

Preventing intimate partner violence in Australia: unlocking the primary prevention potential of general practice

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Violence against women is a pernicious global public health and human rights problem. It is also preventable. One of the key requisites for evidence-based violence prevention policy and practice is robust and reliable data that identify who experiences violence, the types and patterns of violence perpetrated, and insights into the context and settings in which violence occurs. While no single data source can provide all the answers, in this issue of the *MJA*, Mathews and colleagues¹ contribute a crucial piece to the data puzzle.

Prevalence estimates from their large, nationally representative survey confirm what we know about intimate partner violence in Australia: it is pervasive and frequent; the determinants of risk are complex and multifaceted; it disproportionately affects women and people of diverse genders. Importantly, these findings add nuance to what can be gleaned from previous population-based data on intimate partner violence, such as the Australian Bureau of Statistics Personal Safety Survey.² This includes deeper insights into the nature and extent of specific forms of violence included in the broad categories of physical, sexual, and psychological violence, their polymorphic structure, and how it is perpetrated across all types of intimate relationships.

In particular, Mathews and colleagues draw attention to the growing, and concerning, body of evidence about the prominence of violence in the intimate relationships of adolescents and young people, especially young women.^{3,4} The authors report that 48.4% of participants aged 16–24 years have experienced violence in an intimate relationship. For young women, experiences of all types of violence, including multiple, distinct forms of violence was more frequent than for young men of the same age.¹

Their findings prompt Mathews and colleagues to join other researchers, policymakers, and advocates in sounding the alarm that intimate partner violence against women, especially young women, remains widespread, despite decades of research, policy, and practice attention.⁵ It is possible that increasing prevalence reflects a greater willingness among young people to disclose violence, and greater awareness of what constitutes violent and abusive behaviour in early intimate and dating relationships. But overall, the findings give pause for thought about how national policy and prevention strategies can be better tailored to reach and influence young people during this critical developmental stage.

As highlighted by Mathews and colleagues, health systems and clinical care are key settings for effective primary prevention of intimate partner violence and early intervention. First, however, we need a shared understanding of what is meant by prevention. Primary prevention must address gendered social norms, power imbalances and practices that drive and justify violence.⁶

While screening for diseases such as breast cancer is vital for detecting and preventing disease progression, it is an example of early intervention. Screening will not reduce its prevalence unless action is also taken against its root causes and risk factors, and health practitioners play an important role here. The same holds true for violence, but primary prevention interventions in Australian health services, particularly in general practice, have been slow to develop.

Most national and state-based policies on eliminating violence against women, including the *National Plan to End Violence Against Women and Children 2022–2032*,⁷ nominate primary care as an important part of the solution. As a common entry point into the health system, general practitioners do much of the heavy lifting in early intervention and response to violence.⁸ Indeed, screening for violence in general practice, responding to violence, and referring people experiencing violence to support and recovery services are all immensely important. But none of these actions constitutes primary prevention; their purpose is not to prevent violence from happening in the first place. Despite the recent Australian government review of prevention approaches prioritising response measures as the key to unlocking Australia's prevention potential,⁹ imbalanced investment in secondary and tertiary prevention strategies, without adequate and sustained investment in primary prevention, will not achieve the fundamental aim of ending violence against women.

We concur with Mathews and colleagues that solving a complex public health problem such as intimate partner violence requires a large scale effort, engaging communities across the broadest range of sectors and settings. The challenge for general practice is identifying how to be an effective and meaningful part of this multisectoral effort. Harmful gender and social norms, shaped by stereotypes, begin in early childhood, and it has been reported that early adolescence is the critical period during which gender inequalities accelerate.^{10,11} General practice is uniquely positioned to intervene at multiple points across the life course, and to sharpen its focus on shifting gender-related norms that underpin violence.

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