23 Violence Against Women: A Key Determinant of Health and Well-being

LYN WALKER, MICHAEL FLOOD and KIM WEBSTER

KEY CONCEPTS

- Violence against women
- Prevalence of violence against women
- Impact of violence on women's health and well-being
- Determinants of violence against women
- Primary prevention of violence against women

Violence against women occurs in a range of settings and takes many forms. Examples include the trafficking of women and girls, harmful traditional practices such as female genital mutilation, and the rape of women in conflict situations. However, one of the most prevalent and pervasive forms of violence against women in countries around the world is intimate partner violence. Intimate partner violence is violence occurring between people who are, or were formerly, in an intimate relationship. It is sometimes referred to as domestic violence, family violence or relationship violence.

> Violence against women (VAW) is understood to occur on a continuum from economic, psychological and emotional abuse through to physical and sexual violence. The United Nations (UN) defines violence against women as any act of gender based violence that results or is likely to result in physical, sexual or psychological harm or suffering to women including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (UN 1993, 2006a).

This chapter has a particular focus on intimate partner violence. However, many of the concepts canvassed in it also apply to other forms of violence against women. In this chapter we:

- summarise data indicating the prevalent and serious nature of this violence, and in particular its impacts for women's health
- discuss known determinants of intimate partner violence
- present a public health approach to the primary prevention of this violence.

The material in this chapter draws largely on work led by the authors, supported by the Victorian Health Promotion Foundation, as part of a larger program of mental health promotion activity. Violence against women is one of a number of social determinants of poor mental health identified for action within this program. It was selected owing to its prevalence, its contribution to mental health disease burden, and its serious social and economic consequences.

WHY HAVE A SPECIFIC FOCUS ON VIOLENCE AGAINST WOMEN?

Violence is a serious problem affecting both men and women. However, a number of government and non-government organisations have chosen to develop a targeted approach to addressing the particular problem of violence affecting women. This is because there are marked gender differences in patterns and experiences of violence. These in turn have implications for the ways in which we intervene to prevent the problem.

While men are more vulnerable to violence overall, in a majority of cases, their assailant is another man and typically someone who is unknown to them (Flood 2006). The great majority of assaults against men take place in a public place, such as on the street or in licensed premises. Australian survey data indicate that only 4.3 per cent of assaults against men are perpetrated by an intimate partner (Flood 2006).

In contrast, the great majority of assaults against women are perpetrated by men and of these a substantial proportion are perpetrated by a current or former intimate partner. The majority of assaults against women take place in the home and in a large proportion of cases violence is ongoing (Flood 2006). For example, in the recent Personal Safety Survey, a national study involving face-to-face interviews with over 17,300 Australians, most women assaulted in the last 12 months were assaulted by either a current or previous partner (31 per cent), a male family member or friend (28 per cent), or another male person known to them (12 per cent). In comparison, 70 per cent of assaults reported by men were perpetrated by a stranger and only 16 per cent of all assaults involved a female perpetrator (ABS 2006e).

While the causes of violence against women are complex, there is increasing evidence of a link between this form of violence, the unequal distribution of power between men and women and the ways in which gender roles, identities

and relationships are constructed and defined within societies, communities and organisations and by individual men and women (UN 2006a; VicHealth 2007a).

Social and economic inequalities between men and women also make women particularly vulnerable to the impacts of violence once it occurs. For example, there is extensive research showing that women's poor access to resources such as safe housing, legal protection and income support increases their vulnerability as victims (Keys Young 1998; Chung et al. 2000; Kaye et al. 2003; Middleton 2005). In turn, violence can act to compound gender inequality by limiting women's agency and their access to the resources required for social and economic well-being. It is for this reason that the United Nations has identified violence against women as a form of gender discrimination (UN 2006b).

PREVALENCE AND IMPACTS

Prevalence of violence against women

There is increasing recognition internationally that violence perpetrated against women is a common problem with serious health, social and economic consequences for women, their families and communities. It is also defined as a breach of women's human rights (UN 1993).

The World Health Organization estimates prevalence rates of intimate partner violence of between 10 per cent and 70 per cent in regions around the world (WHO 2002b; Garcia-Moreno et al. 2005). In Australia, 16 per cent of women report having experienced violence perpetrated by a current or previous partner since the age of 15 (ABS 2006e). Of these, 36 per cent were pregnant at the time of the violence, and 17 per cent of those experienced violence for the first time when they were pregnant (ABS 2006e).

Violence affects women across the social spectrum and from all ethnic and racial backgrounds. However, Indigenous women and women with disabilities are significantly more likely to be victims of violence (National Crime Prevention 2001; Mouzos and Makkai 2004; VicHealth 2007a). These and other socially marginalised groups are also especially vulnerable to the impacts of violence once it has started (National Crime Prevention 2001; VicHealth 2007a).

The impact of violence on women's health and well-being

Too often intimate partner violence is trivialised in our society as somehow being less serious than violence committed in other contexts. Studies investigating the relationship between intimate partner violence and the health of affected women present a serious challenge to this view. They suggest that intimate partner violence is associated with an increased risk of a range of health consequences, including:

- *Premature death and injury.* For example, Australian research indicates that more than half of all deaths among women resulting from homicide are

perpetrated by an intimate partner, with women being over five times more likely to be killed by an intimate partner than are men (Mouzos 1999).

- *Poor mental health.* Women reporting intimate partner violence face a higher risk of a range of mental health problems including attempted suicide, self-harming behaviours, depression, anxiety, eating disorders and post-traumatic stress symptoms (WHO 2000). They are also more likely than other women to use medication for depression and anxiety (Resnick, Acierno and Kilpatrick 1997; Hathaway, Mucci, Silverman et al. 2000; Coker, Davis, Arias et al. 2002; Campbell 2002; Janssen, Holt, Sugg et al. 2003).
- *Practices and behaviours affecting health.* Women affected by violence are more likely to smoke and use non-prescription drugs, amphetamines and solvents (Roberts, O'Toole; Raphael et al. 1996; Roberts, Lawrence, O'Toole et al. 1997; Roberts, Williams, Lawrence et al. 1998; Golding 1999; Quinlivan and Evans 2001).
- *Reproductive health problems.* For example, women reporting intimate partner violence are more likely to report endo-cervical infections, to have an abnormal pap smear (Quinliven and Evans 2001) and to experience an unplanned pregnancy, termination or miscarriage (Taft 2002).

There is also evidence to suggest that:

- the influence of violence can persist long after the abuse has stopped
- the more serious the abuse, the greater its impact on women's physical and mental health
- the impact over time of different types and multiple episodes of abuse appear to be cumulative (Golding 1999; Taft 2003; WHO 2000).

THE CONTRIBUTION MADE BY INTIMATE PARTNER VIOLENCE TO DISEASE BURDEN

Although there is a strong body of evidence documenting the link between intimate partner violence and poor health, until recently its health impact across the population was not known. Nor was it possible to assess the impact of violence relative to other health problems. These questions were explored for the first time internationally in a recent study, which aimed to estimate the contribution made by intimate partner violence to the total disease and injury burden of women in Victoria (VicHealth 2004; Vos, Astbury et al. 2006).

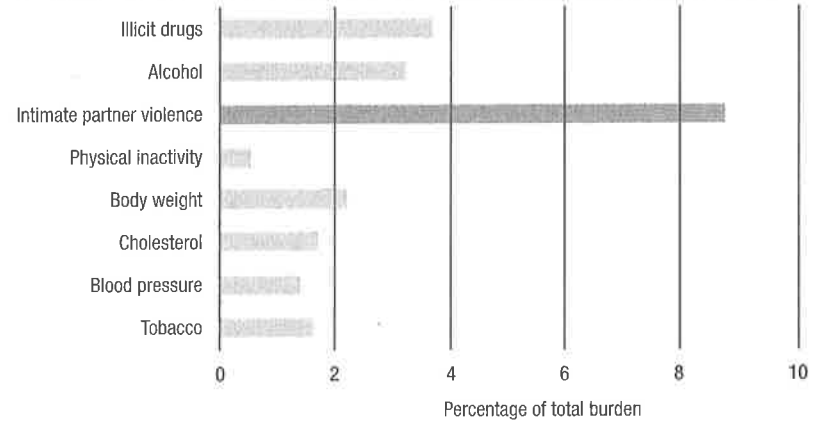
The burden of disease is a measure of the impact of specific health problems across a population taking into account illness, disability and premature death. Estimates are arrived at using an internationally accepted methodology developed by the World Health Organization and its partners. Burden of disease estimates are important because they are a standardised measure, which can be used by governments and health planners to compare the impact of health

problems for the purposes of setting priorities. Estimates of the burden of disease have been developed for many common diseases and risk factors, both globally and for specific countries (Lopez et al. 2006).

The Australian study found that intimate partner violence:

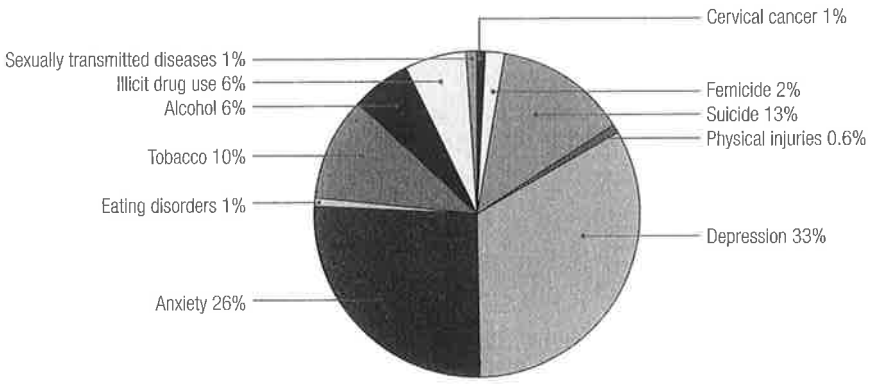
- contributes 9 per cent to the total disease burden in Victorian women aged 15–44
- is the leading contributor to death, disability and illness in Victorian women aged 15–44, being responsible for more of the disease burden than many well-known risk factors such as high blood pressure, smoking and obesity (figure 23.1).

Figure 23.1 Top eight risk factors contributing to the disease burden in women aged 15–44 years, Victoria



Note: The greatest proportion of the disease burden is associated with mental health problems (nearly 60 per cent). Suicide, drug use and risky levels of smoking and alcohol consumption are also significant contributors (figure 23.2).

Figure 23.2 Health outcomes contributing to the disease burden of intimate partner violence in women, Victoria (all women)



ECONOMIC COST OF VIOLENCE AGAINST WOMEN

The economic cost of violence against women is a further, important dimension of its impact. The total estimated cost of intimate partner violence in Australia in 2002–03 was $8.1 billion. Of this, $1.34 billion is borne by governments, $175 million by employers, $4.05 billion by victims, $1.19 billion by the community and $555 million by perpetrators (Access Economics 2004).

SOCIAL COSTS: IMPACTS ON CHILDREN

The behavioural and psychological consequences of growing up in a violent home can be devastating for children, even if they are not directly abused themselves (UNICEF and The Body Shop 2006; UN 2006c). In Victoria, an estimated one in four children and young people has witnessed intimate partner violence (OWP 2002). Further, 34 per cent of Australian women experiencing violence by a current partner and 39 per cent of those by a former partner report that the violence was witnessed by children in their care (ABSd 2006).

This exposure increases children's risk of mental health, behavioural and learning difficulties in the short term (Laing 2000), their risk of developing mental health problems later in life (Edelson 1999) and, in the case of boys, increased risks that they will be perpetrators of violence as adults (Indemaur 2001; Flood and Pease 2006).

VIOLENCE AGAINST WOMEN—A PRIORITY FOR MENTAL HEALTH PROMOTION

Over the past decade there has been an increased focus on the promotion of mental health and the prevention of mental health problems such as stress, anxiety and depression. This is a result of knowledge indicating that:

- by the year 2030 depression will be one of the leading causes of disease worldwide
- the treatment of mental ill health currently is well beyond the capacities of developed and developing countries
- mental health status is directly linked to physical health and quality of life and therefore must be addressed as part of an overall strategy to improve health
- mental ill health results in significant costs to individuals, families, communities and economies
- mental ill health is more common among people with relative social disadvantage (VicHealth 2007b).

Mental health is of particular concern for Australian women, among whom anxiety and depression are predicted to be the top ranking contributors to disease burden by 2023 (Begg et al. 2007).

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In the past, health promotion has focused on supporting changes in the behaviour of individuals, so that they are better able to protect their health. However, over the past fifteen years, in response to increasing evidence of the influence of social and economic factors on health, attention has also been given to supporting positive changes in the environments in which people live, work, play and build relationships with one another.

Given that the disease burden attributable to intimate partner violence is large and that a significant proportion is associated with related anxiety and depression, addressing this problem will have a significant impact on the overall disease burden in Australian women. While the causes of violence against women are complex, there is increasing evidence that social and economic factors play a significant part. Since many of these factors can be modified, there are significant prospects for prevention.

PREVENTING VIOLENCE AGAINST WOMEN

There are three levels at which we can seek to prevent violence against women and its impacts:

- By intervening after the violence has occurred to deal with the violence, prevent its consequences (such as mental health problems) and ensure that violence does not occur again or escalate. Sometimes referred to as *tertiary prevention*, this includes strategies such as counselling or shelters for affected women and children, and legal interventions with violent men.
- By identifying and working with individuals and groups who exhibit early signs of perpetrating violent behaviour or of being subject to violence. Referred to as *early intervention*, this might include interventions in highly masculinised peer cultures where there is evidence of a climate of disrespect for women (a known risk factor for perpetration) (Flood and Pease 2006) or counselling programs for men exhibiting controlling behaviours in their intimate relationships (a predictor of the perpetration of physical violence) (Mouzos and Makkai 2004).
- By preventing violence *before it occurs* by changing environments so that they are safer for women, building the skills and knowledge of individuals or changing behaviour. This is commonly referred to as *primary prevention*. Interventions that do not have a particular focus on violence against women, but address its underlying causes (such as gender inequality and poverty) are also primary prevention strategies.

It is not always possible to make a distinction between these strategies. For example, a policy reform such as a police code of practice mandating arrest of perpetrators of domestic violence is clearly designed to facilitate intervention after the violence has occurred. However, it can also have a primary preventive

effect (by communicating to the wider community that violence against women is a serious issue) and an impact on early intervention by deterring potential perpetrators.

While the focus of governments, advocates and service providers to date has been on intervention strategies, given the prevalence and serious consequences of this problem, increasing attention is being given internationally to primary prevention. That is, there is growing recognition of the need to prevent violence *before it occurs*.

THE KEY DETERMINANTS OF VIOLENCE AGAINST WOMEN

Effective primary prevention is dependent on a sound understanding of the causes of violence. There is an emerging consensus that violence against women cannot be explained by any single factor. Rather, a complex 'interplay of personal, situational and socio-cultural factors ... combine to cause abuse' (CHANGE 1999). These factors can be found in the behaviours and characteristics of individuals; in the dynamics of the relationships between them; in community and organisational environments (such as schools, sporting clubs, peer groups and neighbourhoods); as well as in broader societal influences such as mass communications media, and government policies and legislation (UN 2006a, 2006b; VicHealth 2007a). This suggests the need for an approach to prevention in which interventions are targeted across these levels.

Although it is beyond the scope of this chapter to review in detail the vast body of literature on factors contributing to the perpetration of violence, it is apparent from recent reviews that there are three broad clusters of factors (UN 2006b; VicHealth 2007a). These include those related to:

- the distribution of power and resources between men and women and the construction of gender roles and identities
- exposure to other forms of violence and attitudes and social norms related to violence in general and violence against women in particular
- the availability of resources and systems of support.

In the interests of clarity, the three clusters are discussed separately below. However, there are strong interrelationships between them and this has significant implications for prevention efforts. Many men affected by factors in the second and third clusters, such as exposure to childhood abuse or unemployment, are not violent and these risk factors do not apply to many men who are violent. This suggests that they contribute to violent behaviour in interaction with the influences of structural arrangements and social norms that work against equal and respectful gender relations. For example, as indicated below, violence is more likely to occur in relationships where women hold a more prestigious job than their partner. However, this is primarily the case when men hold traditional

beliefs about their roles and women's employment. When male partners hold egalitarian beliefs, their relative resources have little effect on the likelihood of violence. Similar findings have been documented in relation to alcohol (Johnson 2001) and marital discord (Heise 1998).

Further, mounting evidence indicates that factors associated with gender roles and inequality are among the most influential. For example, in large, well-designed population studies, women's experience of male controlling behaviours has been found to be the strongest predictor of their vulnerability to physical and sexual violence (Mouzos and Mikkai 2004). As Heise argues:

> Any analysis of violence (against women) must recognise the primacy of culturally constructed messages about the proper roles and behaviour of men and women and the power disadvantage that women bring to relationships by virtue of their lack of access to power and resources. Male dominance is the foundation for any realistic theory of violence, but experience suggests that as a single factor explanation it is inadequate. Theory must be able to account for why individual men become violent and why women as a class are so often the target (Heise 1998, p. 263).

It is also important to note that while all the factors discussed below are important to our understanding, none provides justification or excuse for violence. Men are responsible for their use of violence and must take responsibility for adopting non-violent behaviour.

THE CONSTRUCTION OF GENDER ROLES AND RELATIONS AND GENDER EQUALITY

A consistent theme emerging in international studies is the link between violence against women and the way in which gender identities, roles and relationships are constructed and defined within societies. For example, men who hold traditional views about gender roles and relationships and who have a strong belief in male dominance are more likely to perpetrate violence against their intimate partners than those who do not (Anderson and Umberson 2001; Schumacher et al. 2001; Murnen, Wright and Kaluzny 2002; Adams-Curtis and Forbes 2004; Anderson, Simpson-Taylor and Hermann 2004; Stith et al. 2004; Abrahams et al. 2006).

International and Australian surveys also show that people who hold traditional views about gender roles or who have weak support for gender equality are more likely to accept violence against women than those holding more egalitarian beliefs (Flood and Pease 2006; Taylor and Mouzos 2006; VicHealth 2006). A need to exercise power and control over women has been found to be a common motivator for violence (Schumacher et al. 2001; Wilkinson and Hamerschlag 2005). As discussed above, survey data suggest that women's experience of

men's controlling behaviours is among the strongest predictors of physical and sexual violence in intimate relationships.

These factors also operate at peer and organisational levels, with men in some highly masculinised environments such as male residential colleges, male sports clubs, and military and military-like environments being at higher risk of perpetrating violence (Flood and Pease 2006). While in part this may be due to self-selection, there is evidence that the perpetration of violence against women is shaped by patterns of group socialisation and identification in these environments (Godenzi, Schwartz and DeKeseredy 2001; Flood and Pease 2006).

At the community and societal levels, studies have shown that violence against women is more prevalent in societies in which masculinity is defined in terms of male dominance and honour; where gender roles are more rigidly defined; and in which there is a high degree of gender segregation (Sanday 1981; Heise 1998; Nayak et al. 2003; Flood and Pease 2006).

Male economic and decision-making power has also been found to be a factor, with violence being more likely to occur in couples with a clearly dominant partner (Heise 1998) and in countries where male dominance has strong cultural support and in which men control family wealth (Heise 1998).

EXPOSURE TO OTHER FORMS OF VIOLENCE AND SOCIAL NORMS RELATED TO VIOLENCE

There is also a relationship between the perpetration of violence against women and the acceptance and perpetration of other forms of violence. Violence against women has been found to be more prevalent in cultures where violence is used as a means for adults to resolve conflict (Heise 1998). There is emerging evidence that this is also the case at the neighbourhood and school levels (Vezina and Herbert 2007). Men who are violent outside the home are also more likely to be violent towards their intimate partners than those who are not (Mouzos and Mikkai 2004) and involvement in anti-social and aggressive behaviour as an adolescent is a particular risk factor for perpetration of violence against an intimate partner (Heise 1998; Flood and Pease 2006).

Attitudes and social norms relating to violence against women also play a part. Attitudes that are supportive of violence against women (e.g. that violence can be excused in certain circumstances or that women 'ask for' or 'deserve' violence) have been found to influence the perpetration of violence (Flood and Pease 2006), as well as to shape women's own responses to violence, informal community responses (Pavlou and Knowles 2001) and the responses of institutions and organisations (Tilden et al. 1994; Stewart and Maddern 1997; Nayak et al. 2003). Men with close social ties to other men who are physically and

sexually violent toward women are more likely to perpetrate violence than those without such ties (Pease and Flood 2006).

Whether a person acts on the attitudes they hold depends on their perceptions of what others think and factors in the social environment that either censure or permit violence (Azjen and Fishbein 2005; Prislin and Wood 2005). There is some evidence to suggest a relationship between the prevalence of violence against women and the existence of resources to respond to the problem in the form of legal protection and support services (Dugan et al. 2003). Similarly, cross-cultural studies indicate that a predictor of violence at the societal level is whether family and community members say they would intervene if a woman was being beaten or harassed (Heise 1998).

Despite some contradictory findings (Lichter and Mccloskey 2004; Sellers, Cochran and Branch 2005), most studies also suggest a strong association between boys' exposure to violence as children (whether as victims or witnesses) and their perpetration of intimate partner violence in adulthood (Markowitz 2001; National Crime Prevention 2001; Schumacher et al. 2001; Carr and Vandeusen 2002; Abbey et al. 2004; National Institute of Justice 2004).

ACCESS TO RESOURCES AND SYSTEMS OF SUPPORT

The third cluster of factors relate to the material and social resources available to individuals, communities and societies. Studies yield inconsistent findings in relation to many of these factors and the associations are generally weak to modest. Nevertheless, existing research suggests that an increased risk of violence against women is associated with such factors as:

- low income, blue collar occupation and low education attainment in men (Schumacher et al. 2001; Riger and Staggs 2004; Stith et al. 2004), although this association was not found in a recent large Australian population survey (Mouzos and Mikkai 2004)
- men's unemployment (Holtzworth-Munroe et al. 1997; Riggs et al. 2000; Stith et al. 2004)
- disparities between men's and women's employment status in a relationship (i.e. where only the woman is employed or where she has a higher occupational prestige than her partner) (Atkinson, Greenstein and Lang 2005)
- women's social isolation (Heise 1998; Wilkinson and Hamerschlag 2005; Vezina and Herbert 2007) and limited social connections between women at the community and societal levels (WHO 2002b)
- men's social isolation following separation (Brownridge 2006)
- limited social cohesion at the neighbourhood level (Miles-Doan 1998; Browning 2002)
- neighbourhood economic disadvantage (Miles-Doan 1998; Browning 2002)
- alcohol and illicit drug use (Stith et al. 2004)

- poor parenting, which is a risk factor for women (Venzina and Herbert 2007) and for men via its contribution to anti-social and aggressive behaviour in adolescence (Heise 1998).

Situational factors are also implicated, with intimate partner violence being found to be associated with relationship and marital conflict (Riggs et al. 2000; Schumacher et al. 2001), separation and divorce (Riggs et al. 2000), and pregnancy (Bacchus, Mezey and Bewly 2006).

A PUBLIC HEALTH APPROACH TO PREVENT VIOLENCE AGAINST WOMEN

In recent years, a public health approach has been successfully applied to address other significant health challenges such as reducing motor vehicle deaths and tobacco smoking. This approach is increasingly being applied to other more complex social phenomena affecting health and well-being. As discussed in chapters 2 and 3, a public health approach is distinguished by a number of key features including:

- its emphasis on addressing modifiable behavioural, social and economic determinants of health
- the delivery of interventions across the population (as opposed to those with identified problems), while also recognising the need to target more intensive or tailored interventions to 'at-risk' sub-populations
- an emphasis on collaborative work across sectors, recognising that many of the factors that determine health lie outside of the health care system
- the use of evidence to ensure that the best available strategies are used and that these are appropriately targeted and periodically evaluated
- application of a range of strategies (discussed in greater detail below) across levels of the **social ecology** (individual/relationship, organisational, community and societal) in ways that reinforce one another.

Based on knowledge of the determinants of violence discussed above, such an approach would be guided by three interrelated themes for action. These are:

- promoting equal and respectful relationships between men and women
- promoting non-violent social norms and reducing the effects of prior exposure to violence (especially on children)
- improving access to resources and systems of support.

While it is not possible in this chapter to do justice to the range of interventions that could be used to address these themes, broadly these include:

- *direct participation programs* targeted at men, women and children at the individual, relationship or group level to build the knowledge and skills required

to establish and sustain equal, respectful, non-violent relationships; build individuals' access to the resources required for such relationships (such as effective early parenting and connections to social networks) or to seek to prevent or address the impacts of other factors linked to violence against women (such as childhood abuse)

- *community development and strengthening* approaches to foster understanding of the problem and encourage action and dialogue to address violence against women and the norms that make it acceptable. These strategies can also be used to increase community access to the resources required for action and to address broader community-level risk factors, such as high rates of early school leaving or localised violent peer cultures
- *education and training* to support key workforces to undertake primary prevention either informally and opportunistically or at a more formal level
- *organisational development* strategies to support organisations, such as schools, sporting clubs and workplaces, to build environments where non-violent, equitable and respectful gender relations are practised. Organisational development strategies can also seek to harness resources to implement primary prevention (e.g. a football club might sponsor a communications campaign to prevent violence against women)
- *communications and social marketing* activities to increase knowledge about and address attitudes and beliefs about violence against women
- *research and evaluation* to better understand the problem and means of addressing it
- *advocacy* to support *policy and program development and effective legislation* and to ensure that appropriate resources are allocated to address the problem.

SUMMARY

- Violence against women is all too common, has severe and persistent effects on women's physical and mental health, and carries with it an enormous cost in terms of premature death and disability.
- It diminishes and affects us all, marring not only relationships between men and women, but also having long-term social and economic consequences for individuals, families and the broader community.
- It is a crime. It is an act of aggression that is most often perpetrated by an intimate partner or another male known to the victim.
- Violence against women demands that far greater efforts be placed on promoting respectful and equal relationships between men and women.
- It is best addressed within a human rights, legal and public health framework, through development of multi-level strategies and collaborations across community sectors and government.

DISCUSSION TOPICS

1. Violence against women occurs within relationships and within the home. What makes this a *public health* problem rather than a family problem?
2. High-profile media interviews have involved men who seek sympathy and understanding because they claim their violence was caused by events in their childhood. How do you respond to these claims? How would you argue that violence is socially determined, rather than determined by adverse experiences in childhood?
3. What are the most important social determinants of violence against women? Why?
4. Why is it argued that violence by men against women is best addressed not by counselling, but within a human rights, legal and public health framework?

FURTHER READING

Australian Bureau of Statistics 2006, *2005 Personal Safety Survey*, cat. no. 4906.0, Canberra: www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/056A404DAA576AE6CA2571D00080E985/$File/49060_2005%20(reissue).pdf.

WHO 2000, *Women's Mental Health: An Evidence Based Review*, World Health Organization, Geneva: http://whqlibdoc.who.int/hq/2000/who_msd_mdp_00.1.pdf.

WHO 2002, *World Report on Violence and Health*, World Health Organization, Geneva: www.who.int/violence_injury_prevention/violence/world_report/en/.

USEFUL WEBSITES

Violence prevention websites

Family Violence Prevention Fund: www.endabuse.org/programs/publiceducation/

The Family Violence Prevention Fund (FVPF) works to end violence against women and children around the world. This site provides information about the campaigns and resources that support the work of FVPF.

The Prevention Institute: www.preventioninstitute.org

The Prevention Institute is a non-profit national centre dedicated to improving community health and well-being by building momentum for effective primary prevention. The site provides resources on major themes that guide their work, including violence, health equity, mental health and gender.

Australian Domestic and Family Violence Clearinghouse:
www.austdvclearinghouse.unsw.edu.au

This Australian site provides news and information about domestic and family violence, and its prevention.

Australian Institute of Family Studies/Australian Centre for the Study of Sexual Assault:
www.aifs.gov.au/acssa/research/prevention.html

This site provides a bibliography of prevention programs and strategies.

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XY: www.xyonline.net/

XY is a website focused on men, masculinities, and gender politics. XY is a space for the exploration of issues of gender and sexuality, the daily issues of men's and women's lives, and practical discussion of personal and social change. Useful pages within this site include:

resources and information about violence and men:
www.xyonline.net/articles.shtml#Violence

links to men's anti-violence sites: www.xyonline.net/links.shtml#2

academic references on violence prevention:
http://mensbiblio.xyonline.net/violence3.html#Violenceprevention

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