preventing health consequences

Minimising health consequences

Commonwealth, state and territory governments have developed policies and plans and conducted commissions and inquires to identify the actions to achieve this. A coordinated national approach is also supported through:



The National Plan to Reduce Violence Against Women and Their Children 2010-2022. A plan of all Australian governments to support and coordinate prevention and early detection of violence as well as responses to it.



Change the Story. A Shared Framework for the Primary Prevention of Violence Against Women and Their Children in Australia, focusing on preventing violence from occurring in the first place.



The burden of disease

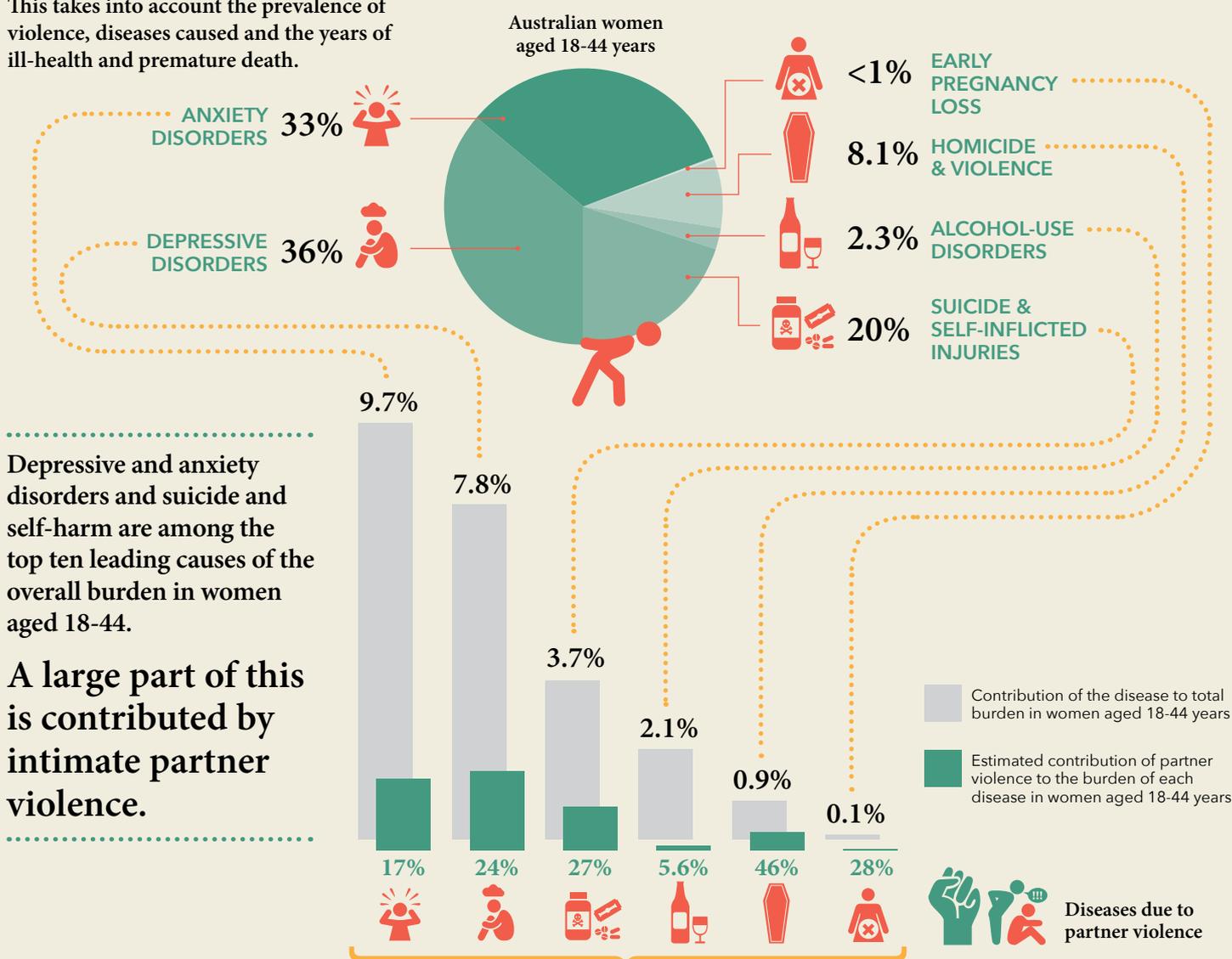
of intimate partner violence in more detail

Estimating the overall disease burden among Australian women



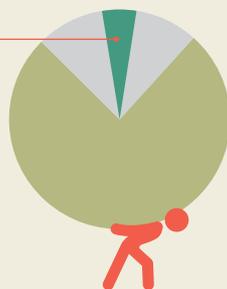
Estimating the disease burden of intimate partner violence

This takes into account the prevalence of violence, diseases caused and the years of ill-health and premature death.



Total disease burden women aged 18-44 years

ESTIMATED CONTRIBUTION OF INTIMATE PARTNER VIOLENCE 5.1%



Reducing intimate partner violence will help to reduce the burden of disease among Australian women.

Source: Ayre, J., Lum On, M., Webster, K., Gourley, M., & Moon, L. (2016). Examination of the burden of disease of intimate partner violence against women: Final report (ANROWS Horizons, no. 06/2016). Sydney: ANROWS.

The contribution of intimate partner violence to the gap between Indigenous and non-Indigenous women

Intimate partner violence is common.



An estimated **3 in 5** Indigenous women have experienced physical or sexual violence by an intimate partner since age 15.¹



This includes violence by a partner they currently or have previously lived with, as well as violence perpetrated by a non-cohabiting partner.

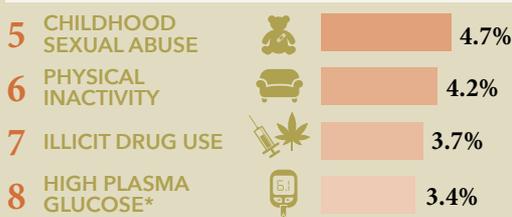
¹ Includes physical and sexual violence only. Data on emotional abuse is not available for Indigenous women.

It contributes an estimated 10.9% to disease burden in Indigenous women aged 18-44 years. This is more than any other risk factor.

Top 8 risk factors contributing to disease burden²



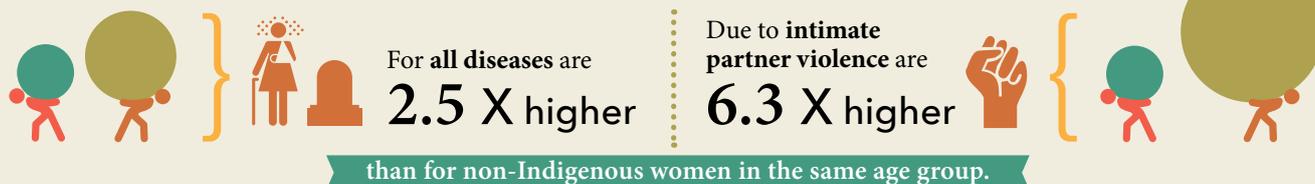
Among all Indigenous women it contributes 6.4% to the burden and is the third largest risk factor.



² As there are interactions between risk factors, it is not correct to add them together. * A risk factor for diabetes and other chronic diseases.

There is a gap in the burden between Indigenous and non-Indigenous women.

Among Indigenous women aged 18-44 years rates of burden:



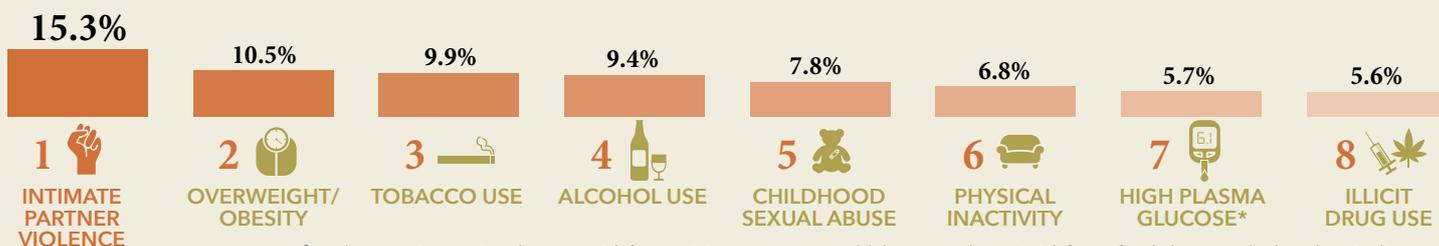
Estimated rates of burden for each disease due to intimate partner violence are higher among Indigenous women aged 18-44 years than non-Indigenous women of the same age.



Intimate partner violence contributes more than any other risk factor to the gap between Indigenous and non-Indigenous women aged 18-44 years.

Estimated contribution made by the top 8 risk factors to the gap in rate of total burden of disease between Indigenous and non-Indigenous women³

It is the sixth largest contributor to the gap among women of all ages.



³ As there are interactions between risk factors, it is not correct to add them together. * A risk factor for diabetes and other chronic diseases.

Eliminating intimate partner violence will help to close the health gap between Indigenous and non-Indigenous Australians.

Source: Ayre, J., Lum On, M., Webster, K., Gourley, M., & Moon, L. (2016). Examination of the burden of disease of intimate partner violence against women: Final report (ANROWS Horizons, no. 06/2016). Sydney: ANROWS.

About this Compass

This report outlines new findings on the health impacts of intimate partner violence and the contribution it makes to the overall disease burden in Australian women. The findings are considered in the context of other evidence and the implications for policy, practice and further research are discussed.

The research was led by the Australian Institute of Health and Welfare (AIHW). It built on previous developments to provide an updated estimate for intimate partner violence that:

- includes the latest evidence on its health impacts;
- is based on health consequences specifically relevant to Australian women; and
- takes into account the most recent estimate of prevalence of intimate partner violence in Australia (Australian Bureau of Statistics [ABS], 2013).

An estimate of the prevalence and burden of intimate partner violence among Aboriginal and Torres Strait Islander women (referred to as Indigenous women) was also made.

More detail on the study can be found in:

- Lum On, M., Ayre, J., Webster, K., & Moon, L. (2016) *Examination of the health outcomes of intimate partner violence against women: State of knowledge paper* (ANROWS Landscapes, no. 03/2016). Sydney: ANROWS; and
- Ayre, J., Lum On, M., Webster, K., Gourley, M., & Moon, L. (2016). *Examination of the burden of disease of intimate partner violence against women: Final report* (ANROWS Horizons, no. 06/2016). Sydney: ANROWS.

The Horizons report provides detailed technical information on the Burden of Disease method and findings. This Compass report explains this study for people less familiar with the methods and outlines key findings. In doing this, it focuses on two populations of particular interest to policy and practice—women of reproductive age (18–44 years) and Indigenous women.

The research also drew on:

- Cox, P. (2015). *Violence against women in Australia: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012* (ANROWS Horizons, no. 01/2016). Sydney: ANROWS;
- Australian Institute of Health and Welfare. (2016a). *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011* (Australian Burden of Disease Study series no. 3). Canberra: AIHW;
- Australian Institute of Health and Welfare. (2016b). *Australian Burden of Disease Study 2011: Methods and supplementary material* (Australian Burden of Disease Study series no. 4; Cat. no. BOD 6). Canberra: AIHW; and

- Australian Institute of Health and Welfare. (2016c). *Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011* (Australian Burden of Disease Study series no. 6; Cat. no. BOD 7). Canberra: AIHW.

An overview of the findings

Intimate partner violence, including violence in both cohabiting and non-cohabiting relationships and emotional abuse:

- **is prevalent**—affecting one in three women since the age of 15. One in four women have experienced violence or abuse from a cohabiting partner. If we only consider physical and sexual violence, then one in six women have experienced at least one incident of violence by a cohabiting partner;
- **has serious impacts for women's health**—contributing to a range of negative health outcomes, including poor mental health, problems during pregnancy and birth, alcohol and illicit drug use, suicide, injuries and homicide;
- **contributes an estimated 5.1 percent to the disease burden** in Australian women aged 18-44 years and 2.2% of the burden in women of all ages;
- **contributes more to the burden than any other risk factor** in women aged 18-44 years, more than well known risk factors like tobacco use, high cholesterol or use of illicit drugs;
- is estimated to **contribute five times more** to the burden of disease among Indigenous than non-Indigenous women;¹
- is estimated to make a **larger contribution than any other risk factor to the gap in the burden between Indigenous and non-Indigenous women** aged 18-44 years;² and
- **has serious consequences for the development and wellbeing of children** living with violence.

There has been no **decrease** in the **prevalence** or **health burden** of intimate partner violence since both were last measured in Australia.

Intimate partner violence and its health impacts are **preventable**. The health burden of intimate partner violence can be reduced by:

- **supporting** women and children's long-term recovery in the aftermath of violence;
- **responding** to violence to stop it occurring again;
- **intervening** when there are early warning signs of violence; and
- **preventing** violence from occurring in the first place by addressing known root causes.

Because experiencing intimate partner violence increases the risk of health problems, to substantially reduce the health burden, it will be necessary to prevent new cases of violence. This will require a **greater emphasis on early intervention and primary prevention** to stop violence from occurring in the first place.

There is agreement among expert bodies that reducing intimate partner violence and the health burden it causes will require a coordinated approach involving all levels of prevention and all sectors of society (Michau, Horn, Bank, Dutt, & Zimmerman, 2014; UN Women, 2015).

Australia is well placed to achieve this because the Commonwealth and state and territory governments have agreed to a coordinated national approach in the *National Plan to Reduce Violence against Women and their Children 2010-2022* (Council of Australian Governments, 2011). This study shows that it will be important to continue to support and strengthen this national approach.

There is a particular need for a focus on reducing violence affecting Indigenous women, and other groups of women experiencing more prevalent, severe or frequent violence.

¹ Based on age-standardised rates.

² The estimates for Indigenous women did not include the burden of emotional abuse, since data on emotional abuse is not available for Indigenous women.

Key terms

Violence: “any incident involving the occurrence, attempt or threat of either physical or sexual assault experienced by a person” (ABS, 2014a). As this report is based on data from the Personal Safety Survey, only incidents since the age of 15 are considered.

Physical violence: involves “the use of physical force with the intent to harm or frighten a person” or an attempt to inflict physical harm or “a threat or suggestion of intent to inflict physical harm, that was made face-to-face where the person believes it was able to and likely to be carried out” (ABS, 2014a).

Sexual violence: “an act of a sexual nature carried out against a person’s will through the use of physical force, intimidation or coercion”, including any attempts or “face-to-face threats to do this where the person believes it is able to and likely to be carried out” (ABS, 2014a).

Emotional abuse: behaviours aimed at preventing or controlling a person’s behaviour, with the intent to cause them emotional harm or fear (ABS, 2014a). There are many emotionally abusive behaviours. Some examples include:

- “stopping or trying to stop their partner from contacting or seeing family or friends;
- constant insults aimed at making their partner feel ashamed, belittled or humiliated;
- monitoring their partner’s whereabouts;
- lying to their child/children with the intent of turning them against their partner;
- controlling their partner’s access to employment, study or household money;
- depriving their partner of their basic needs such as food or sleep; and
- threats of harm against themselves or others” (ABS, 2014b).

A focus on men’s violence against female partners

Both men and women can experience intimate partner violence and both can perpetrate it. Violence is unacceptable regardless of who perpetrates it or the gender of the victim.

The focus of this report is on violence experienced by women. There are differences in the prevalence and patterns of intimate partner violence affecting men as compared with women, including that violence affecting women tends to be more frequent and prolonged, and is more likely to involve multiple forms of violence (Lum On et al., 2016).

The data used to estimate the burden of disease in this research are specific to women. Data specific to men would be needed to estimate the burden for men.

The data in this summary includes violence perpetrated against women by female partners. Violence perpetrated by a same- sex partner represents 0.1% of cohabiting violence (Cox, 2015, p. 35) and 0.2% of non-cohabiting violence experienced by women (Cox, 2015, p. 36). Therefore, the findings relate primarily to violence perpetrated by men.

Intimate partner violence: in this report a broad definition of intimate partner violence is used. It includes physical or sexual violence or emotional abuse perpetrated by a person who is:

- a cohabiting partner—that is a partner a woman currently lives with or has formerly lived with; or
- a non-cohabiting partner—that is boyfriends, ex-boyfriends, girlfriends, ex-girlfriends or dates.

Risk factor: any factor a person has encountered, experienced or had that causes a greater risk of a disease or injury. Intimate partner violence is an example of a risk factor. Other examples are smoking or being overweight or obese.

Diseases: Burden of disease studies measure the impact of injuries and illnesses. Sometimes these are called conditions or diseases. For ease of reference these are referred to collectively as “diseases” in this summary.

A note about definitions

The category of cohabiting partner includes both former and current partners with whom a person has lived. In this study intimate partner violence includes violence in both cohabiting and non-cohabiting relationships, and also includes emotional abuse. However, data is not currently available for all types of violence for all relationship types. This means that the study shows the burden for different types of violence and violence in different relationships. For clarity, throughout the report, each time data is presented, the violence and relationship types are first specified

About burden of disease and the study method

Burden of disease analysis is a standard, internationally accepted way of gauging the overall impact of a disease or risk factor, and of comparing diseases and risk factors with one another.

It measures health loss across a population for a particular year in the form of:

- **non-fatal burden:** the years of what could have been a healthy life, but were instead spent in states of less than full health. This is referred to as Years Lived with a Disability or the acronym YLD (Australian Institute of Health and Welfare, 2016a, p. 2); and
- **fatal burden:** the years of life lost due to premature death. This is defined as dying before the ideal life span (that is the life span that would have been achieved had it been lived free of disease and injury). This is referred to as Years of Life Lost or the acronym YLL (AIHW, 2016a, p. 2).

These are added together to produce a single measure referred to as a Disability-Adjusted Life Year or DALY. For ease of reference in this summary the term “burden” is used in place of DALY and all findings are expressed as percentages or rates of burden.

What is the purpose of burden of disease analysis?

Burden of disease studies can be used to:

- help make a problem visible;
- compare health problems and risk factors with each other when setting priorities for health and other social policy interventions;
- make comparisons between groups to assist with targeting interventions;
- study the economic costs of diseases and risk factors; and
- study the cost effectiveness of interventions.

Why do we need burden of disease estimates? Couldn't we just use data on rates of diseases and what people die from?

Burden of disease estimates are different because they take into account the severity of diseases, and their impact in terms of years lost and years they cause people to be unwell.

This is important because although we are living longer and with lower rates of life threatening diseases (AIHW, 2016a), people are spending a longer period of their lives with chronic diseases, such as cancer, heart disease and poor mental health.

As well as requiring treatment, chronic diseases have a broader social and economic impact that needs to be taken into account when policies, programs and services are developed and priorities are being set (AIHW, 2016a).

How is the burden of each disease measured?

In 2016 the Australian Institute of Health and Welfare calculated the burden of nearly 200 diseases. This was done through modelling using the following data (Forouzanfar et al., 2015):

Figure 1 Measurement of the burden of a disease



How was the burden of intimate partner violence (a risk factor) measured?

Figure 2 Measurement of the burden of a risk factor



Note: See Lum On et al., 2016 for more detail on the methods used to calculate the burden of disease of intimate partner violence.

Prevalence of intimate partner violence

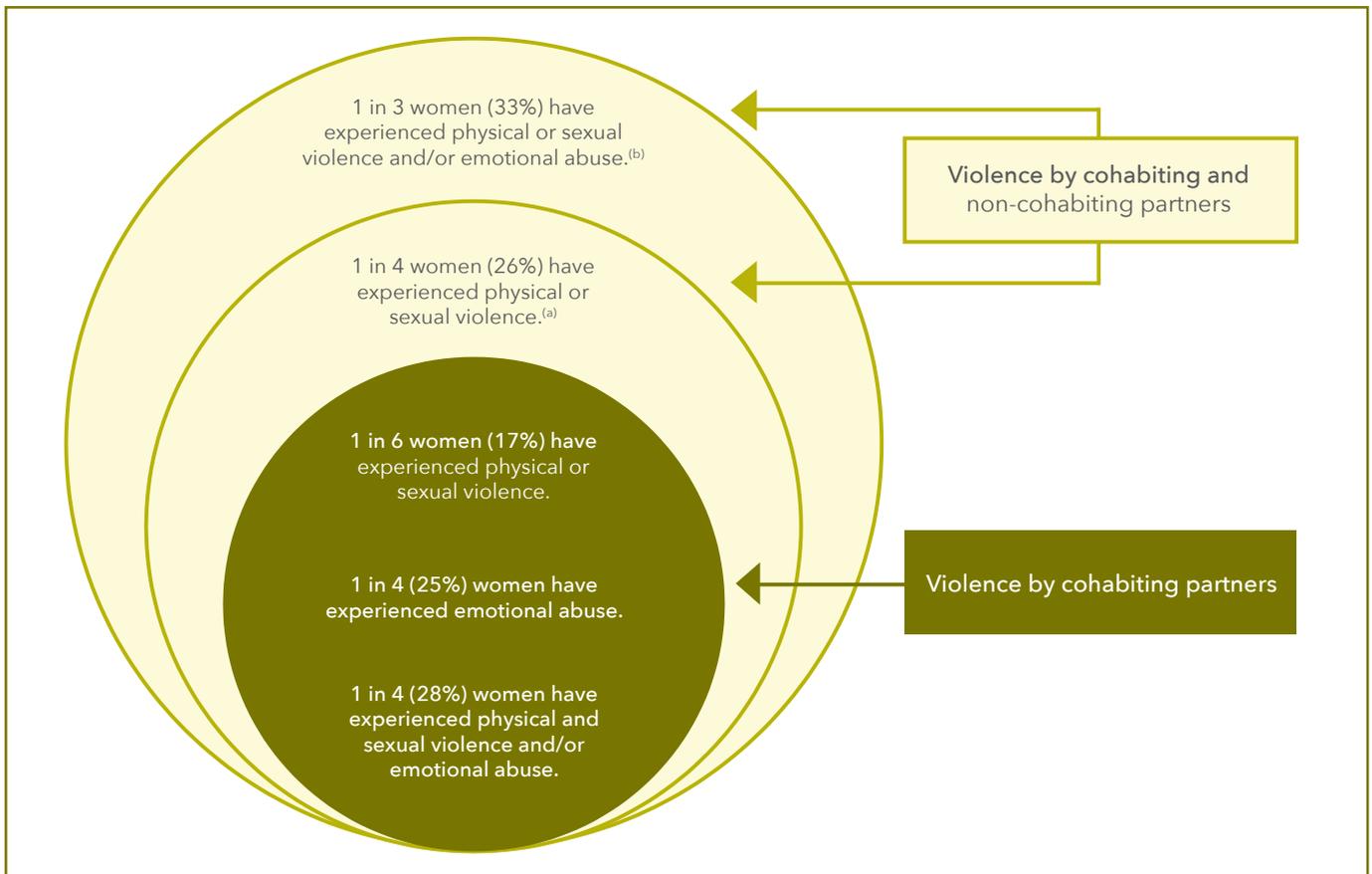
To calculate the burden of disease it is necessary to know the prevalence of the risk factor.

Prevalence was measured in this study using data from the Australian Bureau of Statistics' Personal Safety Survey 2012 (ABS, 2013a), which is funded by the Australian Government Department of Social Services. The survey measured experience of physical and sexual violence since the age of 15 years in both cohabiting and non-cohabiting relationships.

Data were also collected on emotional abuse experienced by women in cohabiting relationships (but not non-cohabiting relationships).

There has been no change in the lifetime experience of physical or sexual violence since age 15 among Australian women since the last Personal Safety Survey (PSS) conducted in 2005 (ABS 2013a).

Figure 3 Prevalence of intimate partner violence by relationship and violence type, Australian women in 2012



Note: (a) May include women who have experienced violence from a cohabiting and non-cohabiting partner
 (b) Emotional abuse refers to emotional abuse by a cohabiting intimate partner only as data on emotional abuse is not collected from women in non-cohabiting relationships. Sources for PSS data include the original ABS analysis (2013a) and additional data requests by ANROWS (Cox, 2015) and AIHW (Ayre et al., 2016).

Prevalence is higher for some women

The prevalence rates above are for the population as whole. In addition to Indigenous women (see p.23), intimate partner violence may be more prevalent and/or more severe and prolonged among women:

- with disabilities (Lum On et al., 2016);
- from some culturally and linguistically diverse communities (Lum On et al., 2016); or
- experiencing social and economic marginalisation (Sokoloff & DuPont, 2005).

Violence also affects women during pregnancy and the children in their care

Since the age of 15, more than 400,000 Australian women report experiencing violence during pregnancy (Cox, 2015, p.99).

Most women who had children in their care during a violent relationship reported that the children heard or saw the violence (Cox, 2015, p.102).

How was emotional abuse included in the burden of disease estimates?

Emotional abuse can be as harmful, if not more so, than physical and sexual violence (Lum On et al., 2016). Physical and sexual violence and emotional abuse often occur together (Lagdon, Armour & Stringer, 2014; Lum On et al., 2016). This means that in most studies on the health impacts of intimate partner violence, the impacts of emotional abuse are likely to be gauged, even if they are not separately measured.

However, some women experience emotional abuse on its own, that is, without physical or sexual violence. This group of women has a higher likelihood of developing certain health problems, especially poor mental health, than women who do not experience any form of intimate partner violence (Lum On et al., 2016).

In 2012, the Personal Safety Survey introduced new questions to measure emotional abuse in cohabiting relationships (ABS, 2014a). This data was used in this study to work out how many women experienced emotional abuse on its own.

In the Burden of Disease study, a separate calculation was done for this group and this burden was added to the burden from intimate partner physical and sexual violence. This calculation did not include the burden for all seven diseases that were in the physical and sexual violence estimate (see p. 14). Instead, a disease was only included in the emotional abuse burden when a study showed a specific link between it and emotional abuse (proven using the criteria described in Figure 2).

This is the first known estimate of the burden from emotional abuse in intimate relationships.

Study findings: Impacts of intimate partner violence on the health of women

There are a diverse range of health problems linked to intimate partner violence. Table 1 summarises those identified in this and prior research.

AIHW assessed each study using strict criteria (adapted from Lim et al., 2013) to see if there was sufficient evidence of a causal relationship. There was sufficient evidence from these studies for only seven health outcomes:

- anxiety;
- depression;
- suicide & self-inflicted injuries;
- alcohol-use disorders;
- homicide & violence;
- early pregnancy loss; and
- complications resulting from being born too early or being of lower than average weight at birth. This can cause complications for the infant that in turn result in health problems later in their life.

The studies for most of the conditions in Table 1 did not meet the required standard of evidence. This does not necessarily mean there is no link between intimate partner violence and these health outcomes. It may mean that there were insufficient studies using the required methodology. It is also possible that future studies may provide the required standard of evidence of a causal relationship.

The burden of pregnancy complications

The burden from pregnancy complications to infants due to intimate partner violence is considered in the main report. However, it was not included in the total burden of disease estimate for intimate partner violence. This is because these analyses were limited to the impacts on adult women. In contrast, pregnancy complications affect both male and female infants. Therefore, all of the analyses in this Compass include six of the seven outcomes above.

... and years of rebuilding my life. As a SURVIVOR. Sleep problems. Weight loss (but that was good, I guess). Flashbacks. Panic attacks. Nightmares (after ten years I still have nightmares). And becoming so sensitive about others who have also been “through tough times”.

– Myna

Table 1 Negative health outcomes associated with intimate partner violence

Fatal impacts	
	Homicide Suicide
Non-fatal impacts	
Injuries	Brain injury Loss of consciousness Genital trauma Fractures and sprains Lacerations, abrasions and bruising Self-harm
Mental health	Depression Anxiety Eating disorders Suicidal ideation
Substance abuse	Alcohol-use disorder Drug-use disorder
Conditions occurring in the period immediately before and after birth	Prematurity, low birth weight
Maternal health	Post-natal depression
Reproductive health	Early pregnancy loss (medical and spontaneous) Gynaecological problems
Involuntary symptoms causing pain or discomfort that cannot be explained by a medical cause (referred to as somatoform disorders)	Chronic fatigue Chronic pain Irritable bowel syndrome
Chronic disease	Cancer Cardiovascular: hypertension, coronary heart disease, stroke Musculoskeletal: arthritis, rheumatoid arthritis, gout, lupus, fibromyalgia
Infections	HIV/AIDS Other sexually transmissible infections
Behaviours and practices affecting health	Unsafe sex High body mass index (BMI) Harmful tobacco/drug/alcohol use
Barriers to accessing health/engaging in self-care	Lack of autonomy Difficulties seeking care Lack of access to contraception

Source: Adapted from WHO, 2013.

He didn't like my friends. He would put them down saying that they were a bad influence on me. He didn't like me going out to see my friends. I could not bring them home. So I felt isolated. I didn't talk about the violence to anyone, not even my primary family. I was ashamed. I felt that it was my fault that he was violent towards me.

– Jenny

How does intimate partner violence contribute to poor health?

The impacts of intimate partner violence on women's health need to be understood in terms of the nature of this violence, in particular that it:

- is often perpetrated repeatedly, rather than being a single incident (ABS, 2013a; Flood, 2006);
- often constitutes a pattern of behaviours perpetrated with the aim of controlling, intimidating and demeaning the victim (Stark, 2009; Wangmann, 2011);
- is a betrayal of the trust we usually expect in intimate relationships;
- is perpetrated by someone a woman may depend on for economic and social support, especially a concern if she has children in her care (Meyer, 2012); and
- is difficult to stop because there are many barriers to holding men accountable for their use of violence and to women seeking safety for themselves and their children (Victorian Royal Commission into Family Violence, 2016).

The particular ways in which intimate partner violence harms health may vary depending on the condition concerned. However, intimate partner violence can:

- disrupt and limit women's access to resources such as secure housing, social support, employment and income (Franzway et al., 2015). People who lack these resources experience poorer health than those with good access to them (Solar & Irwin, 2007);
- cause psychological problems that have been linked to poor physical and mental health, such as poor self-esteem, reduced autonomy and control and impaired trust in others (Evans, 2007; Matheson et al., 2015);
- cause women to delay seeking help for health problems, especially if it involves the perpetrator controlling his partner's movements (Wilson, Silberberg, Brown, & Yaggy, 2007);
- cause stress which can result in physical and biological changes in the body. These changes have in turn been found to cause diseases, in particular chronic diseases such as cancer, diabetes and heart disease (Gilbert et al., 2015; Scott-Storey, 2013);
- lead to women turning to behaviours that are not good for their health in order to manage the stress (e.g. tobacco, alcohol and illicit drug use) (Scott-Storey, 2013);

- impair women's ability to look after their own health (e.g. by maintaining good sleeping and eating habits) (Dillon, Hussain, Loxton, & Rahman, 2013). Their partner may also directly sabotage their attempts to look after their health. For example, many women who experience violence find it hard to negotiate safe sex. This means that they are vulnerable to unplanned pregnancy and sexually transmissible diseases (Maxwell, Devrie, Zions, Alhusen, & Campbell, 2015); and cause physical and cognitive injuries, some of which are fatal or cause long-term impairment (Coker, Smith, & Fadden, 2005).

Some of these problems (e.g. physical injuries) are immediate consequences of violence, while others (e.g. disorders resulting from alcohol misuse) may develop many years after violence first started. Some health problems associated with intimate partner violence, such as poor mental health or cognitive impairments, may persist long after the violence itself has stopped (Evans, 2007; Franzway et al., 2015).

Some of the diseases that intimate partner violence contributes to, can in themselves increase vulnerability to other negative health outcomes. For example, substance-use disorders and mental health problems often co-occur (Weaver, Glibert, El-Bassell, Resnick, & Noursi, 2015). When people have poor mental health, they are also more likely to have poor physical health (Kolappa, Henderson, & Kishore, 2013).

As intimate partner violence affects some groups of women more than others (see p.13), it can also compound existing inequalities in health between these groups and the population as a whole (Humphreys, 2007).

The impacts of intimate partner violence also extend to children exposed to violence against their mothers. Children who live with such violence are more likely to have a range of health, development and social problems, both during childhood and later in life (Campo, Kaspiew, Moore, & Tayton, 2014; Flood & Fergus, 2008; Holt, Buckley, & Whelan, 2008; Humphreys, Houghton, & Ellis, 2008; Richards, 2011).

Not all children who live with violence against their mothers go on to perpetrate violence or to be victims (Holt, Buckley, & Whelan, 2008). However, they are at a higher risk of doing so and this can contribute to intergenerational cycles of violence and associated disadvantage (Stith, Rosen, Middleton, Busch, Lundeberg, & Carlton, 2000).

Study findings: Disease burden of intimate partner violence

- An estimated 5.1% of the burden of disease among women aged 18-44 years was due to intimate partner violence. This includes physical and sexual violence in both cohabiting and non-cohabiting relationships, and emotional abuse in cohabiting relationships.
- Among all women, an estimated 2.2% of the burden was due to intimate partner violence, again including physical and sexual violence in both cohabiting and non-cohabiting relationships, and emotional abuse in cohabiting relationships.
- Among women aged 18-44 years, an estimated 0.4% of the burden was due to women in cohabiting relationships experiencing emotional abuse alone (that is, without physical or sexual violence). Among all women, 0.2% of the burden was due to women experiencing emotional abuse in cohabiting relationships alone.
- There has been no change in the estimated burden of physical and sexual intimate partner violence in cohabiting relationships between 2003 and 2011.

A note about definitions

In the following sections, unless it is specifically indicated, all figures are for the burden from physical and sexual violence and emotional abuse, and violence occurring in both cohabiting and non-cohabiting relationships (noting again that emotional abuse is not included for non-cohabiting relationships because data for emotional abuse in non-cohabiting relationships are not currently available).

However the burden is high regardless of the definition used.

As noted in Figure 4, the burden varies depending on which of the above categories is being considered. However, intimate partner violence is in the top ten risk factors contributing to the disease burden in women regardless of:

- which relationship types are being considered;
- whether the estimate is for all women or women aged 18-44 years;
- whether or not the burden from emotional abuse is included; or
- whether Indigenous or non-Indigenous women are being considered (see following section).

Why data are presented for all women and for women aged 18-44 years

The burden of disease varies across the life-cycle (AIHW, 2016a). The burden of intimate partner violence is larger for women aged under 44 years. This is in part due to the higher prevalence of intimate partner violence among younger women (Cox, 2015, p. 86), and in part to risk factors linked to chronic diseases, such as tobacco smoking and high body mass, making up a larger proportion of the burden in older women (AIHW 2016a).

Women of all ages experience violence, and it is important that this violence is addressed regardless of the age at which it occurs (Stöckl, Watts, & Penhale, 2012). Problems affecting older women often remain hidden and intimate partner violence is no exception (Hightower, Smith, Ward-Hall, & Hightower, 2000).

However, it is important to know about variations throughout the life-cycle as this can help to work out the points when treatment, support and prevention are most likely to be needed within the population as a whole. It can also help to plan programs that are tailored to needs at particular life-cycle stages.

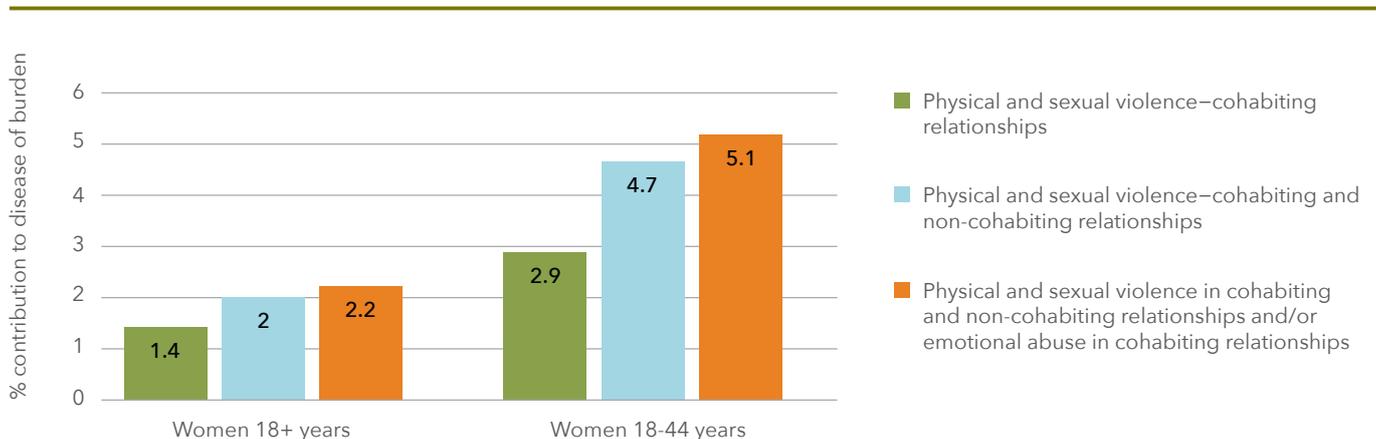
Women under 44 years:

- are more likely than older women to have dependent children. This may make seeking safety from violence more complex (Meyer, 2012);
- experience divorce at higher rates than older women (ABS, 2013b). The risk of violence (Dekeseredy, McKenzie, & Schwartz, 2004) and of more severe and lethal violence (Campbell, 2003) is higher upon separation; and
- are in their reproductive years. Many of the health problems linked to intimate partner violence (see Table 1) are related to reproductive health (e.g. complications of pregnancy).

Other than the burden of preterm & low birth weight complications, the burden of children living with violence perpetrated against their mothers was not included in the study. However, showing the burden among women in their reproductive years highlights the potential to protect and promote not only their health, but also the health and development of children.

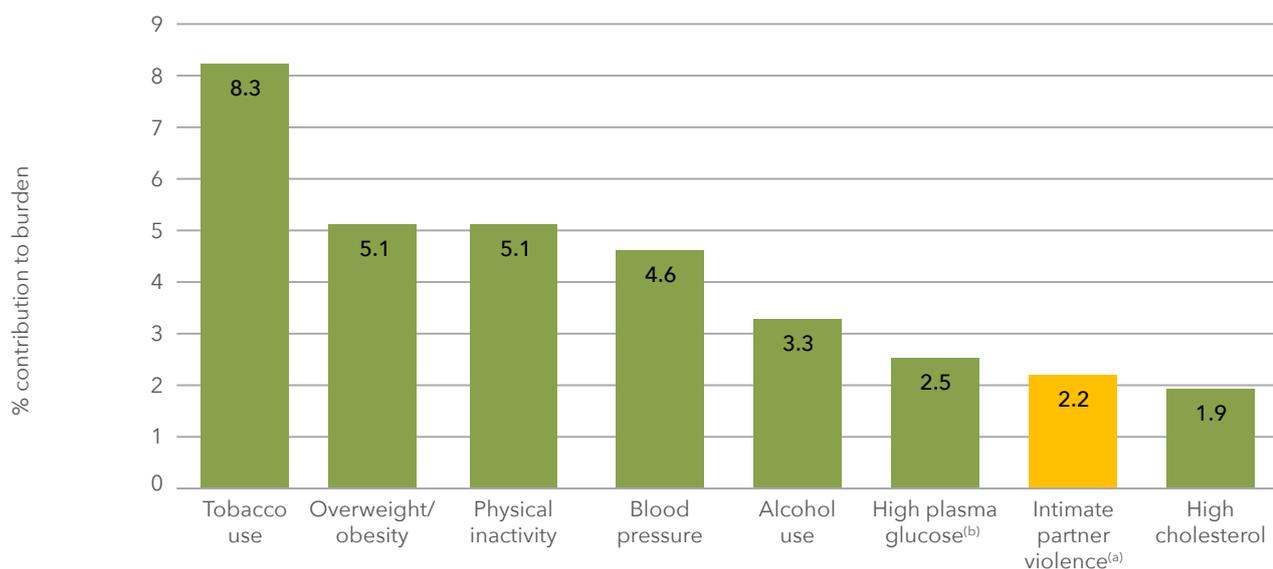
In the detailed report of the study the groups 18-24 years and 25-44 years are looked at separately. For the reasons above, in this summary, data are shown for all women and for women aged 18-44 years (that is, the two age groups in the reproductive years are combined into a single group of 18-44 years). Data for this group can also be found in Appendix B of the detailed Horizons report.

Figure 4 Estimated contribution of physical and sexual intimate partner violence and emotional abuse to the total disease burden in Australian women (2011)



Note: Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016

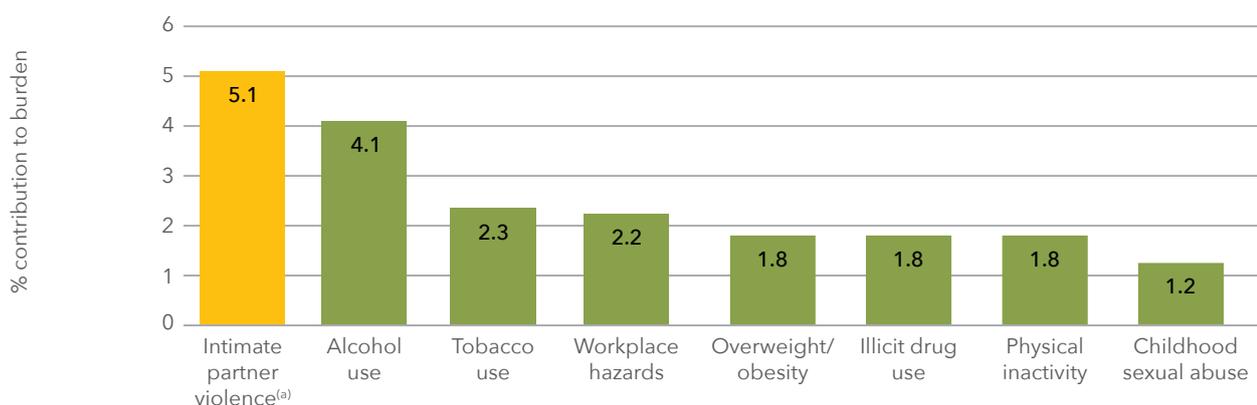
Figure 5 Comparing the burden of intimate partner violence^(a) with the burden of other risk factors in women 18+ years: top eight risk factors (2011)



Notes: (a) Includes physical and sexual violence in cohabiting and non-cohabiting relationships, and emotional abuse in cohabiting relationships. (b) A risk factor for diabetes and other chronic diseases. Refer to pp.8-9 for definitions of relationship and violence types. As there are interactions between risk factors it is not correct to add them together. Source: Ayre et al., 2016

- Among women aged 18 years and over, intimate partner violence ranked as the seventh largest risk factor contributing to the burden of disease.
- In this age group, the burden contributed by cohabiting partner violence alone ranked eighth if the emotional abuse burden was also included, or ninth if considering only the burden contributed by physical and sexual violence.

Figure 6 Comparing the burden of intimate partner violence^(a) with the burden of other risk factors in women 18-44 years: top eight risk factors (2011)



Notes: (a) Includes physical and sexual violence in cohabiting and non-cohabiting relationships, and emotional abuse in cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types. As there are interactions between risk factors it is not correct to add them together. Source: Ayre et al., 2016

- Intimate partner violence (as defined above) contributed a greater proportion to disease burden than any other risk factor among women aged 18-44 years. This ranking was the same whether or not the burden from emotional abuse was included.
- The burden of cohabiting partner violence alone ranked second only to alcohol use among women aged 18-44 years. Again this ranking remained the same whether or not the burden of emotional abuse was included.

As time went by, he became very controlling. He wanted to know where I had been, who with... he would listen to my phone calls, and read my diary. Later, he hit me for the first time. I was so scared. I was shaking and couldn't believe it was happening to me. Hitting me became part of my life...I became so depressed. I didn't think life was worth living. I went to the doctor and he said I had a depressive disorder. I hated the word "disorder". It made me feel that I was going mad or was already crazy.

– Minerva

Of the diseases included in the study, the largest proportion of the intimate partner violence burden in women was due to mental health conditions, including depressive disorders and anxiety disorders. Together these two diseases were estimated to account for around 70% of the burden in both age groups.

Figure 7 Percentage of the intimate partner violence^(a) burden due to each disease in Australian women 18+ years (2011)

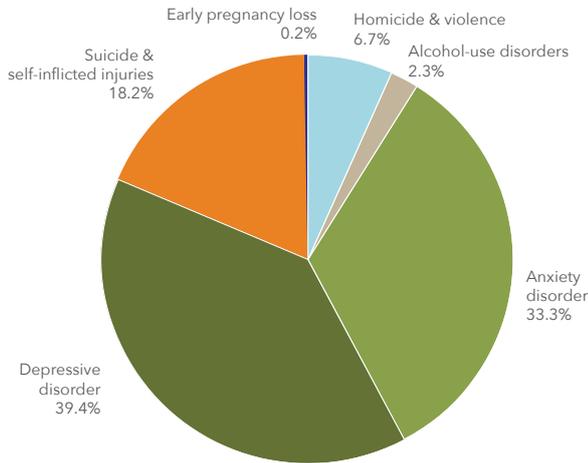
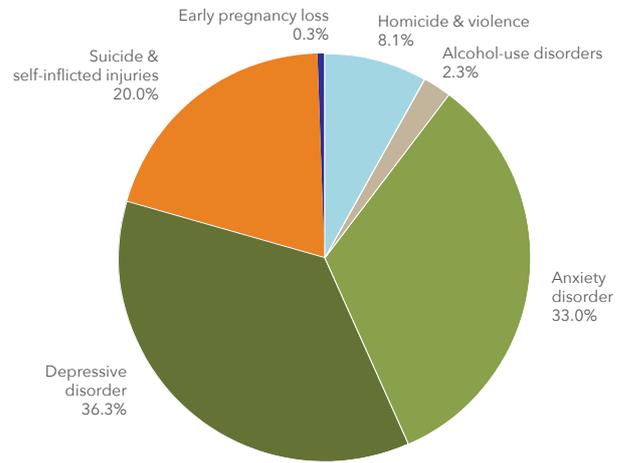


Figure 8 Percentage of the intimate partner violence^(a) burden due to each disease in Australian women 18-44 years (2011)

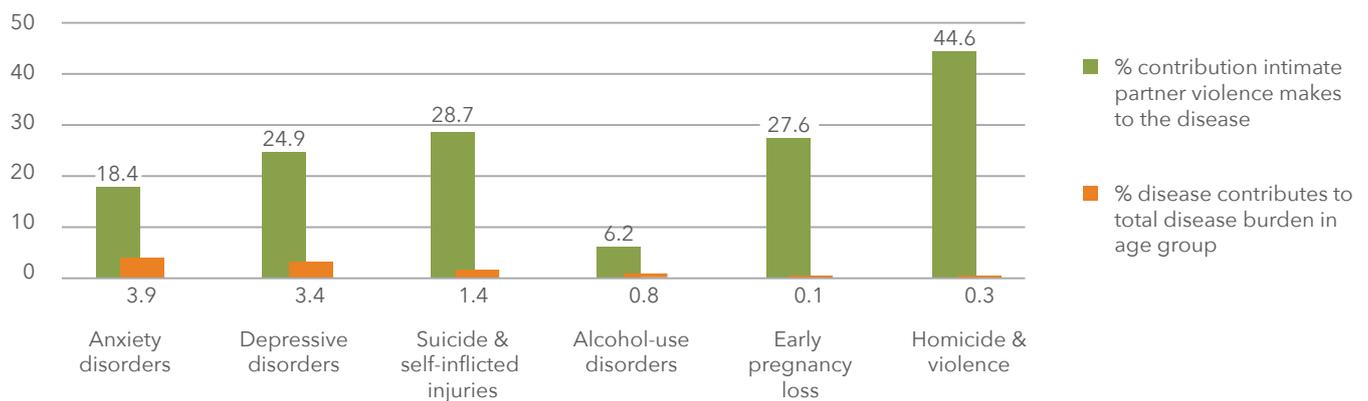


Notes: (a) Includes physical and sexual violence in cohabiting and non-cohabiting relationships, and emotional abuse in cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016. Figures may not add to 100% due to rounding.

Notes: (a) Includes physical and sexual violence in cohabiting and non-cohabiting relationships, and emotional abuse in cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016. Figures may not add to 100% due to rounding.

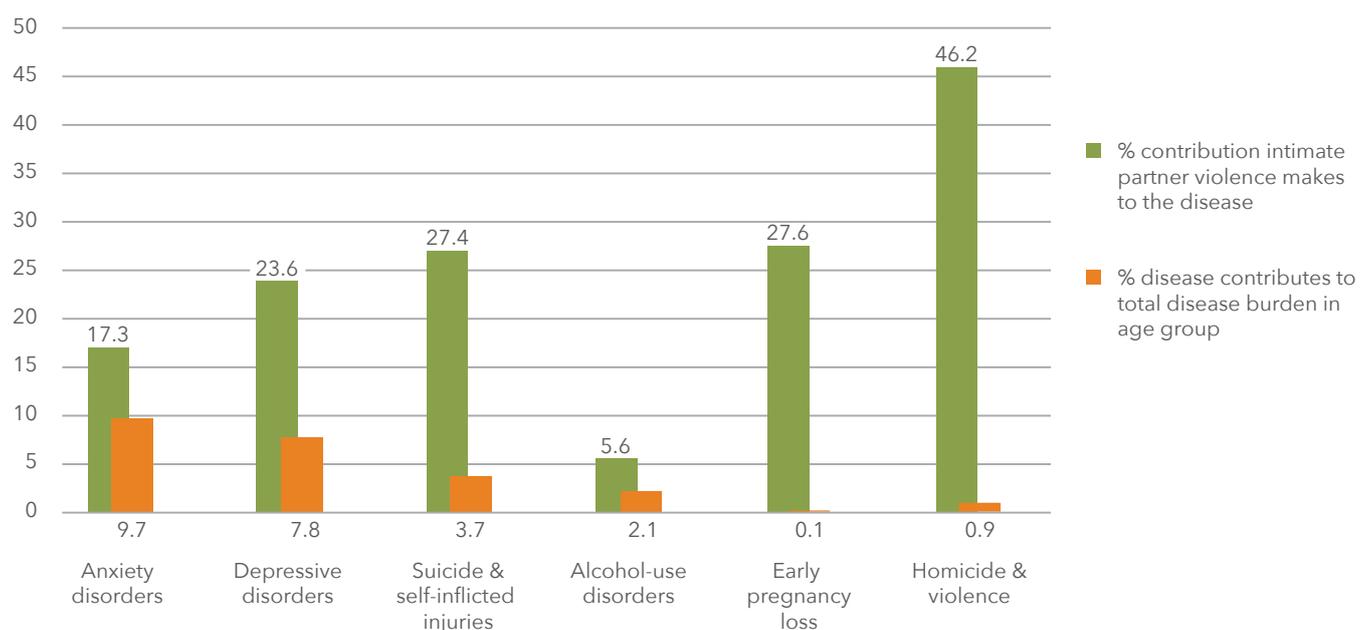
In the data presented in figures 7 and 8, the focus has been on the diseases that contribute to the burden of intimate partner violence. In the following section the contribution of intimate partner violence to the burden of each of the diseases is explored.

Figure 9 Percentage contribution partner violence ^(a) makes to the burden of each disease compared with the percentage the disease makes to the total disease burden in Australian women 18+ years (2011)



Notes: (a) Includes physical and sexual violence in cohabiting and non-cohabiting relationships, and emotional abuse in cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016

Figure 10 Percentage contribution partner violence ^(a) makes to the burden of each disease compared with the percentage the disease makes to the total disease burden in Australian women 18-44 years (2011)



Notes: (a) Includes physical and sexual violence in cohabiting and non-cohabiting relationships, and emotional abuse in cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016

- In both age groups, the burden contributed by intimate partner violence was estimated to make a substantial contribution to the total burden of:
 - homicide & violence, to which it contributed over 40%;
 - anxiety disorders, to which it contributed nearly one-fifth;
 - depressive disorders, to which it contributed approximately one-quarter; and
 - suicide & self-inflicted injuries and early pregnancy loss, to which it contributed just over one-quarter.
- The contribution of intimate partner violence to alcohol-use disorders was relatively smaller at an estimated 6.2% for all women and 5.6% for women aged 18–44 years.
- Although the relative contribution of intimate partner violence to the burden of anxiety disorders and depressive disorders was smaller than that for other outcomes (most notably homicide & violence), the impact of anxiety disorders and depressive disorders contributed by intimate partner violence on the overall burden was greater. This was because these diseases account for a larger proportion of overall disease burden in Australian women.
- Indeed, two of the diseases contributing to the intimate partner violence burden—*anxiety disorders and depressive disorders*—were in the top ten diseases contributing to total disease burden in all Australian women (AIHW, 2016a).
- Among women aged 18–44 years, three of the diseases contributing to the intimate partner violence burden were in the top ten diseases contributing to the total burden (*depressive disorders, anxiety disorders and suicide & self-inflicted injuries*).
- This means that reducing intimate partner violence is likely to have a large impact on the overall disease burden among women, particularly women aged 18–44 years.

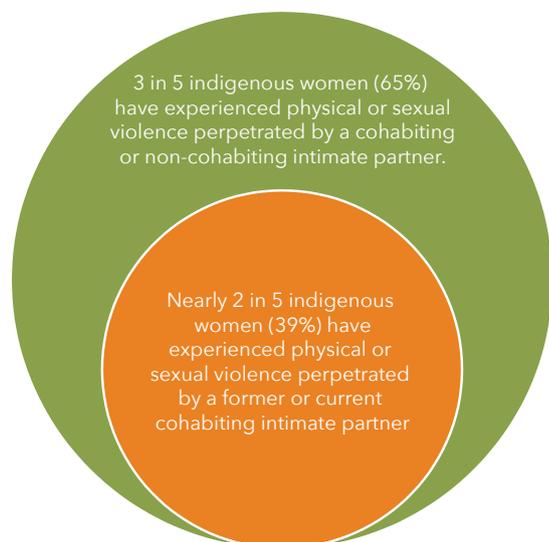
Study findings: Prevalence and burden among Indigenous women

As part of the study, an estimate of the prevalence of intimate partner violence among Indigenous women was made. This was because the Personal Safety Survey did not include a measure to identify Indigenous women. As a result it was not possible to find the prevalence of intimate partner violence among Indigenous women from the survey.

On the basis of data collected in the 2008 National Aboriginal and Torres Strait Islander Social Survey and 2006 General Social Survey, it was estimated that Indigenous women were 2.5 times more likely than non-Indigenous women to have experienced physical or sexual violence over a 12-month period (Ayre, Lum On, Webster, Gourley, & Moon, 2016). This difference in rates (known as a “rate ratio”) was applied to the national prevalence rates for intimate partner violence used in this study to estimate the prevalence of intimate partner violence amongst Indigenous women.

Figure 11 Estimated prevalence, Indigenous women (2012)

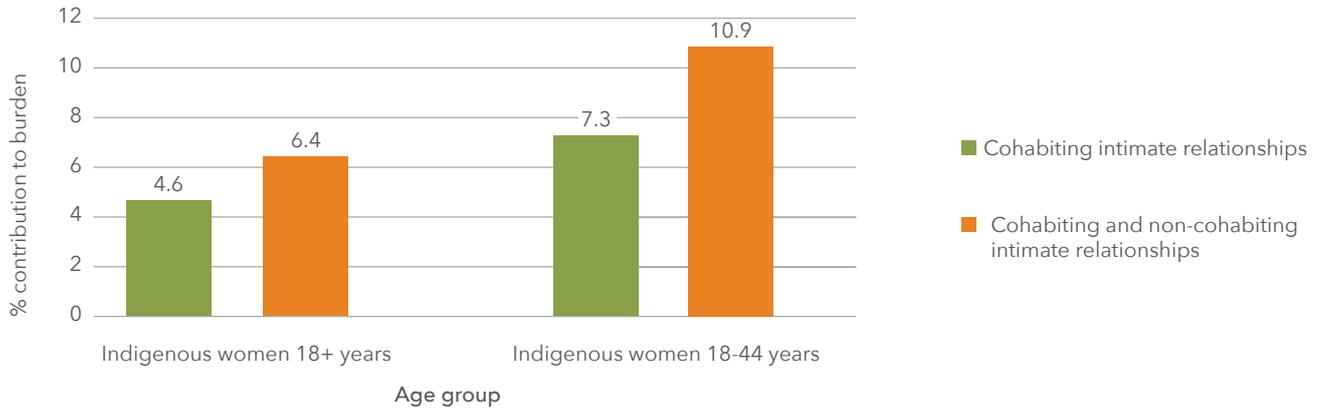
On the basis of this data it was estimated that:



Notes: See Ayre et al. (2016) for further detail on the method used. Refer to pp. 8-9 for definitions of relationship types. Source: data based on analysis prepared by the AIHW (Ayre et al., 2016).

As there was no data source for the prevalence of emotional abuse among Indigenous women, data presented in this and the following sections are for physical and sexual violence only. Unless it is specifically indicated, all figures are for both cohabiting and non-cohabiting violence.

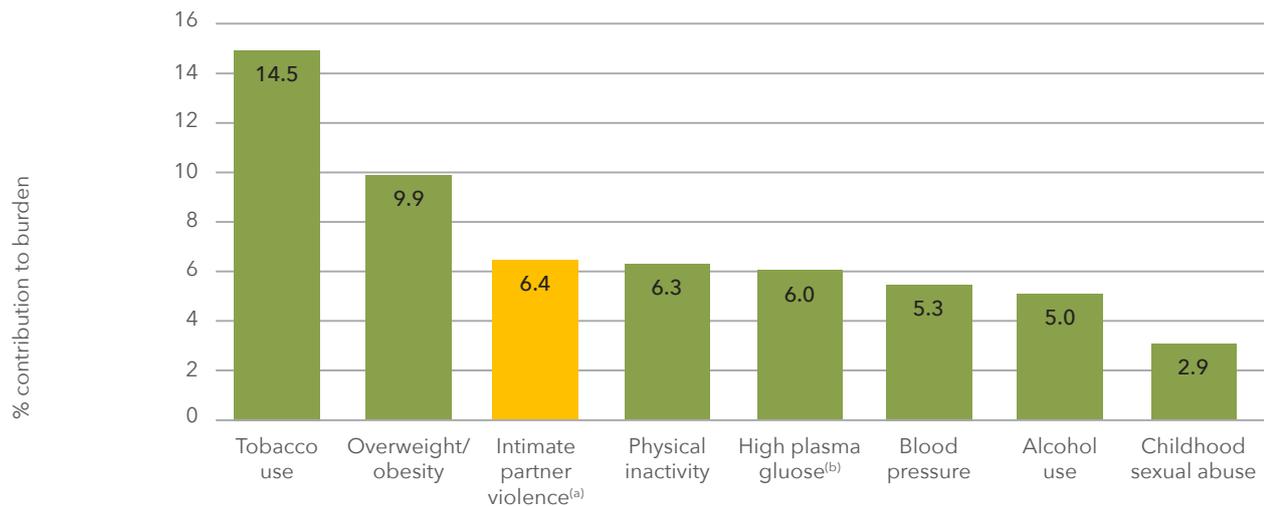
Figure 12 Estimated contribution of physical and sexual intimate partner violence to the total disease burden in Indigenous women (2011)



Note: Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016.

- Partner violence contributed 6.4% of disease burden in all Indigenous women. Among women 18-44 years, the burden of intimate partner violence is 10.9%.

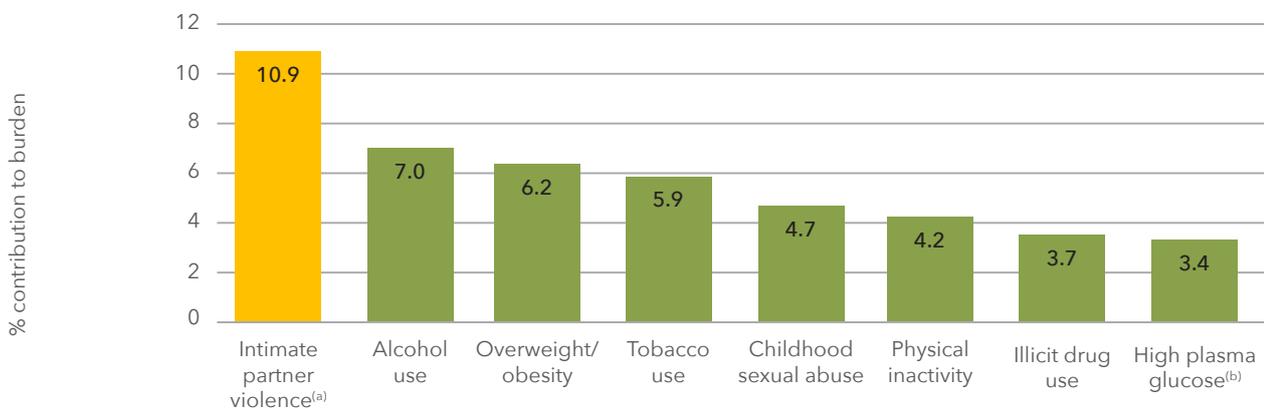
Figure 13 Top eight risk factors contributing to the burden in Indigenous women 18+ (2011)



Notes: (a) Includes physical and/or sexual violence in both cohabiting and non-cohabiting relationships. (b) A risk factor for diabetes and other chronic diseases. Refer to pp.8-9 for definitions of relationship and violence types. As there are interactions between risk factors it is not correct to add them together. Source: Ayre et al., 2016.

- Among all Indigenous women, intimate partner violence was the third largest contributor to disease burden exceeded only by the health impacts of tobacco use and being overweight or obese.
- If the burden of cohabiting partner violence alone is considered, it was the seventh largest risk factor among women aged 18 years and over.

Figure 14 Top eight risk factors contributing to the burden in Indigenous women 18-44 years (2011)



Notes: (a) Includes physical and/or sexual violence in both cohabiting and non-cohabiting relationships. (b) A risk factor for diabetes and other chronic diseases. Refer to pp.8-9 for definitions of relationship and violence types. As there are interactions between risk factors it is not correct to add them together. Source: Ayre et al., 2016.

- Physical and sexual violence by an intimate partner contributed a greater proportion to the disease burden than any other risk factor among Indigenous women aged 18-44 years.
- This rank was the same when the burden of cohabiting partner violence alone was considered.

Figure 15 Percentage of the intimate partner violence^(a) burden due to each disease in Indigenous women 18+ years (2011)

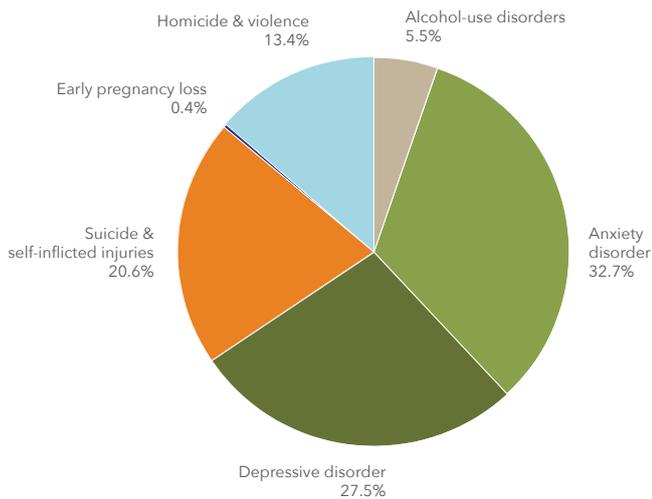
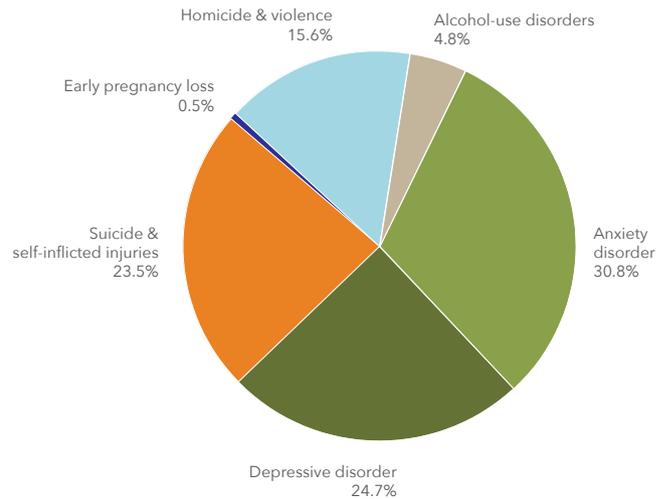


Figure 16 Percentage of the intimate partner violence^(a) burden due to each disease in Indigenous women 18-44 years (2011)

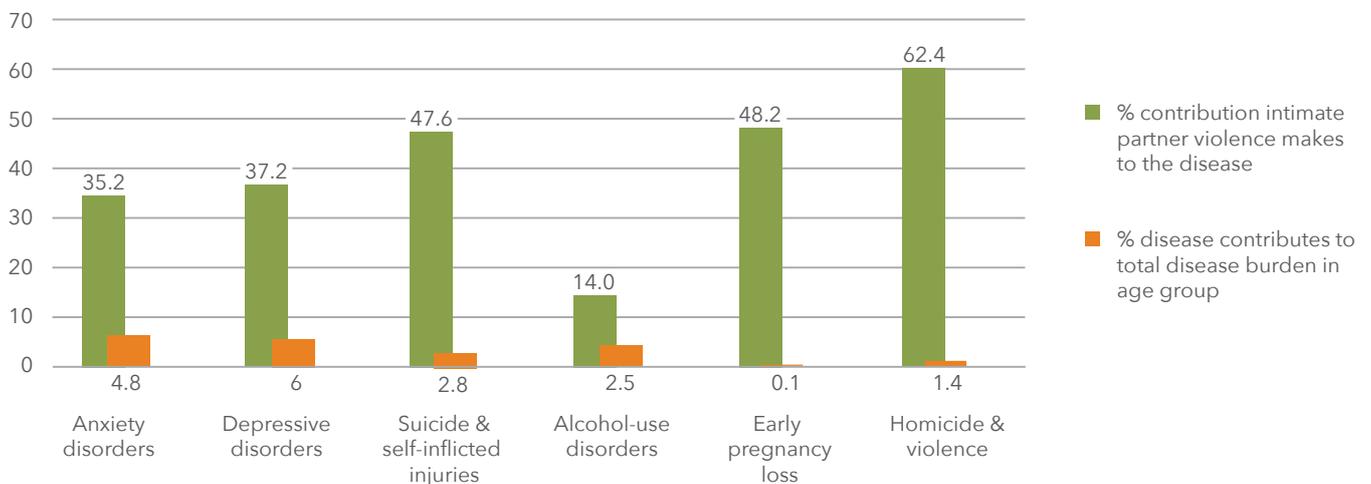


Note: (a) Includes physical and/or sexual violence in both cohabiting and non-cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016. Figures may not add to 100% due to rounding.

Note: (a) Includes physical and/or sexual violence in both cohabiting and non-cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016. Figures may not add to 100% due to rounding.

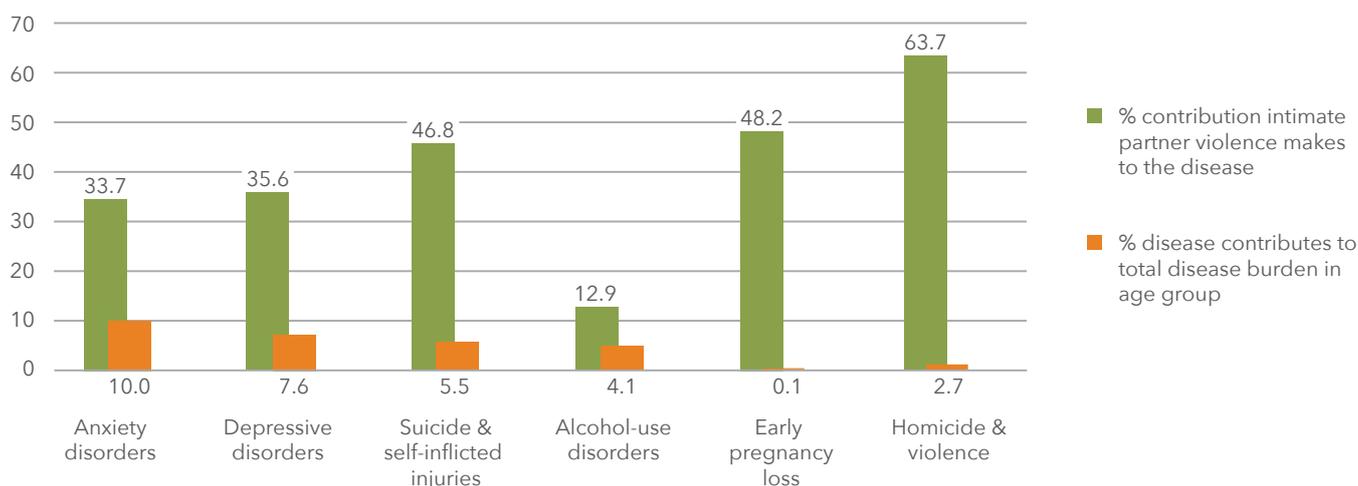
- Together, depressive disorders and anxiety disorders accounted for over half of the intimate partner violence burden experienced by Indigenous women: 60% among women of all ages and 56% among those aged 18-44 years.

Figure 17 The percentage contribution intimate partner violence^(a) makes to the burden of each disease compared with the percentage the disease makes to the total disease burden in Indigenous women 18+ years (2011)



Note: (a) Includes physical and/or sexual violence in both cohabiting and non-cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016.

Figure 18 The percentage contribution intimate partner violence^(a) makes to the burden of each disease compared with the percentage the disease makes to the total disease burden in Indigenous women 18-44 years (2011)



Notes: (a) Includes physical and/or sexual violence by both cohabiting and non-cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016.

- Intimate partner violence made a substantial contribution to the burden of each of the diseases among Indigenous women: over a third in the case of anxiety disorders and depressive disorders and nearly half of the burden of suicide & self-inflicted injury and early pregnancy loss.
- Well over half of the burden of homicide & violence among Indigenous women was due to intimate partner violence.
- Its contribution to alcohol-use disorders was smaller, although still substantial, at 14% for all women and nearly 13% for women aged 18-44 years.
- Although the contribution made to the burden of anxiety and depressive disorders was notably smaller than the other diseases (excepting alcohol-use disorders), the impact on the total disease burden was greater because these diseases contributed a greater proportion to the total disease burden in Indigenous women.
- Indeed, three of the diseases—anxiety disorders, depressive disorders and suicide & self-inflicted injuries—were in the top ten diseases contributing to total burden in Indigenous women.
- Among Indigenous women aged 18-44 years, five of the diseases contributing to the intimate partner violence burden are in the top ten diseases contributing to the total burden. These include anxiety disorders, depressive disorders, suicide & self-inflicted injuries, alcohol-use disorders, and homicide & violence.

This helps to explain why intimate partner violence had a large impact on the overall disease burden among Indigenous women, particularly women aged 18-44 years. It shows that reducing intimate partner violence could help to reduce the overall disease burden in Indigenous women.

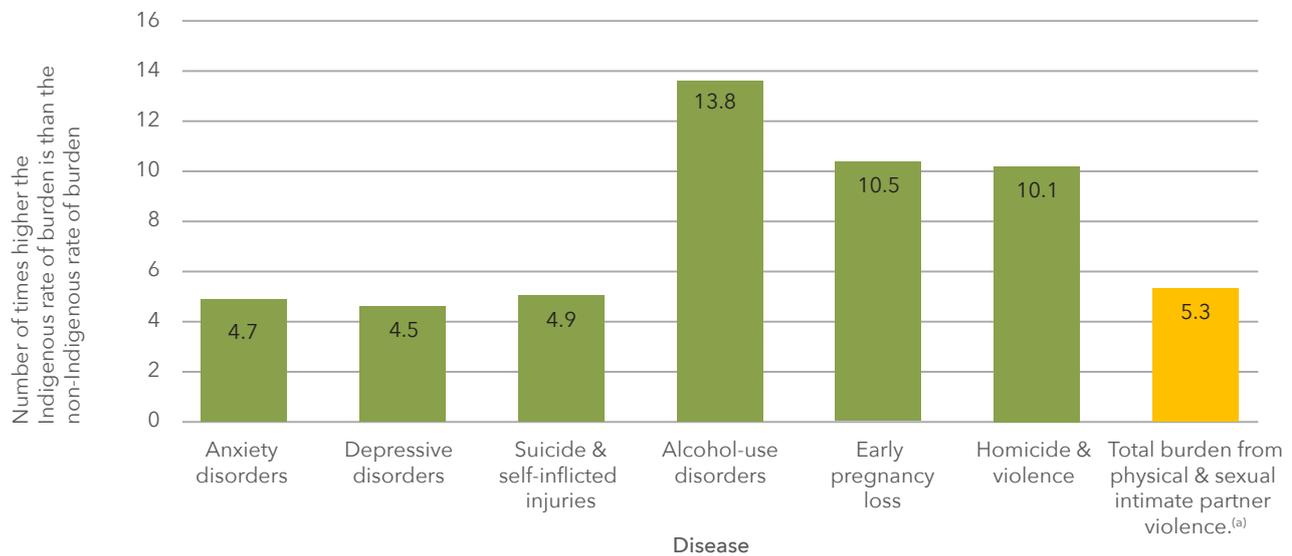
Making comparisons between Indigenous and non-Indigenous women

The data above for Indigenous women cannot be directly compared with the data presented for all Australian women because there are differences in the age structure of the two populations that may distort the results.

To make comparisons the impact of this difference was removed using a statistical process referred to as "age standardising". Results are expressed as "rates of burden".

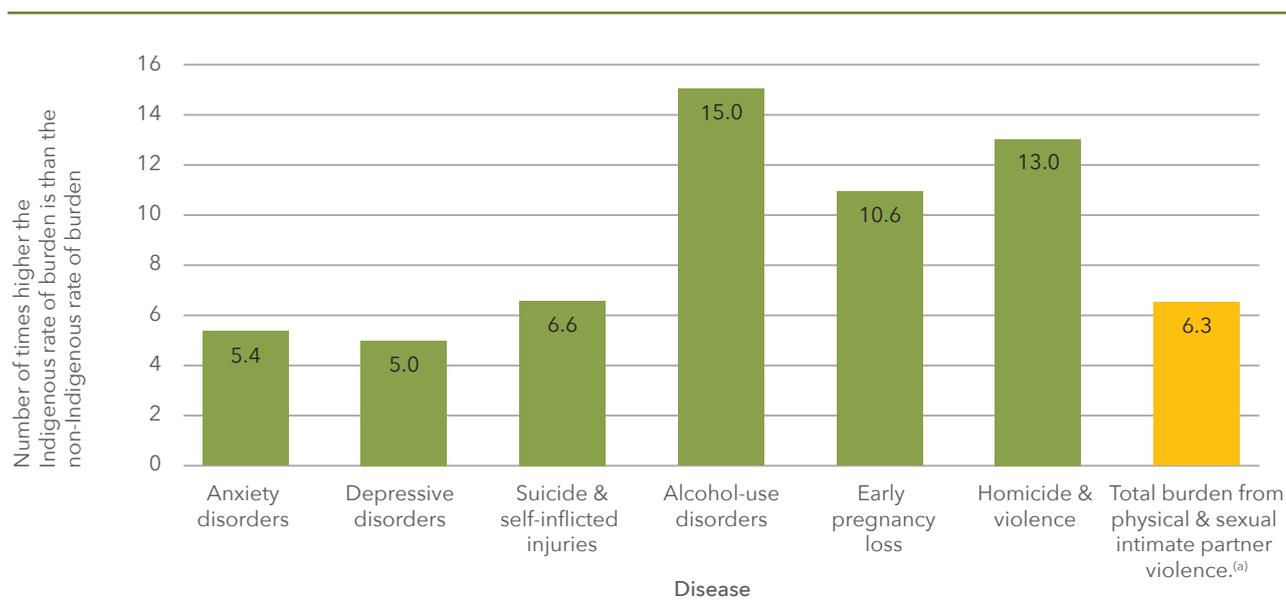
Since there is no prevalence data for emotional abuse among Indigenous women, the following comparisons are made using data for physical and sexual violence only.

Figure 19 Estimated number of times higher the Indigenous burden of intimate partner violence^(a) is than the non-Indigenous burden^(b) in women 18+ years (2011)



Notes: Numbers indicate the number of times higher the rate of burden due to IPV was for Indigenous women compared to non-Indigenous women.
 (a) Includes both cohabiting and non-cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types.
 (b) Rates are age-standardised to the 2001 Australian Standard Population.
 Source: Ayre et al., 2016.

Figure 20 Estimated number of times higher the Indigenous burden of intimate partner violence^(a) is than the non-Indigenous burden^(b) in women 18-44 years (2011)



Notes: Numbers indicate the number of times higher the rate of burden due to IPV was for Indigenous women compared to non-Indigenous women.
 (a) Includes both cohabiting and non-cohabiting relationships. Refer to pp.8-9 for definitions of relationship and violence types.
 (b) Rates are age-standardised to the 2001 Australian Standard Population.
 Source: Ayre et al., 2016.

Figures 19 and 20 show that:

- The rate of burden of intimate partner violence among Indigenous women was more than five times higher than among non-Indigenous women (Figure 19).
- Among women aged 18-44 years the Indigenous rate of burden associated with intimate partner violence is more than six times higher than for non-Indigenous women (Figure 20).
- The largest differences between Indigenous and non-Indigenous women in both age groups were for the burden for alcohol-use disorders, homicide & violence and early pregnancy loss due to intimate partner violence.

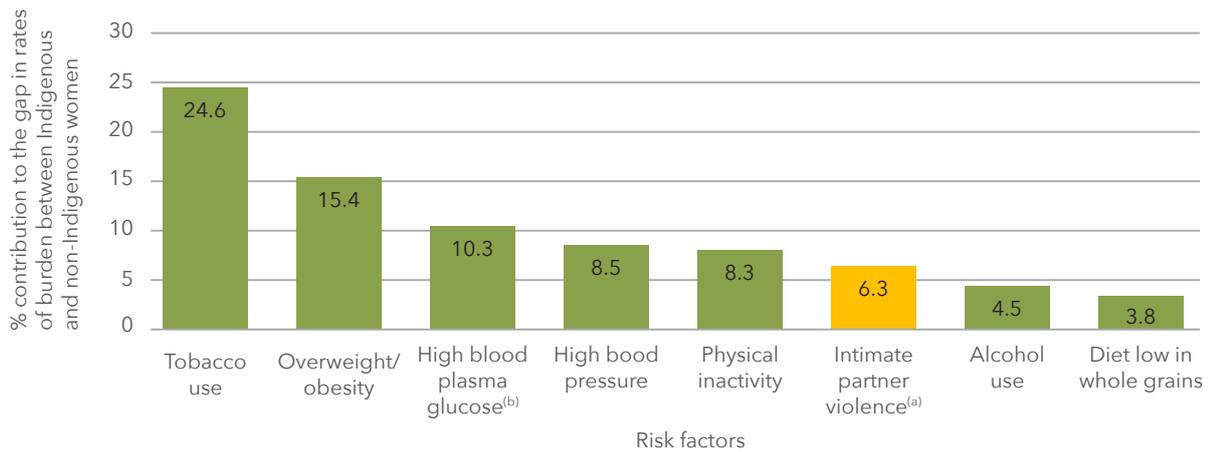
After differences in the age structure of the Indigenous and non-Indigenous population were taken into account, the overall rate of disease burden (i.e. the burden from all 200 causes included in the burden of disease) was higher among Indigenous than non-Indigenous women.

- Among Indigenous women aged 18-44 years, the rate was 2.5 times higher.
- Among all adult Indigenous women, it was 2.4 times higher (AIHW, 2016c).

Figures 21 and 22 overleaf show that diseases and injuries associated with intimate partner violence contributed:

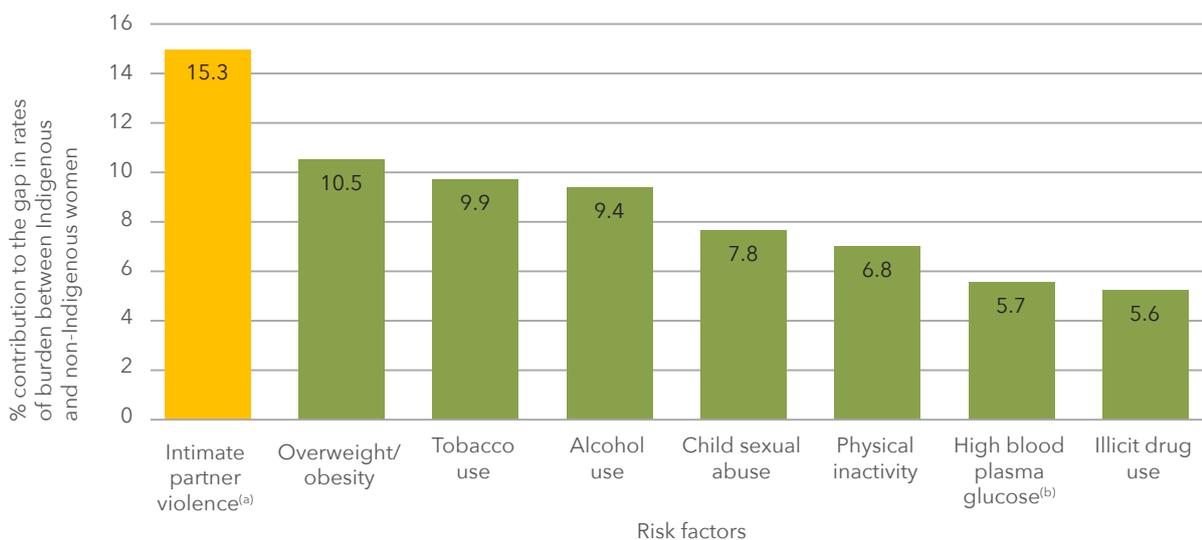
- Over 6% (6.3%) of the difference in rates of overall disease burden between adult Indigenous and non-Indigenous women (Figure 21); and
- 15.3% of the difference in rates of overall disease burden between Indigenous and non-Indigenous women aged 18-44 years (Figure 22).

Figure 21 The percentage contribution the top eight risk factors make to the gap in burden between Indigenous and non-Indigenous women 18+ years (2011)



Notes: (a) Includes both cohabiting and non-cohabiting relationships. (b) A risk factor for diabetes and other chronic diseases. Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016.

Figure 22 The percentage contribution the top eight risk factors make to the gap in burden between Indigenous and non-Indigenous women 18-44 years (2011)



(a) Includes both cohabiting and non-cohabiting relationships. (b) A risk factor for diabetes and other chronic diseases. Refer to pp.8-9 for definitions of relationship and violence types. Source: Ayre et al., 2016.

- Intimate partner violence made a larger contribution to the gap in rates of burden between Indigenous and non-Indigenous women aged 18-44 than any other factor. It made the sixth largest contribution to the gap in all adult women.
- In both age groups, the ranking of intimate partner violence as a contributor to the gap remained the same regardless of whether or not the disease burden from non-cohabiting violence was included.

Strengths and limitations of the study

Strengths

- The study used an internationally accepted method that was applied in a standard way across all risk factors and diseases in the Australian Burden of Disease Study (AIHW, 2016a).
- The intimate partner violence prevalence data—a key input to the burden of disease estimate—was from a reputable, high quality survey conducted by the Australian Bureau of Statistics (ABS, 2013a).
- The burden from non-cohabiting violence and emotional abuse was included for the first time in any (known) burden of disease study.
- Estimates for Indigenous women were included.
- The studies used to identify diseases linked to intimate partner violence were assessed for their relevance to Australian women.
- A causal relationship between a risk factor and health outcome is difficult to establish with absolute certainty. However, the advantage of burden of disease methodology is that it provides a way of assessing this relationship that is common to all risk factors.

Limitations

- Data on the prevalence of intimate partner violence among Indigenous women were limited, so prevalence for this group was calculated using several data sources. Although not ideal, the approach used was transparent and was reviewed by external experts. It highlights a key gap in data.
- Estimating the burden in groups experiencing higher rates, or more severe and prolonged violence (other than Indigenous women), was beyond the scope of this study. The inputs required to arrive at these estimates were either unavailable or inadequate (Lum On et al., 2016).
- The burden of emotional abuse could not be included for Indigenous women, or women experiencing non-cohabiting partner violence. There was no data source for prevalence of emotional abuse in these groups.
- The study did not include the burden of women's exposure to partner violence as a child, or the impact of current intimate partner violence on children who are exposed to violence after their birth.

Due to the stress and anxiety of living like this I developed a muscular disease called fibromyalgia which I have to learn to live with as there is no cure. Any stress now aggravates me to a point where it's too painful to get out of bed and live a normal life.

– Jan

A conservative approach was taken

The estimates are likely to be conservative.

- Estimates are dependent on high quality studies on the relationship between the risk factor and adverse health outcomes. There was insufficient evidence of a causal association for many of the diseases identified in the literature as being more common among women who have experienced intimate partner violence (see Table 1). It is possible that more diseases could be included in future estimates as the evidence base improves.
- For some of the outcomes identified in the broader literature, there is a long period between exposure and the development of disease. This is especially the case for chronic diseases such as cardiovascular disease and cancers. This makes it much harder to establish a causal relationship in studies. Some studies do show a correlation between these outcomes and intimate partner violence. There are theoretical grounds for proposing the possibility that this link is causal. For example, research on the impacts of abuse and neglect in childhood (Gilbert et al., 2015) and racism (Trenerry, Franklin, & Paradies, 2012) demonstrate that people exposed to these adversities are more likely to have certain biological markers known to be linked to the development of chronic disease such as increased heart rate or damage to red blood cells (Trenerry et al., 2012). Similar linkages have been hypothesised in relation to intimate partner violence (Scott-Storey, 2013).
- The methods to estimate the indirect health burden of other risk factors associated with intimate partner violence are not well developed (e.g. the health burden of tobacco use or unsafe sex) and therefore this indirect burden has not been included.
- Women with disabilities and women from some culturally diverse backgrounds experience more frequent and severe violence (Lum On et al., 2016). Yet these groups are likely to be underrepresented in prevalence studies (ABS, 2013a), as well as in studies investigating the relationship between intimate partner violence and adverse health outcomes.

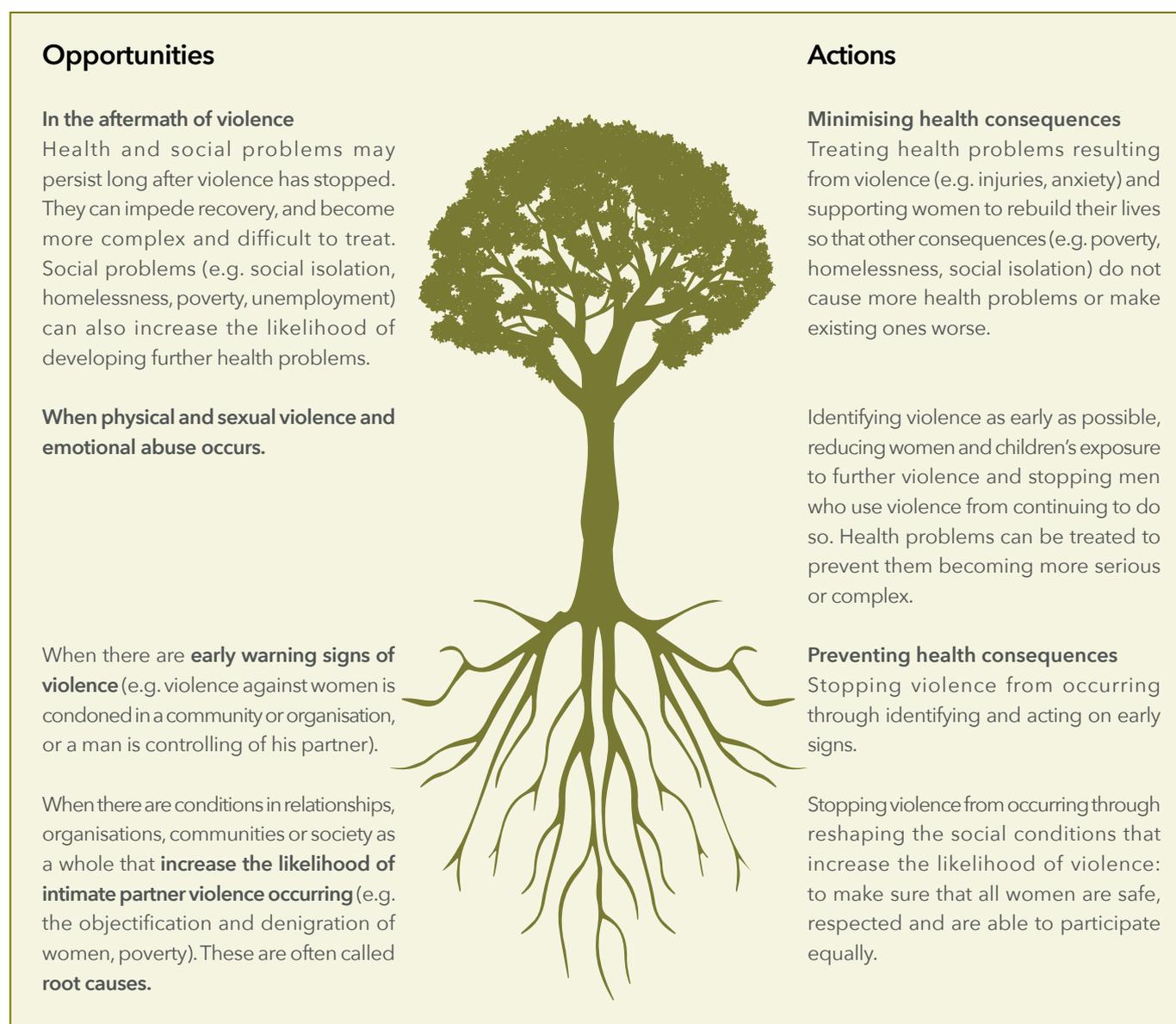
Preventing the health impacts of intimate partner violence

There are many opportunities to reduce the health problems found in this study as well as to prevent them altogether (Figure 23). They can be found:

They can be found:

- in the aftermath of violence;
- when violence is occurring in a relationship; and
- prior to violence occurring.

Figure 23 Opportunities and actions to minimise and prevent the health impacts of intimate partner violence



Initiatives at all of these levels are important. However, the experience of preventing other major health problems has shown that to really make a difference to the health burden, it is necessary to identify the root causes of the problem, and address them, so that people are not exposed to the problem in the first place.

A familiar example of this is the approach taken to reduce diseases caused by smoking. This initially involved providing treatment services for people who developed smoking-related diseases, and programs to help smokers “quit”. However, these programs did nothing to stop other people from starting to smoke. Once they did so, they faced an increased risk of developing a disease due to their smoking.

This meant that the real challenge was to stop people taking up smoking in the first place. This led to a coordinated, multi-pronged approach involving public campaigns to shift attitudes and social norms on the acceptability of smoking, organisational change to stop endorsement or encouragement of smoking in and by key institutions (e.g. sporting clubs, airlines), laws to stop tobacco advertising and regulate other tobacco industry practices inducing people to smoke, and taxation and other measures to serve as disincentives to smoking. This approach, adopted in high income countries throughout the world, has been extraordinarily successful. It has resulted in marked declines in the number of people taking up smoking, increases in the number quitting, and, importantly, significant reductions in disease due to smoking among those populations with reduced rates of smoking (MacKay, Bettcher, Minhas, & Schotte, 2012; AIHW, 2011).

Intimate partner violence and tobacco use are very different issues and so different strategies are needed to address them. However, there are also parallels between them. In the last three decades in Australia, as in other high income countries, there has been much change for the better in responses to women and children affected by violence and to the men who use it (RCFV, 2016).

However, despite these efforts, intimate partner violence remains a persistent problem (RCFV, Vol 2, 2016).³ Moreover, as reporting has increased, response services, such as refuges, health and counselling services, the police, and the courts are finding it increasingly difficult to cope with demand (RCFV, 2016). Further, intervening after violence has occurred can only limit the health consequences of violence. To make a significant impact on the burden it will be necessary to complement this work with measures to prevent new cases. This will involve understanding, identifying and addressing the root causes of violence.

As many of the root causes also contribute to repeated violence, addressing them can help to stop violence that is already occurring. Since addressing root causes focuses on building communities and organisations that are safe and respectful for women and their children, it can also contribute to the recovery of those in the aftermath of intimate partner violence

3 It is difficult to determine whether the overall prevalence or incidence of intimate partner violence has reduced as a result of these efforts, since greater awareness of the problem and improvements in responses may lead to increased reporting, without there necessarily being an increase in violence itself. The Victorian Royal Commission on Family Violence found evidence of increases in reported incidences of family violence (RCFV, Vol. 1, 2016). The evidence from population surveys is mixed. There was a decline in all forms of interpersonal violence—not just partner violence—experienced by women in the preceding 12 months between the 1996 Women’s Safety Survey and the 2005 PSS. However, between the 2005 and 2012 waves of the PSS, there was no statistically significant change in the experience of intimate partner violence in the preceding 12 months among women.

Understanding the causes of intimate partner violence

No single factor can be said to cause intimate partner violence. It is a complex problem and many inter-related factors contribute to it (Hagemann-White et al., 2010; Heise, 2011). However, there is increasing understanding of these factors. Prevention of violence—both in the first place and as part of a reoccurring pattern—is possible because many of these factors can be modified (World Health Organization, 2010). These factors have been identified in a recent national framework for the prevention of violence against women and their children (Our Watch, ANROWS, & VicHealth, 2015). It notes that the factors contributing to partner violence can be found in:

- the characteristics, beliefs and life histories of individuals;
- the dynamics and practices of intimate and family relationships;
- norms, structures and practices within communities as well as organisations, such as workplaces, schools and sports clubs; and
- societal level norms, structures and practices such as those of the media or large systems such as the criminal justice system (Our Watch, ANROWS, & VicHealth, 2015).

A significant underlying factor is inequality between men and women (Ellsberg et al., 2014; UN Women, 2015; WHO, 2010). This may be expressed through:

- gender inequalities in decision-making in relationships and public life (e.g. when decision-making is not equally shared in a relationship, or women experience difficulties securing their economic independence);
- stereotyped constructions of masculinity and femininity (e.g. the belief that being “in charge” in intimate relationships is part of masculinity);
- peer relations, in particular ways in which men and boys relate to one another, and to women. These relationships are sometimes dependent on men conforming to negative aspects of masculinity and/or involve disrespect for women; and
- overt or tacit support for the use of violence against women (e.g. beliefs blaming women for the violence) (Our Watch, ANROWS, & VicHealth, 2015).

These are referred to as the root causes or primary drivers of partner violence (Our Watch, ANROWS, & VicHealth, 2015).

Other factors can interact with, and reinforce these primary drivers to influence particular patterns of partner violence across the community. Among these are:

- the ways in which violence in general may be condoned in families, communities and the wider society;
- exposure to other forms of violence, such as community violence, child maltreatment, or violence in war or in the course of colonisation;
- other forms of social inequality and discrimination, in particular those based on race, ethnicity and ability;
- factors that weaken positive social behaviours (such as harmful use of alcohol); and
- social and economic stressors that challenge power in relationships or men’s ability to meet stereotyped roles and constructions of masculinity (e.g. the impact of unemployment on men’s role as breadwinner) (Our Watch, ANROWS, & VicHealth 2015).

There are a number of individual level factors that may be associated with a higher risk of men perpetrating intimate partner violence. Many men affected by these factors do not use violence, so on their own they do not explain violence. However, they may increase the likelihood of more severe or frequent forms of violence and make intervention more complicated (Hilton & Harris, 2005). Examples of these factors are cognitive impairment, certain personality traits and severe mental illnesses, such as major depression or post-traumatic stress disorder (Ali & Naylor, 2013; Hilton & Harris, 2005).

Although responsibility for violence lies with those who perpetrate it and not its victims, there are also factors that may make some women especially vulnerable to violence or serve as barriers to them seeking safety (e.g. poverty, disability) (WHO, 2010).

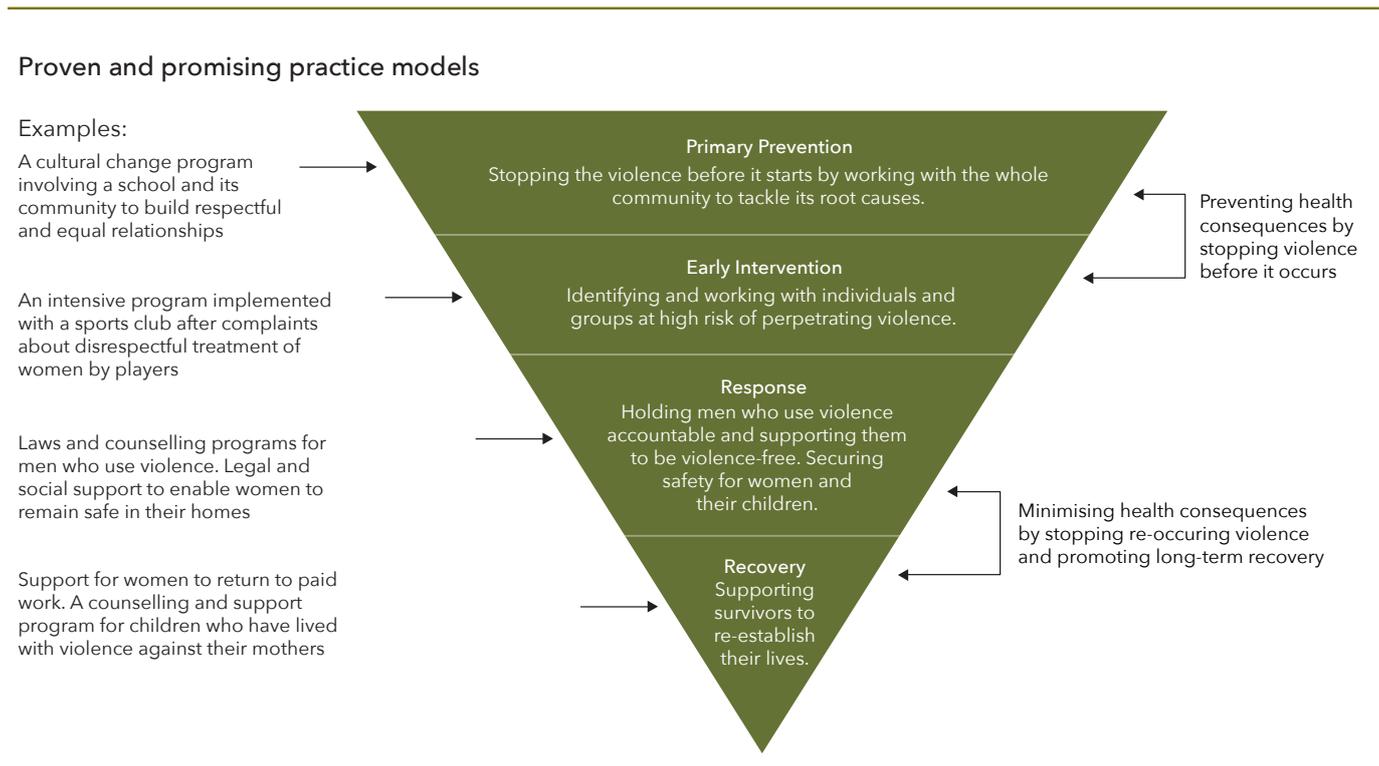
A continuum of approaches

Reflecting this complex understanding of intimate partner violence, expert bodies promote the need for a coordinated approach involving a continuum of strategies (see Figure 24) that support and reinforce one another. These need to involve individuals, families and relationships, as well as communities, organisations and society-wide institutions such as the media and the justice system (Michau et al., 2014).

Such an approach involves all sectors of society. This is because the causes of violence, and many of the solutions, lie in a diverse range of sectors, not just with health and response services. Many other sectors, such as housing, employment, sports and education, also have a role to play.

Although there remains much to be learned about effective approaches to respond to and prevent intimate partner violence and reduce its harms, there is a growing body of proven and promising practice (Arango, Morton, Gennari, Kiplesund, & Ellsberg, 2014; Ellsberg et al. 2014; Flood, 2014; Fulu, Kerr-Wilson & Lang, 2014; Heise, 2011; WHO, 2010).

Figure 24 Levels of prevention of intimate partner violence and its health impacts



My daughters were traumatised from seeing their mother being hit and yelled at and particularly at those times when I left the house to hide outside. They didn't know that I would come back. He was a good father to them until they reached adolescence. Then he turned on them. I became afraid for them and after many pleas from them to leave him, I did.

– Jenny

Universal and targeted action

Groups at high risk

As intimate partner violence affects women across all groups in society, there is a need to reach the population as a whole. However, violence is more prevalent and/or more severe and prolonged among certain groups of women (see p.13). There is a consensus among international experts that this calls for additional efforts to prevent intimate partner violence, undertaken in partnership with these groups (UN Women, 2015). This can be achieved through specialist policies and programs to prevent and respond to violence. There are also likely to be opportunities to reduce the factors contributing to violence discussed above in policies, programs and services relevant to the groups. This includes those concerned with:

- promoting cultural diversity;
- supporting migrant and refugee settlement;
- promoting the rights and wellbeing of Indigenous Australians;
- promoting the participation and wellbeing of people with disabilities; and
- addressing social and economic exclusion.

Stages of the lifecycle

- Although intimate partner violence occurs across the lifecycle, there is a need to focus efforts to address violence affecting women under 44 years, since the burden is highest in this age group.
- There are particular opportunities in working with children and young people to prevent the consequences of their exposure to violence. Childhood and adolescence are also times when we learn how to behave in relationships and about gender roles. This makes them good times for learning about respectful and non-violent ways to relate to one another and about more equitable and flexible gender roles. Laying down good practices in childhood and adolescence can provide a positive foundation on which people can build healthy roles and relationships when they are adults (Flood & Fergus, 2008; Harris, Honey, Webster, Diemer, & Politoff, 2015).

Men, boys and gender relationships

Prevalence and burden of disease studies focus on women as the victims of intimate partner violence. Australia does not have a study that asks men about their perpetration of violence. However, international surveys show that men report having perpetrated physical or sexual violence or emotional abuse against an intimate partner in proportions similar to those reported in victimisation studies (Abbey, Parkhill, BeShears, Clinton-Sherrod, & Zawacki, 2006; Fleming et al., 2015; Fulu, Warner, Miedema, Jewkes, Roselli, & Lang 2013; Loh, Gidycz, Lobo & Luthra, 2005; Luthra, & Gidycz, 2006).

Preventing and responding to violence will also need to focus on the men and boys who perpetrate it and the environments influencing their behaviours and relationships between men and women by:

- reaching men and boys who use or are at risk of using violence;
- engaging the leadership and pro-social support of the great majority of men who do not perpetrate violence against women; and
- addressing particular aspects of masculinity and gender relationships that have been implicated in the prevalence of violence against women (Jewkes, Flood, & Lang 2015).

Implications for policy, practice and research

Special policies and programs to prevent and respond to violence against women are important. Health systems and services also have a key role to play. However, many of the factors that contribute to intimate partner violence and its re-occurrence and impede women's long-term recovery lie outside the specialist response and health systems. So too do many of the solutions (e.g. workplace leave provisions, programs to support respectful relationships among school-aged children). The findings and implications of this study are relevant across a range of sectors, including those concerned with education, employment, child development, housing, media and communications, and sports and active recreation.

Implications for policy

Strengthen and build on the existing coordinated policy approach

Australia has a coordinated approach to preventing and responding to intimate partner violence through:

- Commonwealth and state and territory government policies and strategies (COAG, 2011);
- The *National Plan to Reduce Violence against Women and their Children* which supports a coordinated national approach and has the support of all Australian governments (COAG, 2011); and
- *Change the story: A shared national framework to guide primary prevention of violence against women in Australia*, which has been developed in consultation with stakeholders and governments across Australia (Our Watch, ANROWS, & VicHealth, 2015).

These plans and frameworks reflect many of the best practice approaches identified by experts. Their success will be dependent upon the establishment of sound coordinating mechanisms and ongoing monitoring and evaluation (Michau et al., 2015). This study provides compelling evidence of the need for these plans and for increased investment in their implementation. Based on experience in reducing health problems caused by other complex social issues such as tobacco use and road-safety, a long-term commitment will be required, one that extends beyond the life of the current plans.

Closing the gap between Indigenous and non-Indigenous Australians

The Australian Government has a commitment to close the gap in life expectancy between Indigenous and non-Indigenous Australians in a generation (COAG, 2008, p. 8). This is currently an estimated 10 years (AIHW, 2014). There is a gap between the Indigenous and non-Indigenous health burden (see p. 29) and this study shows that intimate partner violence makes a substantial contribution to it. This means that reducing intimate partner violence and its harms is likely to help reduce the health gap between Indigenous and non-Indigenous Australians. It is also likely to help meet targets in other areas, in particular those concerned with the health and development of Indigenous children.

However, to reduce intimate partner violence and its health burden, it will also be important to reduce gaps between Indigenous and non-Indigenous Australians on other indicators, such as education and employment. This is because social and economic marginalisation is identified as a reinforcing factor in intimate partner violence (see p. 35). Such marginalisation particularly affects Indigenous communities (Holland, 2015).

Violence prevention is needed to meet other policy goals

In recent decades, Australian governments have focused on policy development in a number of key areas. The findings of this study show that preventing and responding to intimate partner violence will be integral to meeting many of the policy goals set, in particular those concerned with:

- preventing and reducing mental illness—given the strong evidence of a causal link between exposure to intimate partner violence and anxiety disorders and depressive disorders and the large contribution intimate partner violence makes to the mental health burden;
- preventing suicide and self-harm—given both evidence of a causal link and the sizeable contribution made by intimate partner violence to the burden of suicide and self-harm;
- reducing alcohol harm—as intimate partner violence contributes to alcohol-use disorders;
- child health and development—given evidence from other research of the negative impact of living with violence on children's health and development (see p.16); and
- achieving gender equality—as intimate partner violence has been found to contribute to this inequality (UN Women, 2013). Although Australia has a commitment to achieving gender equality as a signatory to the *Convention on the Elimination of All Forms of Discrimination against Women* (UN, 1979), it lags behind many other comparable countries on key indicators (Bekhouche, Hausmann, Tyson, & Zahidi, 2013; United Nations Development Programme, 2015).

Implications for practice

Practice: Supporting the long-term recovery of women and their children

For many women, the physical and mental health consequences of intimate partner violence persist long after their exposure to violence has ended (Evans, 2007; Franzway et al., 2015). Treatment, rehabilitation and support services can help to address this. Providing these can help to prevent problems from becoming more serious and complex (Palpant, Steimnitz, Bornemann, & Hawkins, 2006).

The disruption to housing, employment and social networks often resulting from intimate partner violence may place women at significant long-term disadvantage (Franzway et al., 2015). Such disadvantage can cause further health problems (Solar & Irwin, 2007). Support with housing, health and employment can help prevent these impacts (RCFV, 2016). Longer term support and rehabilitation are especially important for women with complex mental health problems or physical or cognitive disabilities who have experienced violence (UN General Assembly, 2012).

There are also some promising counselling and support interventions involving children and their families to address these impacts and, in theory, to halt the intergenerational cycle of violence (Fulu, Warner, Kerr-Wilson, & Lang, 2014).

Inquiries have pointed to the lack of attention paid to supporting women and children in the recovery period and the need to strengthen this (RCVE, Vol 1, 2016).

Practice: Responding to violence to prevent its recurrence and associated health, social and economic consequences

It will be important for services treating women with the health problems identified in this research to be aware of the possibility of prior or current exposure to intimate partner violence, and to develop appropriate responses. This has particular implications for service providers in the areas of:

- mental health;
- antenatal and birthing care;
- alcohol and illicit drug-use treatment and rehabilitation;
- reproductive health and sexuality;
- childhood health, wellbeing and development;
- acute and emergency care (in particular hospital emergency and outpatient clinics); and
- support and rehabilitation for people with disabilities, in particular cognitive injuries.

Women experiencing intimate partner violence comprise a substantial proportion of presentations to primary care services, such as community health services and general practitioners (Hegarty & O'Doherty, 2011). These services have a pivotal role in detection and response.

Likewise, there is a need for services responding to intimate partner violence (such as women's refuges, the police) to consider the health consequences of violence when providing support and to link women and their children with specialist services.

Awareness raising, professional development and sound service coordination within and between the service sectors identified above will be important to ensure effective early identification and response (RCFV, Vol 2, 2016).

Although there has been significant improvement in response services in recent decades, there is a continuing need to strengthen them so that they are able to be accessed more readily and are more effective at stopping the violence and protecting women and their children (RCFV, 2016; Special Taskforce on Domestic and Family Violence in Queensland, 2014).

It is also important to build awareness of violence in the wider community, as well as knowledge of where help can be found if a person becomes aware a close family member or friend is affected by violence. This is because family, friends and work colleagues are often in a position to notice violence and are commonly those to whom violence may be disclosed in the first instance (Cox, 2015, p. 69, 111).

Other organisations in the community also have a role to play. Examples include systems to identify and support women affected by violence in schools and universities; procedures to ensure a swift response to violence in education facilities, sports clubs and health and social services; and workplace leave provisions for women experiencing violence.

Among the most tragic outcomes of intimate partner violence is partner homicide. This makes a notable contribution to the burden of intimate partner violence, and intimate partner violence in turn makes a marked contribution to the burden of violence & homicide among women. The majority of female homicides (46% of those nationally and 65% among Indigenous women in 2011-12) were perpetrated by an intimate partner (Bryant & Cussen, 2015; Cussen & Bryant, 2015).

Much work has been undertaken to help identify high risk

intimate partner violence cases and to more effectively intervene to reduce this risk (Victoria. Department of Human Services, 2012; Australian Capital Territory. Domestic Violence Prevention Council, 2016; Government of Western Australia, WA Police, & Women's Council for Domestic and Family Violence Services, 2013). These findings suggest the need to continue this work and to focus on preventing and reducing intimate partner violence as a key strategy to reduce homicide among women.

Practice: preventing violence

The key to reducing the health burden of intimate partner violence is to extend efforts beyond responding to violence after it has occurred to seeking to prevent it from occurring. This work needs to take place in the environments in which people experience and learn about gender relations and violence. These are environments that influence people's day-to-day lives such as homes, schools, universities, workplaces, sport and recreation clubs and the media.

Key future challenges are to raise awareness of the prevalence and consequences of intimate partner violence in these environments and the roles that different sectors can play in addressing it. There will also need to be investment in building skills and capacity to do so (Michau, et al., 2015; Our Watch, ANROWS, & VicHealth, 2015).

Implications for research

Future prevalence and burden of disease research

Burden of disease studies need quality research and data as inputs. The Personal Safety Survey 2012 was a critical data source. Future estimates would benefit from data development and further research to enable:

- the inclusion of the burden from emotional abuse in non-cohabiting relationships and children's exposure to intimate partner violence;
- calculation of burden for other groups of women of particular concern (for example women with disabilities); and
- the relationship between intimate partner violence and further diseases (as documented in Table 1) to be assessed and included in the estimates (not just the seven included in this study).

Future estimates for Indigenous women could be strengthened if the same data were available for them as were collected for all women in the Personal Safety Survey.

Using burden of disease estimates for other research

The estimates are an important resource for future research as they can be used to help calculate the economic costs of intimate partner violence and the likely cost savings when acting to prevent it.

Research to strengthen understanding to reduce the burden

Reducing the burden of intimate partner violence depends on there being evidence about what works to reduce the problem. Although the knowledge and evidence base is growing, there is a need to continue to build this through continued support for intervention research and evaluation (Ellsberg et al., 2014).

Factors to consider when communicating the findings to others

Developing messages about the burden

It is important to:

- frame the burden of disease from intimate partner violence as a measure applying to a population rather than to the risk faced by an individual woman. The burden of disease estimate does not tell us about the individual woman's chance of dying or becoming ill from intimate partner violence. Rather it is a sum of all the years lost due to illness and premature death across a population;
- understand the differences between burden of disease measures and other health indicators (see p.10); and
- be familiar with the strengths and weaknesses of burden of disease estimates and this study (see p.31).

The relationship between the estimates in this study and other estimates

There have been a number of previous estimates of burden of disease of intimate partner violence including in:

- a study undertaken in 2004 by Victorian Department of Human Services in partnership with the Victorian Health Promotion Foundation (VicHealth) (Victorian Health Promotion Foundation [VicHealth], 2004). This was the first such estimate globally;
- global studies undertaken by the Institute of Health Metrics and Evaluation for the reference years 2010 and 2013 (Lim et al., 2013; Forouzanfar et al., 2015); and
- Australian studies published by the AIHW in 2007 (based on estimates for the reference year 2003) (Begg et al., 2007) and 2016 (based on estimates for the reference year 2011) (AIHW, 2016a).

The findings of this research are not vastly different to previous published estimates for intimate partner violence, in terms of the magnitude of the burden, the diseases contributing to it and its ranking among other risk factors.

However, there are some differences which may be due to one or more of the following:

- This research used a broader definition of intimate partner violence, as it was able to include emotional abuse and non-cohabiting violence in the estimates.
- Standard protocols have been applied. However, the research on health outcomes linked to risk factors (in this case intimate partner violence) is constantly developing. New studies may result in changes to the diseases included in the estimates. They can also result in changes to how strong the relationship is between risk factor and a health outcome.
- Standardised protocols have themselves been strengthened. This has resulted in changes in estimates across all diseases and risk factors, not just intimate partner violence. In particular, in the 2004 Victorian study, based on 2001 data, the burden of other risk factors (such as illness from tobacco use) was included in the estimate for intimate partner violence. This is called the indirect burden. More recently, the impact of one risk factor on another has not been included in any burden of disease estimates. This will be the case until more robust ways of measuring the indirect burden are available.

- Only studies relevant to the Australian context (that is from Australia or other high income countries) were considered in this research, whereas estimates from the Global Burden of Disease Study included findings from studies conducted across the world.

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