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Literature Review

Prevention of violence against women and children regional action plan capacity building project: Women with disabilities

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Women with Disabilities Victoria

Contents

1. Introduction

This literature review has been prepared as a component of the *Regional Action Plans for the Prevention of Violence Against Women and Children and Workforce Capacity Building Project*: Women with disabilities, auspiced by Women with Disabilities Victoria (WDV). The purpose of the literature review is to build the capacity of prevention of violence against women (PVAW) sector professionals to deliver high quality activities that are inclusive of women with disabilities through improving Regional Action Planning (RAP). More specifically, the literature review seeks to contribute to the body of knowledge on the best practice approaches for including women with disabilities and disability organisations into regional action plans for PVAW activities.

The aim of the review has been to capture current key themes, gaps and nuances that can inform our understanding of current research and writing on the subject of violence against women with disabilities; as well indicate gaps in available literature; and future research requirements. More specifically we have attempted to focus the literature search on discourse informing primary prevention of violence against women with disabilities.

1.1   Scope of this Literature Review

Desktop research of 'grey' literature and seminal literature relevant to the subject of primary prevention of violence against women with disabilities was identified and reviewed. This review has not accessed all available scholarly literature in the field. Little of this research based literature finds its way into the 'grey' literature with the exception of organisations such as *Our Watch* which has worked with Australia's Research Organisation for Women's Safety (*ANROWS*) and VicHealth drawing on scholarly studies in their reviews and evaluations and also generating evidence through rigorous primary research. VicHealth brings to this partnership expertise gained from over a decade of research and practice to support population level prevention of violence against women (Webster & Flood, 2015).

1.2   Literature Scan

International research indicates that women with disabilities face a higher risk of violence than other women, however, according to Our Watch, there is very little Australian evidence on the prevalence of violence among women with a disability (Webster & Flood, 2015).

The literature search identified a paucity of both academic and practice-informed writing on the prevention of violence against women with disabilities; and even less literature on primary prevention initiatives aimed at reducing and eradicating violence against women with disabilities. Most of what is publicly available comes from Government commissioned reports or the work of

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organisations such as Women with Disabilities Australia (WDA) and WDV; as well as Our Watch – frequently supported by government; often referred to as 'grey' literature.

The gaps in literature on the subject could be understood as a reflection of a lack of formal studies on this subject, including studies capturing women with disabilities' lived experiences; and very limited capture of the knowledge held by workers supporting those women with disabilities who experience violence and those implementing prevention activities.

1.3   Key concepts and definitions

The literature reflects the nuanced language used in discussions on violence against women as well as the inaccurate or interchangeable use of some terms and concepts- this becomes more evident later in this document; the latter suggesting a lack of clarity or common understandings of the concepts and terms.

According to VicHealth, violence against women may be referred to as 'domestic violence', 'intimate partner violence' and 'family violence' and these terms may be used interchangeably. The term 'violence against women' is a definition that encapsulates various forms of violence along the continuum of violence perpetrated against women (VicHealth, 2011). However, these terms have specific meanings and should not be used interchangeably. Distinctions are also made in the service sector between 'primary prevention', 'early intervention' and 'response' – see terms below.

Consistent definitions and understandings are reflected in the literature as shown in the following table.

Term/Concept	How it is used
Ableism (also known as ablism, disablism, disability discrimination and handicapism)	Ableism is a neologism (a new word) used to describe effective discrimination against people with disabilities in favour of people who are not disabled. An ableist society is said to be one that treats non-disabled individuals as the standard of 'normal living', which results in public and private places and services, education, and social work that are built to serve 'standard' people, thereby inherently excluding those with various disabilities. Ableism – are the practices and dominant attitudes in society that devalue and limit the potential of persons with disabilities. Ableism - a set of practices and beliefs that assign inferior value (worth) to people who have developmental, emotional, physical or psychiatric disabilities. Disablism - a set of assumptions (conscious or unconscious) and practices that promote the differential or unequal treatment of

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Term/Concept	How it is used
	people because of actual or presumed disabilities (Stop Ableism, 2017)
Collaborative	Working together as a partnership to share learnings and support each other in our work to prevent violence against women.
Disability	'Many disability theorists and people with a disabilities, including Women with Disabilities Victoria, view 'disability' within a human rights framework and as a social construct created by the interaction of a person's **functional impairment** with a **disabling environment**.' **Functional impairment** includes one or more of sensory, physical, mental or cognitive (the latter includes cognitive impairments, intellectual disability, acquired brain injury and dementia). **Disabling environments** create structural, attitudinal and behavioural barriers; for example, by preventing people with functional impairments from accessing housing, education, work opportunities, transport and services. Disabling environments are also created through negative stereotyping of people with disabilities as inherently frail, stupid, or vulnerable regardless of the functional impairment. Other disabling environments create physical, sensory or cognitive barriers that are specific to a particular physical, sensory or cognitive impairment; the obvious ones are buildings and modes of transport that are physically inaccessible to people who use wheelchairs or poor signage for people with communication or cognitive impairments. (Healey, 2015)
Disability-based violence	'Involves a diverse range of behaviours that, in addition to sexual assault and family violence, includes being a target of impairment-related violence and abuse, hate crimes, ongoing neglect, the use of constraint or restrictive practices and institutional violence (rigid regimes, poor quality care, unethical or unauthorised practices in response to challenging behaviours and mental ill health needs and breaches of professional boundaries by staff). the violence is often experienced over long periods of time and inflicted by multiple perpetrators, including those providing personal care or services in institutional, public or service settings.' (International Network of Women with Disabilities, 2010; Saxton et al. 2001; Hague et al. 2008; Women with Disabilities Australia, 2007; cited in (Healy, 2013, p. 18).

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Term/Concept	How it is used
	'Disability-based violence is experienced differently by girl, boys, women and me with disabilities and is thus gendered and intersects with other forms of discrimination including race, sex and class.' (Healy, 2013, p. 18).
Early Intervention	Refers to taking action on the early signs of violence to reduce risk of violence occurring or escalating.
Ecological approach	This approach is based on the idea that the causes of violence against women lie at multiple and interrelated levels of social ecology. In the literature on violence against women three levels are commonly distinguished – individual and relationship, organisational and community, and societal. Certain factors, identified at each of these levels, are understood to increase the likelihood of violence against women however it should be noted that this model is about probability, i.e. not every individual experiencing these factors will become violent. Instead, particular factor increase the probability of violence against women in society and the probability of violence increases where multiple factors are present at multiple levels (Heise 2012, p21 cited in: (Webster & Flood, 2015).
Economic abuse	Behaviours that control a woman's ability to acquire, use and maintain economic resources thereby threatening her economic security and potential for self-sufficiency, e.g. a perpetrator controlling a woman's finances, denying her access to her property or abusing financial Power of Attorney; or exploiting a woman sexually in return for money (Healy, 2013).
Emotional or psychological violence	Behaviours that torment, intimidate, harass or offend an individual, e.g. yelling abuse, name calling, mind games, threats to kill or harm; or to commit suicide. Withholding medication and preventing a person from maintain contact/communication with their family, friends and culture can also be considered emotional or psychological abuse (Healy, 2013).
Engaging men	Recognises that preventing violence against women is everyone's responsibility and engages men and boys as active partners in addressing the gendered drivers. This is based on analyses of men's controlling behaviours and beliefs in unequal gender roles; women's lower levels of autonomy and civic participation; and traditional gender norms (Garcia-Moreno et al. 2005; Clark & Quadara 2010; Webster et al. 2014; Flood 2007; WHO 2010; Htun

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Term/Concept	How it is used
	& Weldon 2010; Grey 2002; Jones 1997; Taylor-Robinson & Heath 2013 cited in (Webster & Flood, 2015) There is emerging evidence that interventions involving both men and women (whether in mixed sex or single-sex groups) are more effective than interventions engaging only men or only women (Fulu et al. 2013b; 2014) cited in (Webster & Flood, 2015, p. 64)
Evidencebased and evaluated	Based on current evidence, research and consultation, and focus on long term change. Evaluation is built in from the start and is applied for continuous improvement and to build the evidence base. 'Generating evidence for practice ultimately depends on first building a practice base to evaluate. This does not mean that practice simply proceeds on the basis of 'trial and error'. Rather it is informed by evidence from available evaluations along with theory and evidence on the causes of the problem concerned. This approach is dependent upon a strong research and evaluation capacity' (Webster & Flood, 2015)p.61
Family violence	Behaviour that is physically or sexually abusive, emotionally, psychologically or economically abusive, threatening or coercive, or in any other way controls or dominates the family member and causes that family member to fear for their safety or wellbeing or for the safety and wellbeing of another person (Victorian family violence protection act 2008). The Victorian Indigenous Family Violence Task Force defines family violence as: 'An issue focused around a wide range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur within families, intimate relationships, extended families, kinship networks and communities. It extends to one-on-one fighting, abuse of Indigenous community workers as well as self-harm, injury and suicide (Department for Victorian Communities 2003).
Gender transformative	Refers to strategies that aim to transform gender relations in order to progress towards gender equality. 'The most successful interventions are those that seek to transform gender relations rather than simply changing attitudes and behaviours (Fulu et al. 2013b; 2014). Gender transformative approaches encourage critical awareness of gender roles and norms. They include ways to change harmful to more equitable

Term/Concept	How it is used
	gender norms in order to foster more equitable power relationships between women and men and between women and others in the community. They promote women's rights and dignity; challenge unfair and unequal distribution of resources and allocation of duties between men and women; and consider specific needs of women and men' (World Health Organization 2013a) cited in (Webster & Flood, 2015, p. 62).
Gendered approach to health and wellbeing	Acknowledges that women and men experience health differently and purports that a gender lens must be applied in order to reduce inequality and improve health outcomes (Women's Health West, 2014)
	The term gender is used to analyse the roles, responsibilities, constraints, opportunities and needs of women and men in all areas and in any given social context. The term sex refers exclusively to the biological differences between men and women. Gender roles are learned behaviours in a given society, community or other social group. They condition which activities, tasks and responsibilities are perceived as male or female. Gender roles are affected by age, disability, class, race, ethnicity and religion, and by the geographical, economic and political environment (United Nations Educational, Scientific and Cultural Organization (UNESCO) (2000) Gender Equality and Equity. A summary review of UNESCO's accomplishments since the Fourth World Conference on Women (Beijing 1995). UNESCO, Paris, France) cited in (Frohmader C, 2010).
Gendering Women with Disability	Disability-based violence is experienced differently by girls, boys, women and men with disabilities and is thus gendered and intersects with other forms of discrimination including race, sexuality and class
Human rights-based	An approach that places women's human rights, including their rights to physical integrity, agency and autonomy at the centre of prevention efforts.
Intersectinality	A power analysis that recognises that intersecting forms of discrimination can increase the prevalence and/or severity of violence. This analysis uses an inclusive lens that complements population-wide approaches with targeted strategies.

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Term/Concept	How it is used
	Intersectionality is an approach that considers intersecting and overlapping aspects of a person's identity, such as ethnicity, sexual orientation, disability or age. In particular, it applies a power analysis to recognise overlapping forms of discrimination or oppression. In relation to violence against women, an intersectional approach highlights that structural and social discrimination such as racism, ableism, colonisation, class oppression, homophobia, transphobia, ageism or ableism can intersect with gender inequality to increase the prevalence and/or severity of violence, and increase barriers to accessing help.

An intersectional approach suggests that work to prevent violence against women cannot be done in isolation from work to address racism and other forms of discrimination. Australia has a history of state-sanctioned violence against specific groups, for example, laws prohibiting homosexuality that existed as recently as 1997. In some cases, this violence continues, such as the violence experienced by asylum seekers in immigration detention centres (Womens Health West (WHW), 2017). |
Primary Prevention	'Primary prevention requires changing the social conditions, such as gender inequality, that excuse, justify or even promote violence against women and their children. Individual behaviour change may be the intended result of prevention activity, but such change cannot be achieved prior to, or in isolation from, a broader change in the underlying drivers of such violence across communities, organisations and society as a whole. A primary prevention approach works across the whole population to address the attitudes, practices and power differentials that drive violence against women and their children' (Our Watch, Australia's National Reserach Organisation for Women's Safety (ANROWS) and VicHealth, 2015, p. 13).
Response	Includes supporting survivors and holding perpetrators to account.
Sexual violence	Sexual activity that happens where consent is not obtained or freely given. It occurs any time a person is forced, coerced or manipulated into any unwanted sexual activity, such as touching, sexual harassment and intimidation, forced marriage, trafficking for the purpose of sexual exploitation, sexual abuse, sexual assault and rape (Our Watch et al., 2015 cited in (Womens Health West (WHW), 2017).

Term/Concept	How it is used
Social Model of Disability	The social model of disability explains disability as the result of the interaction between a person's impairment and disabling environment (Healy, 2013).
Social model of health	Recognises the impact of social, cultural, political and economic factors on a woman's health and wellbeing (Women's Health West, 2014)
Sustainable	Strategies that are designed to be sustainable through the engagement of leadership at every level; cross-sector partnerships; adequate, long-term funding; and embedding change in systems and structures.

2. Context

Internationally and nationally we have observed over the past few years substantial advances in policy and planning for preventing violence against women. The Australian Government has made significant efforts funding the Australian Centre for Research on Women's Safety and Our Watch; as well as policy to prevent violence against women with disabilities through the Quality and Safeguarding Framework.

The Victorian Government has made significant investments, with the Royal Commission into Family Violence in 2015, followed by *Ending Family Violence: Victoria's Plan for Change* (2016). In addition, a Parliamentary Inquiry into Abuse in Disability Services was proposed by the Victorian Government to examine some of the systemic issues impacting on the reporting and prevention of abuse. In response to the inquiry's final report, the Victorian Government has stated it will take a zero tolerance approach to abuse of people with a disability and will ensure that if abuse or neglect does occur, there will be strong and effective processes in place to report, investigate and respond.

Further, Victoria will introduce the first code of conduct for disability workers, train the workforce to better recognise, prevent and report abuse, and strengthen the oversight of disability services. It will also build the capacity of people with a disability, their families and carers to recognise and report abuse. Importantly actions will be taken to strengthen safeguards immediately and provide a model to influence and inform the further development of the National Framework to ensure the rights of people with a disability are protected once the National Disability Insurance Scheme (NDIS) is rolled out (Folley, Martin, 2016; Parliament of Victoria Family and Community Development Committee, 2016).

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Key documents include:

- Regional plans to prevent violence against women across all regions of Victoria (2017).

- Free from Violence, Victoria's strategy to prevent family violence and all forms of violence against women and create a safer Victoria (Victorian Government 2017).

- Emergency Management Diversity and Inclusion Framework: Respect and Inclusion for All (2017)

- Forthcoming Victorian Prevention Agency

- Ending Family Violence: Victoria's Plan for Change (State of Victoria, 2016)

- Safe and Strong, a Victorian Gender Equality Strategy (State of Victoria, 2016)

- A Framework to Underpin Action to Prevent Violence against Women (UN Women, 2015)

- Australian's attitudes to violence against women: Findings from the 2013 National Community Attitudes towards Violence Against Women Survey (VicHealth, 2015)

- National Plan to Reduce Violence against Women and their Children 2010-2022 and the Third Action Plan 2016-2019 (Commonwealth of Australia, 2011)

Two national agencies are funded under the National Plan to support preventing violence against women:

- Our Watch, a foundation to provide leadership on preventing violence against women

- Australia's National Research Organisation for Women's Safety (ANROWS).

Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia (Our Watch, 2016) is the National Framework guiding all PVAW work in Australia that advocates the following essential actions:

- Challenge condoning violence against women.

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

- Foster positive personal identities and challenge gender stereotypes and roles.

- Strengthen positive, equal and respectful relations between and among women and men, girls and boys.

- Promote and normalise gender equality in public and private life.

Change the story defines gender inequality as 'a social condition characterised by unequal value afforded to men and women and an unequal distribution of power, resources and opportunity between them'. It identifies four particular expressions of gender inequality that cause violence against women, known as the 'gendered drivers'.

1. Condoning of violence against women

2. Men's control of decision-making and limits to women's independence in public and private life

3. Rigid gender roles and stereotyped constructions of masculinity and femininity

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4. Male peer relations that emphasise aggression and disrespect towards women

The Quality and Safeguarding Framework

The roll out of the NDIS across Australia is changing the way people with a disability are being supported and the nature of their relationships with support providers and individual carers. There has been limited attention to violence against women with disabilities in the shaping and implementation of the NDIS; however Commonwealth, State and Territory Governments have been developing a national approach to quality and safeguarding for the NDIS. A 2015 consultation explored quality and safeguarding measures that should be adopted for the NDIS. Stakeholder consultations identified that particular consideration should be paid to gender-based violence and the heightened vulnerability of women and girls with disability to exploitation, violence and abuse; and that adequate safeguard be provided. Stakeholders also highlighted the need for specialist violence prevention workforce training that should be developed with women with disabilities, family violence, sexual assault, justice, police, mental health, aged care and disability organisations. They also advocated training on the gendered nature of violence and abuse (ARTD Consultants, 2015).

The Disability Industry Demand Analysis of the Workforce Development Program on Gender and Disability has indicated that disability service organisations are overwhelmingly occupied with their transition to the NDIS. The environmental conditions as a result of the NDIS present considerable challenges to disability service organisations. Most organisations reported being completely occupied with transitioning to the NDIS and estimated that it will be between 3-5 years before the reforms are settled, with some estimating it may be up to 10 years. Whilst the NDIS reforms are essentially viewed positively, there is significant disruption and uncertainty across the non-government sector, considerable pressure on staff and organisations and a strong sense that the sector will look different in the next 3 -5 years (Effective Change Pty Ltd, 2016).

3. Prevalence of violence against women with Disabilities

Violence against women can take the forms of physical, sexual, psychological and financial violence, as well as threats of violence. Violence against women can occur in public or private spaces, including institutional and online settings. In Australia, one in three women have experienced physical violence and one in five have experienced sexual violence since the age of 15 (Australian Bureau of Statistics, 2012). On average one woman a week is killed by a partner or former partner (W Cussen T & Bryant, 2015). Violence against women and their children costs Australia $21.7 billion each year (Price Waterhouse Coopers Australia (PwC), 2015).

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Despite concerns about the increased risks to violence against women with disabilities, we do not have a system for the collection of data in Australia that can measure the prevalence of violence against women with disabilities. Further, a national scale study into the prevalence of violence against girls and women with disabilities has not been undertaken (Healy, 2013).

However, Kavanagh et al. (2015) used a large population-based disability-focused survey of Australians, analyzing data from 33,101 participants aged 25to 64 to investigate socio-economic disadvantage for men and women with different types of disabilities. The study found that women with disabilities experience health consequences based on their gender including high levels of gender based violence and forced sterilization (Barrett, Roche et al. 2009 and Parker 2013 cited in Kavanagh, et al., 2015.

It is also documented that:

'…researchers in the family violence–sexual assault arena highlight unacceptably high levels of 'violence against women' with the emphasis on the gender of victim–survivors and relegate women with disabilities – like Indigenous, immigrant and lesbian women, those identifying as intersexed or transgendered, rural and older women – to a subset of all women'. The result of this dissonance is that violence against women with disabilities is not well understood in the disability sector and violence against people with disabilities is not well understood by family violence–sexual assault services (Healy, 2013, p. 22).

Other forms of discrimination – including colonization, racism, ableism, homophobia, transphobia, and classism – intersect with sexism and misogyny to increase the prevalence and severity of violence and create barriers to seeking help. In particular, this affects Aboriginal women, women from migrant and refugee backgrounds, women with disabilities, LBTI women, women in prison, women in institutional care and women facing socio-economic inequality (Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth, 2015).

Change the Story identifies that:

- Violence against women is prevalent, serious and preventable (VicHealth, 2007)
- Family violence is gendered and disproportionate with men predominately perpetuating violence against women (VicHealth, 2011)
- Violence against women is now widely recognised as a global problem and one of the most widespread violations of human rights (VicHealth, 2007)
- Family violence and sexual assault are the most common forms of violence experienced by women in Victoria (COAG advisory panel on reducing violence against women and their children, 2016; Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth, 2015)

Women with Disabilities Victoria states that:

- Gender-based and disability-based discrimination increase the risk of violence for women and girls with disabilities.

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- Men who use violence often target women who they perceive are less powerful, such as women who are unable to communicate to others what has happened to them, and those restricted in their physical movement.

- Women and girls with disabilities are twice as likely as women and girls without disabilities to experience violence throughout their lives.

- Over one-third of women with disabilities experience some form of intimate partner violence.

- In mental health inpatient services, 45% of women experienced sexual assault and more than 80 per cent lived in fear of being abused, while 67 per cent of women reported harassment during admission.

- Many women experience social isolation as both a risk factor for, and a consequence of, violence. Some perpetrators use social isolation as a form of controlling behaviour in itself.

- Isolation can be compounded for women living rurally or remotely, women who are culturally isolated and for older women (sometimes called elder abuse (Women with Disabilites Victoria, 2014).

Identified studies have consistently urged for more robust data collection and consideration of risks for women with disabilities and different sectors of service provision. In Australia and Victoria there are limited sources of correlated data that provide accurate information about the prevalence of violence against girls and women with disability. The Australian Bureau of Statistics (ABS) recently published a conceptual data framework that outlines the background and policy context in relation to family, domestic and sexual violence and describes the challenges and complexities involved in their statistical measurement (Healy, 2013).

Issues that make it difficult to determine the prevalence of violence against girls and women with disabilities include:

- Under-reporting of crimes

- Under-recording of incidents due to particular service systems and procedures

- Hidden reporting where the victim seeks services but does not disclose the violence

- Different recording rules across Australia

- Fear of asking questions about sensitive personal issues (Healy, 2013)

A number of studies (Commonwealth of Australia, 2009; see also Fitzsimons, Hagemeister, Braun, 2011 cited in Healy (2013) have indicated that under-reporting is more likely to occur when women with disabilities live in institutional settings, supported residential units or in rural and remote communities; or lack a stable home. When they have poor telecommunication access or face communication barriers due to their disability, race or ethnicity; and as an Aboriginal or Torres Strait Islander or asylum seeker, where reporting to an authority never represents a route to safety. In addition, it has been reported that some police are reluctant to take statements from women with cognitive disabilities who report violence, believing they will not be seen as credible witnesses in court (Camilleri, 2009 cited in Healy, 2013).

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According to Brownbridge, 2009, cited in Healy, 2013, p. 34), 'perpetrators' use of coercive control such as controlling access to medication, mobility and external supports) and violence is fuelled by compounding ableist and sexist views. The violence that women with disabilities experience can be the same as those experienced by women without disabilities, however there are some types of violence that are specific to women with disabilities that are characterised by particular behaviours and relationships with perpetrators, e.g. support workers or intimate partners; and support settings, e.g. supported accommodation. For example:

- *Physical violence* may include: administration of poisonous substances and inappropriate medication; withholding food, water or heat; rough handling and physical or chemical restraint; withholding equipment, medications or transportation; not providing assistance with essential daily care; confinement; altering, destroying or not using assistive equipment; and neglect, abandonment and deprivation.

- *Sexual violence* may include sexual activity in return for care; forced sexual activity; sexual assault; being left naked or exposed; and denial of sexuality.

- *Emotional and psychological violence* may include threats to withdraw care and support; ignoring requests for assistance; threats of punishment or abandonment; violations of privacy; and threats to institutionalise.

- *Economic abuse* may include inappropriate management of funds and theft of disability support payments; bank fraud; and abuse of Power of Attorney.

- *Reproductive abuse* may include controlling menstruation by streilisation; controlling termination of pregnancy – particularly girls and women with intellectual disabilities; denial of sex education; and denial of appropriate reproductive health care (Healy, 2013).

According to the World Health Organisation women who have experienced violence, whether in childhood or adult life, have increased rates of depression and anxiety, stress related symptoms, pain syndromes, phobias, chemical dependency, substance use suicidality, somatic and medical symptoms, negative health behaviours, poor subjective health and changed to health service utilization (World Health Organisation, 2002).

While more specific information on the relationship between violence against women with disabilities and its impact on their mental health and wellbeing was not found, survey research conducted in Cambodia on the impact of disability and partner violence on women's mental health, reveals that there was a strong relationship between disability and symptoms of severe psychological distress, and that the presence of partner violence further accentuates this relationship. The psychological or mental health of women with disabilities increases their chances of being victims of violence. Social and cultural discrimination and use of stereotypes may be internalized by women, translating into self-devaluation, poor self-esteem and body image (Astbury 2012; Hassouneh-Phillips & McNeff 2005, cited in Heijden, 2014), and feelings of blame related to the abuse. They fear of rejection and being alone, forcing them to stay in an abusive relationship. Once in a relationship, Oktay and Tompkins (2004) found that women with disabilities were more likely to tolerate abuse from their partners rather than leave and be single. Therefore studies suggest that women with disabilities experience abuse for longer periods of time compared to those

without disabilities (Plummer & Findley 2012; Nosek et al 2001; Oktay and Tompkins 2004; Young et al. 1997, cited in Heijden, 2014).

Overall, gender-based violence is a major health issue, with both adverse mental and physical health outcomes for women, and physical and psychological health effects can linger long after the abuse has stopped. Pain and injuries range in intensity and chronic stress, anxiety and depression, sleep disorders and substance abuse can manifest or increase as a result of the abuse and add further impairments to women with disabilities. Astbury (2012) recognises the important gap in the evidence base on how gender-based violence affects the psychological well-being of women with disabilities. These consequences need to be further elaborated in more studies (Nosek et al. 1997; Astbury, 2012 cited in Heijden, 2014).

Curry's research in 2002 showed that women with disabilities were more likely to experience abuse by health care providers and personal assistants, both formal and informal, family members, intimate partners, friends or professionals and for longer periods of time. It is important to recognize the complex relationship between women with disabilities and the people who provide their personal support (Curry MA, 2002).

4. Drivers and Impacts of Violence against Women

Gender inequality sets the necessary social context in which violence against women occurs. It is a social condition characterised by unequal value afforded to men and women and an unequal distribution of power, resources and opportunity between them. Gender inequality is influenced by other forms of systemic social, political and economic disadvantage and discrimination. Other factors interact with or reinforce gender inequality to contribute to increased frequency and severity of violence against women, but do not drive violence in and of themselves (Our Watch, Australia's National Reserach Organisation for Women's Safety (ANROWS) and VicHealth, 2015).

Research indicates that gender inequality is maintained and perpetuated through structures that continue to organise and reinforce an unequal distribution of economic, social and political power and resources between women and men. This results in limiting social norms that prescribe the type of conduct, roles, interests and contributions expected from women and men; and the practices, behaviours and choices made on a daily basis that reinforce these gendered structures and norms (Our Watch, Australia's National Reserach Organisation for Women's Safety (ANROWS) and VicHealth, 2015).

According to Our Watch, there are factors associated with higher levels of violence against women including ideas, values or beliefs that are common or dominant in our society or community, i.e.

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cultural norms which are reflected in institutional or community practices and behaviours and which are supported by formal and informal social structures such as legislation, family and community hierarchies. This socio-ecological approach is reflected in the diagram below.
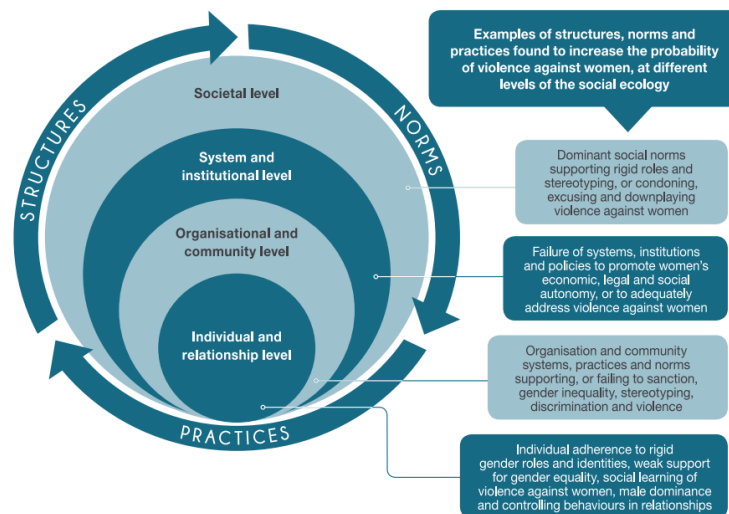

Figure 3 Socio-ecological model of violence against women

Source: (Our Watch, Australia's National Reserach Organisation for Women's Safety (ANROWS) and VicHealth, 2015, p. 21)

The impact of violence has profound consequences for women, children, families and whole communities (Our Watch, Australia's National Reserach Organisation for Women's Safety (ANROWS) and VicHealth, 2015). Violence against women has serious and long-lasting consequences for women's health, in particular their sexual and reproductive health and mental health. It also has significant social and economic consequences, negatively affecting academic performance, employment and participation in public life (UN Women, 2015; Australian Women's Health Network, 2014).

Gendered drivers have been identified that consistently predict higher rates of violence against women. They include:

- Condoning violence against women
- Men's control of decision-making and limits to women's independence in public and private life
- Rigid gender roles and stereotyped constructions of masculinity and femininity
- Male peer relations that emphasise aggression and disrespect towards women

Further, reinforcing factors can increase the frequency or severity of violence and they include:

- Condoning of violence in general
- Experience of and exposure to violence

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- Weakening of pro-social behaviour, especially harmful use of alcohol

- Socio-economic inequality and discrimination

- Backlash factors (increases in violence when male dominance, power or status is challenged (Our Watch, Australia's National Reserach Organisation for Women's Safety (ANROWS) and VicHealth, 2015).

According to WWDA (Frohmader C, 2010), and consistent with other literature, women with disabilities face multiple discriminations and are often more disadvantaged than men with disabilities in similar circumstances. Women with disabilities are often denied equal enjoyment of their human rights, in particular by virtue of the lesser status ascribed to them by tradition and custom, or as a Women with disabilities face multiple discriminations and are often more disadvantaged than men with disabilities in similar circumstances. Women with disabilities are often denied equal enjoyment of their human rights, in particular by virtue of the lesser status ascribed to them by tradition and custom, or as a result of overt or covert discrimination. Women with disabilities face *particular* disadvantages in the areas of education, work and employment, family and reproductive rights, health, violence and abuse. For example, women with disabilities experience violence, particularly family violence and violence in institutions, more often than disabled men.

According to Krnjacki et al. (2015), women with disabilities at a higher risk of sexual and intimate partner violence while men with disabilities have a higher risk of physical and non-domestic violence (Krnjacki, et al., 2015).

WDA (Frohmader C, 2010) argue that it is important for gender to be mainstreamed into all aspects of disability care and support schemes because women and girls with disabilities have fewer opportunities, lower status and less power and influence than men and boys with disabilities. According to Women with Disabilities Australia, women with disabilities:

- are poorer and have to work harder than disabled men to secure their livelihoods

- have less control over income and assets

- bear the responsibility for unpaid work in the private and social spheres

- have a smaller share of opportunities for human development

- are subject to violence, abuse and intimidation

- have a subordinate social position

- are poorly represented in policy and decision-making (Department for International Development, 2002; Krnjacki, et al., 2015)

In many cases, women with disabilities do not have equal access to household income and resources and consideration must be given to women and girls who are:

- are socially excluded

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- are subject to, and at risk of, violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation
- experience pervasive poverty
- are denied access to education and employment
- are subject to violations of their fundamental human rights
- are segregated and incarcerated in institutions and other forms of congregate care arrangements

4.1 Drivers and Impacts of Violence against Women with Disabilities

Key themes on writings on violence against women with disabilities focus on socio-economic factors; social systems, structures and norms; and the experiences of women with disabilities and the people they interact with, including family and support workers.

Gender-based assumptions and expectations generally place women with disabilities at a disadvantage with respect to substantive enjoyment of rights, such as freedom to act and to be recognised as autonomous, fully capable adults, to participate fully in economic, social and political development, and to make decisions concerning their circumstances and conditions (Frohmader C, 2010).

Women with disabilities are more likely than men with disabilities to have lower standards of living given the discriminatory access to mainstream services and public resources; they are more likely to be at risk of violence. This risk is significantly greater for Indigenous women with disabilities (OHCHR, 2012 cited in Healy, 2013).

Heijden (2014) notes that women with disabilities often find themselves trapped in abusive or neglectful relationships because they are financially and physically dependent on their partners, families or care givers who are perpetrators of violence and abuse. More importantly, their reliance on others increases their risk of forms of emotional and physical abuse which are disability-based forms of violence, such as being prevented from using a wheelchair or other assistive device, being over or under-medicated, being neglected or refused help, or the misuse of their welfare grants by family members adds further exploitation and vulnerability (Brownridge 2006; Curry, Renker, Hughes et al 2009 cited in Heijden, 2014).

While research specifically focusing on violence against women with disabilities is not extensive, some evidence suggests that societal structures and norms that lead to gender inequality apply even more strongly to women with disabilities. Women with disabilities may experience both gender inequality as well as inequality related to their disability. Research shows that there is a gendered pattern to violence against women with disabilities where perpetrators are most likely to be men in

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an intimate or family-like relationship or who are providing disability related care and are repeatedly using abuse, coercion and violence or threatening to do so (Clark and Fileborn, 2011; McLain, 2011; Pence, 2010; The National Council to Reduce Violence Against Women and Their Children, 2009; WWDA, 2007 cited in Healy, 2013).

Discriminatory practices towards women with disabilities foster systemic violence by restricting access to resources and services that will enable them to be free of violence. These barriers are seen to stem from society's disablist environments which prevent equitable access to work, education, housing, community inclusion and support services; and ultimately result in poverty and isolation. Further, sufficient protections against violence are not provided by the community and institutional environments in which women with disabilities live. The very reasons why women with disabilities are targeted by perpetrators, e.g. financial, relational, emotional dependence, are also the reasons why they cannot access services, thereby perpetuating a vicious cycle. Negative attitudes about disability are endemic to our society, including the view that women with cognitive disabilities have a propensity to lie, are sexually promiscuous or are unreliable witnesses because they have poor memory recall or are highly suggestible (Healy, 2013).

According to WWDA, people with disabilities are often treated as asexual, genderless human beings. This view is borne out in Australian disability policies, which have consistently failed to apply a gender lens. Most have proceeded as though there are a common set of issues - and that men and women experience disability in the same way. (Gray, G. [2010 draft] By Women for Women, the Australian women's health movement and public policy cited in (Frohmader C, 2010).

According to the National Survey on Community Attitudes to Violence Against Women 2009, cited in Healy, 2013), there is poor community understanding of the nature, impact and greater risk of experiencing violence for women with disabilities and little awareness of the barriers to disclosing violence.

The social and cultural myths around disability equally work to increase a women's likelihood of victimisation. The sexuality of women with disabilities is often denied or ignored and there is pervasive stereotyping of women with disabilities as asexual because of the stigma associated with their disability. A woman with a disability is perceived as unable to reproduce. This can prevent women with disabilities from fulfilling normative gender roles of reproduction and motherhood and resulting in increased difficulties to access reproductive health care services. This can include limited contraceptive options, health care providers' insensitivity and lack of knowledge about disabilities, and limited information tailored to their health needs and on the most perverse side, forced sterilization or forced abortion (Nosek et al. 1997; Groce & Trasi 2004; Becker 1997; Ortoleva & Lewis 2012, cited in Heijden, 2014). Longstanding research also shows that parents with disabilities experience significant discrimination, particularly within the child welfare and family law systems. Based on prejudiced and antiquated policies that presume unfitness, parents with disabilities are much more likely to be referred to the child welfare system and to have their children removed from their homes. Likewise, parents with disabilities often are denied custody or visitation of their children during divorce proceedings (Powell, 2012).

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Women with disabilities are less likely to receive sex education or information on reproductive health, and are assumed to not be eligible for marriage and are more likely to be divorced and less likely to marry than men with disabilities or women without disabilities. Because of myths around the asexuality and ineligibility for marriage, it is rarely assumed that women with disabilities have intimate partners, so (intimate partner violence) IPV often goes undetected (Naidu, Haffejee, Vetten & Hargreaves 2005; Gerschick 2000; Barnett et al 2005, p353, cited in Heijden, 2014).

It is commonly assumed that women with developmental disabilities and cognitive impairments are most at risk for stigma and therefore more likely to be victims of abuse, violence and neglect. Risk factors are found with greater prevalence among women with intellectual disabilities; they are less likely to receive any sexual education, often socialized to be compliant, more likely to live in poverty and are more reliant on caregivers. They are more likely to be institutionalized and are unlikely to disclose violence as for them communication may be difficult or they are unlikely to be believed. Institutionalization is associated with mistreatment and abuse, and women with disabilities, in greater numbers than men with disabilities, have been incarcerated in prisons, hospitals, nursing homes, psychiatric and other institutions. Also, the bodily signs of disability may put women with physical disabilities at risk of stigma and therefore violence or abuse. Furthermore, vision impairment may hamper women from identifying perpetrators, or their immobility put them at increased risk of non-escape from violent acts (Powers, Renker, Robinson-Whelen et al. 2009; Barger et al 2009; Powers, Renker, Robinson-Whelen et al 2009; Meekosha 1998; (Young et al 1997; Nosek et al. 1996; Plummer and Findley 2012, cited in Heijden, 2014).

Violence perpetrated by female family members or service providers against women with disabilities indicates that gendered power is not the whole explanation for violence against women with disabilities. This suggests that gender may not be the only source of oppression for women with disabilities (Healy, 2013).

'Women with disabilities are more likely to be victims of violence and less likely to receive an adequate response to violence when it occurs? The key answer to this lies not so much in any inherent traits exhibited by women with disabilities, but rather in society's response to disability. Disability has been found to be a risk factor for violence 'in cultures that devalue people with disabilities, but not in cultures that place a higher value on them' (Sobsey and Doe in Healey et al, 2008, p.36 cited in McGuire, 2013, p. 16).

Women with disabilities' experiences and risks of violence are compounded by physical, sensory or intellectual impairments, marginalisation from society and inaccessible environments. Their physical, economic and social dependence is a key risk factor associated with gender based violence. Women with disabilities are exposed to multiple potential perpetrators on which they are dependent, including intimate partners, family members, health care providers and personal assistance workers (Plummer & Findley 2012, cited in Heijden 2014).

The variety of impairments associated with a disability is wide and can make a significant difference in the risks and forms of abuse women face. Hughes, Bellis, Jones et al. (2012) report the association between intellectual impairment and risk of violence to be significantly higher than with women

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with other disabilities. Impairments that reduce emotional and physical defences, communication barriers that hamper the reporting of violence, societal stigma and discrimination, and institutionalization contribute to women with disabilities increased vulnerability to violence (Hughes, Bellis, Jones et al. 2012; Nosek, Howland & Hughes 2001; Saxton, Curry, Powers et al 2001, cited in Heijden, 2014).

The 2012 Australian Personal Safety Survey attempted to gauge the number of women with disabilities experiencing violence by a man; however, the data did not indicate a significant difference between women with disabilities and other women experiencing violence by a man in the past 12 months. **Women with disabilities were however, significantly more likely to have experienced violence over their lifetime**, **and it should be noted that the survey only included particular cohorts of women with disabilities, i.e. women in private dwellings; and may therefore not reflect the full picture of violence against women with disabilities**. Canadian research has identified that partners who perpetrate violence against women with disabilities are likely to be more domineering and possessive, and display increased sexual jealousy. Interestingly a National *Community Attitudes Towards Violence Against Women* Survey in 2014 showed that men with disabilities were more likely than men without disabilities to support violence against women and less likely to support gender equality (Our Watch, Australia's National Reserach Organisation for Women's Safety (ANROWS) and VicHealth, 2015).

It is understood from qualitative studies that most interpersonal violence (including family violence, sexual assault) is perpetrated by men towards women with disabilities, although we cannot be sure if this dominant gendered pattern exists to the same degree in violence perpetrated against women with disabilities in institutional settings. Further, women with disabilities are at greater risk of experiencing violence compared with both men with disabilities and women without disabilities; and women with intellectual disabilities are more likely to experience sexual assault compared with other women with disabilities (Healy, 2013).

Summarised studies consistently concluded that women with disabilities are at greater risk of violence than women without disabilities and that women with particular impairments (variously identified as intellectual, mental ill health or as severely limiting) are at greater risk of sexual assault, in particular (Healy, 2013).

According to Curry (2002), the fear of not having basic physical needs met when assistance is not provided is identified as a powerful method by which people with disabilities have been victimized. The power dynamics and resolution of subsequent abuse may become more difficult or confusing if the caregiver is also a family member or intimate partner. This increases the chance the abuse will remain hidden because of fears of losing the relationship or fear of being institutionalized (Curry MA, 2002).

Women with disabilities experiencing family violence tend to suffer from additional types of abuse, for longer durations, and at the hands of a greater number of perpetrators. Women with disabilities experience violence within a broader range of relationships than those typically pertaining to women without disabilities. Although intimate male partners of women with disabilities are the

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most common perpetrators, personal assistants working in both institutional and private residential settings are a significant perpetrator group. Additionally, women with disabilities are at risk of experiencing violence by other support staff, service providers, medical and transportation staff, and taxi drivers, peers and male residents of a shared residential home (Healy, 2013).

Because these forms of abuse are little known, women with disabilities are further isolated and underserved by providers whose non-recognition creates a barrier to providing them with an option to disclose the abuse (Curry MA, 2002). Curry advocates that women with disabilities need to be provided:

- Opportunities to identify if they are experiencing abuse. Advocates and health providers need to ask about specific behaviours – screening questions
- Assessment for at risk factors e.g. absence of a backup personal assistance provider
- Safety planning – backup caregivers, bag with critical documents resources etc
- Screening done in a culturally competent manner – e.g. privacy (Heijden, 2014).

Women with disabilities are less likely to disclose violence or seek help. This is due to women being unaware they are being abused or recognizing ill treatment – thinking it is normal; a cognitive inability to comprehend what is happening; dependence on partner and/or fear of losing partner or children; fear of institutionalization, lack of screening for violence, not being aware of her rights and laws to protect her, and lack of access to information on prevention or protection. If they do seek help, they are met with physical, resource and attitudinal barriers. Some of the reasons why women with disabilities may not get the help they need include:

- Lack of physical access to justice system and courts, communication barriers and not seen an credible witnesses
- They are met with insensitive behaviour by service providers
- Social workers may not understand the issues facing women with disabilities, and disability sector workers may not be educated about the high risk of violence.
- The various agencies that help people with disabilities aren't networked well, creating service gaps. For example, a woman might be referred back and forth between two agencies, such as sexual assault services and disability services, without receiving help from either because she falls outside the guidelines of both agencies (Swedlund & Nosek, 2000, cited in Heijden, 2014).

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5. Prevention of violence against women with Disabilities

There is limited evidence on the particular forms of primary prevention intervention that may be relevant to vulnerable groups such as girls and women with disabilities (Fulu & Kerr-Wilson, 2015).

The literature strongly purports or advocates that prevention strategies must address the systemic and structural issues discussed earlier, that underlie violence against all women in addition to the specific societal factors that exacerbate violence against women with disabilities. The following points emphasise the importance of focusing on a socio-ecological approach in order to have maximum impact.

- Primary prevention seeks to prevent violence before it occurs; critical to this important work is the 'undoing' of social structures that reinforce male privilege and gender inequity

- The primary prevention of violence against women is about taking coordinated and integrated action on the underlying determinants across the different levels of their influence

- With increasing momentum, preventing violence against women has become a key priority across government, business, and health and community sectors

- Action cannot be deemed primary prevention if it focuses only on individual knowledge, skills and behaviours. The structural contexts of organisational and community life are also critical targets, as is the broader societal context that both shapes and is shaped by the other levels of the ecology

- The problem of violence against women is unlikely to abate, let alone be eradicated, without multi-level action on the two underlying determinants: (1) the unequal distribution of power and resources men and women, and (2) an adherence to rigidly defined gender roles (VicHealth, 2007; Our Watch, Australia's National Reserach Organisation for Women's Safety (ANROWS) and VicHealth, 2015).

6. Primary Prevention Strategies, Good Practice, Tools and Resources

The literature outlines the PVAW principles that need to guide prevention strategies and while practitioners are developing a range of programs/interventions based on some of these principles very little of this is systematically evaluated especially for impact. So we are in the early phases of getting clear about what works and a good deal more research and evaluation needs to be undertaken.

The recently released *Victorian Government Prevention Strategy - Free from* Violence (Victorian Government, 2017) seeks to implement a reform agenda that will initiate whole-of-communitychange and prevention to create long term change over many years and across all parts of the community. The strategy acknowledges that social norms, structues and practices are the leading cause of violence against people with a disability. The approach includes:

- Focusing on the drivers of violence
- Acting on reinforcing factors
- Working with the whole community
- Reaching people in a range of places
- Connecting and coordinating prevention efforts
- Building continuity with the response system

Five priorities for action have been identified:

1. Building prevention structures and systems
2. Scaling up and bulding on what we know
3. Inovating and informing
4. Research and evaluation
5. Engaging the community

Factors that are foundational to this approach are:

- Prevention in universal services
- Dedicated and enduring funding
- Coordination and advocacy
- Policy reform in family violence and gender equality

An outcomes framework has been developed as an accountabilty tool and includes domains and indicators of success (Victorian Government, 2017).

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The literature review found few references that could directly inform best practice approaches for including women with disabilities and disability organisations into regional action plans and PVAW activities. However, literature is available on broad strategies for the prevention of violence against all women that may inform strategies and good practices applicable to women with disabilities. Some key prevention strategies are described below.

6.2   Prevention Strategies for women with disabilities

WDV state that to prevent violence against women with disabilities, it is important to:

- *Listen to women with disabilities*: women report that the most important help they received was that people listened to them.

- *Empower women*: representation of women in staff, on boards and in all levels of decision making is a critical way to reduce discrimination and break down power imbalances.

- Provide accessible information on rights and services: "Unless you know the systems you don't know what to ask for and you don't have any power." Sam, WDV member.

- *Find out about services in your area:* we need to work together to remove barriers for women with disabilities to access safety and justice.

- *Understand the causes of violence against women with* disabilities: layers of power and discrimination combine with negative stereotypes.

- *Address discrimination*: environments and attitudes are often disabling. Take steps to reduce the access barriers that you can see (Women with Disabilites Victoria, 2014)

WDV assert that tailored violence prevention programs are needed and only with leadership in this direction can we really address violence against women with disabilities. The organisation has focused on approaches to prevention that address both gender inequality and disability discrimination. For example, the Women with Disabilities Victoria's pilot violence prevention training program:

- Involves women with disabilities co-facilitating groups of disability service staff

- The women work alongside trainers with experience in violence prevention and response

A strength of this training is that it builds relationships between disability services and women's services who have expertise in violence prevention approaches and reinforces disability service's understanding of gender inequality. This is exactly what is needed across services and government departments (Women with Disabilities Victoria, 2014).

A key strategic intervention driven by WDV is the *Enabling Women in Leadership* program. The program reaches into regional and rural Victoria and builds the confidence of women with disabilities to step up in their own communities. The program provides the opportunity for women from diverse backgrounds to come together, share stories and find solutions to physical, social,

political and economic barriers they experience. Women who have graduated from this program have provided a valuable touchpoint for Women's Health Services to better understand disability discrimination and access, and to link women with disabilities with the planning processes. By understanding how gender based violence combines and compounds with disability based violence, and intersects with additional forms of inequity, Women's services are more equipped to develop regional plans and activities which are responsive to the rights of women at higher risk of violence.

Several Women's Health Services and metropolitan and regional violence prevention and response services have initiated a range of programs and projects that focus on women with disabilities as a population group and highlight practical strategies that contribute to preventing violence against women with disabilities. These can inform and support regional planning processes that are more inclusive of all women, including women with disabilities (Women with Disabilities Victoria, 2017).

WDA states that in relation to the NDIS, for some women with disabilities, self-directed funding may lead to increased vulnerability and potential for exploitation and abuse. It also advocates that Gender disaggregated indicators should be built into the scheme design; and monitoring and evaluation mechanisms should include both quantitative and qualitative approaches and measures (Women with Disabilities Victoria, 2013)

Frohmader (2015) argues that the Human Rights Framework demonstrates responses to violence against women cannot be considered in isolation from the context of individuals, households, settings, communities or States. Discrimination affects women in different ways depending on how they are positioned in social, economic and cultural hierarchies (Frohmader C, 2015). Frohmader (2015) recommends the following:

- Adopt a due diligence framework to operationalise VAW as a human rights violation and a form of discrimination

- Integrated and standardised definitions and understandings of gender based violence that are inclusive of all women and girls with disabilities

- Recognition of the disproportionate effect of gender based violence on women with disabilities

- Have inter and intra gender inequality discrimination and centre of prevention measures

- Such measures connect causes and consequences of violence against women with multiple and intersecting forms of discrimination

- Recognise that multifaceted prevention strategies are required to address multiplicity of forms of violence and intersectionality of violence

- Ensure prevention strategies include positive obligations – beyond awareness raising, education, training and sensitisation of the media – to include government policy and legislative reforms to promote gender equality across all sectors and jurisdictions

- Include women with disabilities at the centre of planning and development of prevention measures that best address their needs and rights and in all implementation, evaluation and monitoring of all prevention efforts

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- Avoid re-victimisation by ensuring prevention measures place the human rights of all victims at the centre of prevention strategies (Frohmader C, 2014).

Heijden (2014) specifically addresses the prevention of violence against women and girls with disabilities noting that:

- Women with disabilities are at increased risk for gender based violence due to the intersection of gender bias and disability stigma and discrimination.

- In order to develop appropriate responses and interventions to prevent violence and protect women with disabilities, we need to know the risk factors and context respond to them accordingly.

- Some violence and abuse prevention interventions for women with disabilities have been developed.

- None of these prevention interventions demonstrate a decreased incidence of violence, and many lack rigorous planning, implementation and evaluation.

- There is only one published systematic review of the prevalence of violence against adults with disabilities – but does not include gender-based violence against women

- Much more research and innovation is needed to develop effective approaches to recognise and prevent violence against women with disabilities, especially in low and middle income settings.

Mobility International USA has identified five Starting Strategies for Inclusive Health, Wellness and Safety Programs and Services:

1. Facilitate collaboration and coordination between stakeholders including: criminal justice, health, welfare, social service systems with organizations and groups of women with disabilities, so that in any given community a disabled woman who is a victim of violence will be directed towards an integrated network of services that can offer both solutions and hope, no matter where she makes her first point of contact.

2. Train service providers and staff in public service (i.e. police, schools, health services, social services and other community networks) on the issues of women with disabilities – ensure these trainings are run with women with disabilities.

3. Educate parents and families on rights of women and girls with disabilities and importance of access to information and services.

4. Educate women with disabilities about their rights to violence prevention, safety and wellness and about the available programs and services.

5. Work with disabled women and their representative organizations or networks to understand how to better reach and include women with disabilities in violence prevention and health programs (MIUSA mobility international USA, 2017).

It should be noted however that many of these approaches are focused at the individual and service provider level which is not the remit of primary prevention.

Our Watch have produced a toolkit for practitioners and community organisations that provides a suite of materials for practitioners wishing to work with communities to prevent violence against

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women (Our Watch, 2016). The strategies and actions included in the toolkit provide a starting point for adaptation for different contexts. This would include specific strategies to address the needs of women with disabilities as outlined in this review.

Evidence presented to the Royal Commission into Family Violence was clear that school-based prevention is effective to reduce the incidence of family violence. Recommendations handed down by the Royal Commission as part of their report reflect the evidence that school-based efforts are required as a long-term prevention strategy (Victorian Government Education Department, 2017). This is based on understanding that prevention work through schools, social media and other settings can help develop young people's ability to critique such influences, and build their capacity to create healthy sexual identities and respectful, egalitarian intimate relationships. To this end the Respectful Relationships program has been implemented in schools across Victoria; however it must be noted that the programs does not include specific actions focused on girls with disabilities. It should be noted that in 2017 Our Watch is working with special schools to introduce Respectful Relationships to students with disability (Our Watch, 2016).

In conclusion, there are few violence and abuse prevention efforts geared towards women with disabilities and none of these prevention interventions demonstrate that they decrease incidence of violence, or help to mitigate risk factors. They lack rigorous planning, implementation and evaluation. There is a need for substantial work in this area. Issues to consider and pointers for future intervention development include the following:

- Interventions need to be informed by evidence and theory of what increases risk of violence against women with disabilities

- Interventions need to include caretakers on prevention of violence against women with disabilities as protectors and potential perpetrators

- Social services and agencies need to be more aware of disability-based forms of violence, such as being prevented from using a wheelchair or other assistive device, being over or under-medicated, being neglected or refused help, or the misuse of their welfare grants by family members

- Interventions need to be developed to empower WWD to strengthen resilience through economic empowerment to decrease dependency and social empowerment to become more knowledgeable partners in their own health care - focus on sex education and reproductive health. These need to be evaluated.

- Social norm change interventions are needed to address perpetuation of social and cultural myths that encourage disability stigma and gender stereotypes, and denial of sexuality of women with disabilities which leads to silence around their IPV

- Safety planning discourse and strategies for women with disabilities need to take into account their impairments and the accessibility of their environments

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6.3   6.3 Workforce and Organisational Development

Workforce capacity building strategies in primary prevention, including tools and resource, do not make specific references to violence against women with disabilities, although these resources may be further tailored to include women with disabilities. Some specific examples of workforce and organisation capability initiatives are as follows:

Example: Women with Disabilities Victoria Workforce Development Program on Gender and Disability

Women with Disabilities Victoria have developed this program for disability service organisations. It is a cultural change program to support organisations to develop and implement gender-responsive and sensitive practices. The program, in partnership with participating organisations, includes:

- Workshops for management staff and disability support providers
- Peer education/empowerment program for women with disabilities
- Communities of practice for ongoing professional development and reflective practice

A fundamental feature of the Program is the co-facilitation model that involves women with disabilities and violence prevention workers (from women's health, centres against sexual assault and family violence and women's legal services) co-facilitating workshops, training and communities of practice. In this way the model demonstrates equitable professional relationships between the co-facilitators.

The program focuses on disability support organisations providing support in the area of gender sensitive practice and violence against women. An evaluation of the Program in 2016 identified that despite the overwhelming demands of transitioning to the NDIS, there was widespread support that the Program is important and reflects the purpose of their organisation. While awareness of the Program varied, there was a shared view that training in gender and disability is particularly valuable. The contributions and involvement of Women with Disabilities Victoria in policy advocacy added value to the Program for supporting workforce development, according to the evaluation.

The important of providing sufficient training opportunities on violence prevention within the pricing framework of the NDIS was indicated by stakeholders consulted; as was a review of disability qualifications to ensure inclusion of modules on violence prevention (Effective Chamge Pty Ltd, 2016).

EXAMPLE: INCREASING CAPACITY AND POLITICAL WILL

Primary prevention strategies and action plans, such as VicHealth's: Preventing violence against women in Australia: Research summary, addressing the social and economic determinants of mental and physical health (2011)tend to seek to increase the capacity and political will of organisations to prevent violence against women by:

- Prioritising the prevention of violence against women as core business

- Promoting equal and respectful relationships

- Contributing to the evidence base

- Investing in workforce development

- Strengthening partnerships

VicHealth (2011) drew on inputs form all LGA's, community health services, Medicare Locals, PCP's and the regional family violence partnership; and on evidence available primarily from Australian 'grey literature' and particularly VicHealth's work, DV services reports, Women's Health Victoria, Australian Institute of Criminology, Vic Government reports and some UN/World Health reports. VicHealth also used:

- The health promotion principles of the Ottawa Charter.

- A feminist approach which values the diversity of women's lived experiences and advocates for the equality of women and men in all aspects of public and private life. Feminism recognises the social structures that reinforce male privilege and gender inequality as the root causes of violence against women and argues that societal values with respect to women, men and violence need to change.

EXAMPLE: PAR MODEL

The **PAR Model** has been implemented at MonashLink (a health services provider). The PAR Model does not make specific reference to women with disabilities; however there are good practice ideas that may be applied to the prevention of violence against women with disabilities, particularly on inclusivity to prevent discrimination as described below:

The PAR model was a project of MonashLink and has been used to empower staff and the organisation to reflect and review policies and practices on responses to violence against women. The PAR Model used Violence Prevention Gender Audit Tool as a framework for policy analysis, focus groups and advisory committee reflective meetings. The project also recommended the development of a comprehensive package of training on family violence, violence against women and its relationship to gender equality (Dr Tracey Castelino, 2012).

The PAR Model states that:

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To prevent discrimination, to recognise gender and diversity complexities and to provide opportunities for people from all different groups to fulfil their potential the development of cross-disciplinary and multi-sector partnerships is considered an effective strategy. Possible strategies include:

- Targeting groups or individuals that are under-represented, socially excluded or disadvantaged and that traditionally have not benefited from such investment – this may involve researching and understanding their specific needs

- Providing integrated and "joined up" delivery to ensure that a project's activities link with other initiatives aimed at the same groups and individuals (such as an integrated service delivery model for intake and assessment

- Providing easily accessible and sometimes non-traditional support to help overcome specific barriers for certain groups perhaps by developing partnerships with key organisations in the area that are involved with, represent or have access to seldom heard or socially excluded groups

- Considering transport needs associated with projects – the correlation between social exclusion and lack of access to transport is high and projects should consider how this can be addressed in development and planning

- Providing facilities and opportunities which are flexible and allow access at different times/ways to fit with a variety of lifestyles or working patterns, such as considering childcare provision for parents who work

- Monitoring on-going use of facilities to identify any groups that may be under-represented and actively target those groups where possible

- Making workplaces safe, comfortable and welcoming to men, women and people undergoing gender reassignment

The project identified MonashLink's position on gender equality and violence against women, strengthening action taking, articulate the business case on the effects of VAW in workplace, develop action plans for the organisation and build capacity of staff across the organisation:

- Develop an organisational statement on zero tolerance of violence against women.

- Develop a procedure, a guideline for appropriate responses colleagues who may be experiencing stress and trauma, in particular, issues and responses to domestic violence.

- Provide basic and advance training on domestic violence and validating and helpful responses.

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7. Inclusive Planning Frameworks and Standards

Regional plans for the prevention of violence against girls and women have been developed across Victoria by Women's Health Services for initiating change in the community that can prevent violence from occurring in the first place. These regional plans have acknowledged the importance of preventing violence against women with disabilities through working with women with disabilities, the community and relevant organisations. Specifically, they identify the importance of working with disability organisations and women with disabilities (Women's Health Association of Victoria, 2017).

An important gap in the literature is the absence of a comprehensive planning framework for guiding the prevention of violence against women with disabilities which can inform regional planning. While useful frameworks have been identified for the prevention of violence against all women, the specific issues for women with disabilities, highlighted earlier, are not methodically addressed. To this end, (Healey, et al., 2013) advocate for a set of internationally transferrable standards for inclusive practice, for the purpose of supporting organisational change in the family violence sector. Healey et al., (2013) recommended the following minimum standards:

1. The voices of women with disabilities – ensuring that women with disabilities who have a gendered perspective on violence against women are resourced as advocates who are resourced to participate in key sector and government forums

2. An inclusive definition – that recognises the range of living, relationship and support arrangements of women with disabilities in categorisations of the types of violence experienced by women.

3. Disability as a risk factor – to acknowledge that there is increased prevalence of violence for women with disabilities

7.2   Evaluations of Prevention Programs

Evaluations of prevention programs are important for determining program outcomes and impact. Without this information it is difficult to know what difference prevention programs are making. Practitioners and researchers acknowledge that there are many potentially valuable prevention interventions occurring in the context of everyday service delivery but the resource/time/evaluation capability constraints mean most of this is not captured and evaluated in a way to demonstrate impact and guide future practice.

While there are now numerous well-designed population-level studies on violence against women, according to DeKeseredy, 2000, cited in Webster & Flood (2015) there are continuing complexities in the measurement of this violence, in particular its non-physical forms. Further, less is known about

the prevalence and nature of violence in groups *within* the population, especially smaller groups, such as women with disabilities. This is due to the difficulties in obtaining robust sample sizes of smaller groups in population-level studies. Findings from administrative datasets such as hospitals and the police are likely to *underrepresent* violence against women, in particular non-physical forms of abuse (which are less likely to be reported or reportable) and *over-represent* violence experienced by people from minority ethnic and racial communities and those affected by socio-economic inequality. This is because violence affecting women in these groups is *more* likely to be reported to the police and other public authorities (Ackerman & Love 2014; Avakame et al. 1999; MacQueen & Norris 2014, cited in Webster & Flood, 2015).It is important to note that this type of data measures the incidence of violence and that measuring violence prevention is a developing area.
According to Fulu & Kerr-Wilson (2015), the majority of evaluations on violence against women:

- Provide limited evidence on some intervention types, i.e. transforming masculinities and social norm change.

- Provide limited evidence on interventions especially relevant for vulnerable groups including girls and women with disabilities

- Do not measure violence as an outcome

- Assess the impact on direct recipients of the intervention and not at a community or population level

- Include indicators that vary widely in nature and in data collection, making comparison difficult.

- Have limited synthesis (across interventions) of key pathways through which interventions may be achieving their impacts.

- Provide limited evidence on scalability of interventions

In addition, short follow-up means we understand little about how change is sustained. And for multi-component interventions, it is difficult to attribute outcomes to various intervention components (Fulu & Kerr-Wilson, 2015).

It is also argued that the particular factors influencing violence against women in a given context vary such that the finding of a study in one context may not necessarily apply, or apply as strongly, in another, e.g. we could apply this to violence against women with disabilities in institutional settings, those living with family and those living in supported residential accommodation. The literature generally suggests that the correlates of violence against women are remarkably similar across settings and nations. Further, until recently much of what was known about population-level factors influencing violence against women came from studies of women, commonly women who were victims of violence. The strongest studies are those that investigate a link between violence against women and a specific factor, e.g. whether men who use pornography are more likely to perpetrate violence against women. The literature acknowledges the difficulty of developing study designs that examine the direct link between a particular factor and violence where researchers and evaluators sometimes use measures that are indicators of violence against women. While increasingly sophisticated research designs are being used to study violence against

women, many findings are based on cross sectional study designs. Cross sectional studies look at the relationship between violence against women and a given factor, such as education, at a particular point in time. Where these show a correlation between violence against women and the factor concerned, it cannot be said from cross sectional studies alone that factors are causally related with violence against women (Webster & Flood, 2015).

To support the sound evaluation of projects for the primary prevention of violence against women, the Victorian health Foundation has published a concise guide directed primarily at practitioners in the field undertaking internal project evaluations but is also useful for external evaluators. It outlines nine steps for evaluation primary prevention projects and associated tools. Language, questions and strategies would need to be tailored to the specific issues association with prevention programs for women with disabilities (The Victorian Health Promotion Foundation, 2015).

8. Conclusion

There is increasing interest and action on preventing violence against women in Australia born from the lived experiences of women and strong advocacy by individual women and key organisations. The literature captures some of this activity but does not reflect the sophisticated dialogue and breadth of discussion that is now occurring in health and social sector networks on strategies for preventing violence against women. Moreover, the literature appears to be at the beginning stages of specifically writing about women with disabilities' experiences of violence in relation to effective primary prevention. The systematic evaluation of prevention strategies also appears to be a gap.

To this end, this literature review aims to further our understanding of the specific issues affecting women with disabilities who experience violence across their life stages and support circumstances, in order to generate interest and effective action on preventing violence against women with disabilities.

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