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Victorian Health Promotion Foundation (VicHealth)

Submission to the Royal Commission into Family Violence

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Executive summary

Family violence is largely perpetrated by men against current or former female partners, and therefore is a significant component of the internationally recognised issue of violence against women (VAW). VAW is prevalent, serious and preventable, and over the past decade VicHealth has worked with partners to prevent it from occurring in the first place.[1]

The key driver of VAW is unequal access to power and resources between women and men at every level – in other words gender inequality in relationships/families, organisations, communities and societies as a whole. International research has established that countries performing well on indicators of gender equality have lower levels of VAW.[2] Currently, Australia has some way to go in creating true gender equality. In the Global Gender Gap Index 2014 Australia was ranked 24, nine places below our 2006 position.[3]

At this time in Victoria there is a critical opportunity to reduce levels of VAW through strategies that address the social determinants of violence and improve gender equality. Broadly referred to as 'primary prevention', these strategies that address the underlying social determinants of violence are distinct from, but complementary to, other strategies that improve responses to existing victims and perpetrators.

Victoria is well-positioned to lead in this area due to the strong emerging evidence base in primary prevention and the high level of readiness across sectors and industries to work towards gender equality goals in the short to medium term.

However, strategies to reduce the levels of VAW require significant, planned and ongoing investment. The inequalities that drive violence are deeply entrenched at every level – from the division of household and caring responsibilities to the unequal representation of gender in public and private leadership roles – and are reinforced through very common social trends such as gender stereotyping, sexualisation of women, and sexual harassment and discrimination in the workplace.[4]

While VAW is a complex issue, it is similar to other health and social problems in that it can be addressed through long-term comprehensive efforts to change outcomes. Over the last 30 years in Victoria there have been great gains in addressing health and social problems which, prior to state-level intervention, also created preventable health and economic burdens as well as impacts on individuals and families – for example, tobacco control and prevention of road trauma.[5]

The success of interventions in these areas clearly demonstrates that long-term investment models supporting multifaceted public health methodologies offer strong potential to significantly reduce harmful behaviours and preventable physical and mental ill health at a population level in relation to VAW.

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[1] ABS (Australian Bureau of Statistics) 2013, *Personal Safety Survey, Australia, 2012*, cat. no. 4906.0, www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0; VicHealth 2004, *The health costs of violence: Measuring the burden of disease caused by intimate partner violence,* Victorian Health Promotion Foundation, Melbourne.

[2] United Nations Development Fund for Women (UNIFEM) 2010, *Investing in gender equality: Ending violence against women and girls*, United Nations, Geneva

[3] Hausmann, R, Tyson, LD, Bekhouce, Y & Zahidi, S 2014, *The Global Gender Gap Report 2014*, World Economic Forum, Geneva.

[4] VicHealth 2014, *Australians' attitudes to violence against women: Findings from the 2013 National Community Attitudes towards Violence Against Women Survey*, Victorian Health Promotion Foundation, Melbourne.

[5] National Preventative Health Taskforce 2009, *Australia: The healthiest country by 2020. National Preventative Health Strategy – the roadmap for action,* Australian Government, Canberra.

Public health methodologies include: research, monitoring and evaluation; direct participation programs; organisational and workforce development; community strengthening; communications and social marketing; advocacy; and legislative and policy reform.[6]

Early work has commenced to apply these methodologies to the issue of VAW in Victoria. Importantly, this has involved cross-sector activity outside of health, justice and human services. However, due to the absence of sustained investment in VAW to date, there are significant gaps in research, policy and practice. Victoria is now well-positioned to consolidate early activity and move towards more cohesive and coordinated policy and programs that result in a reduction in levels of VAW.

VicHealth is now focusing on integrating our knowledge of reducing VAW, as well as continuing to lead new, high quality research that can advance our understanding and underpin further solutions to this important health issue. We look forward to working with the Royal Commission and other partners to create sustainable and effective policy and programmatic responses to VAW.

[6] VicHealth 2007, *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria,* Victorian Health Promotion Foundation, Melbourne

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Recommendations

VicHealth recommends that the Royal Commission:

1. Ensures **sustained investment with bipartisan commitment** at all levels of government in order to achieve coordination across the spectrum of responses to family violence – including crisis response, early intervention and primary prevention – and to achieve coordination across government and non-government sectors.

2. Considers the introduction of a **new statewide mechanism** to coordinate policy and programmatic responses to the issue across Victoria. In relation to the reduction of family violence, a new statewide mechanism could have mandate to:
   - coordinate activity across crisis response, early intervention and primary prevention
   - drive and/or assist whole-of-government policy and activity
   - lead primary prevention, using the public health approach outlined below.

3. Ensure that the new statewide mechanism has capacity to drive **primary prevention** responses to family violence utilising a public health approach as the basis to coordinate delivery of proven methodologies:*
   - *Direct participation programs* – to increase individuals' skills, attitudes and knowledge of respectful and equitable relationships.
   - *Organisational and workforce development* – to create environments that model, promote and facilitate respectful and equitable gender relations.
   - *Community strengthening* – to mobilise and support communities to address VAW and the social norms that make it acceptable.
   - *Communications and social marketing* – to raise awareness of VAW and address attitudes, behaviours and social norms that contribute to this problem.
   - *Advocacy* – to build collective activity and mobilisations to raise awareness and to encourage governments, organisations, corporations and communities to take action.
   - *Legislative and policy reform* – to ensure laws and regulations complement strategies to build equitable gender relations, and to reorient policy approaches across government to address the social determinants of violence.
   - *Research, monitoring and evaluation* – to underpin activity in the areas above by informing action, improving the evidence and knowledge base for future planning and enabling efforts to be both effectively targeted and monitored.

** For an example of coordinated delivery of proven methodologies see the case study in Appendix 3 on VicHealth's Generating Equality and Respect Program.*

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1. Introduction

VicHealth commends the State Government's leadership in holding this Royal Commission into Family Violence, and we welcome the opportunity to inform the Commission's outcomes.

1.1 About VicHealth

VicHealth was established by the Victorian Parliament in accordance with the *Tobacco Act 1987* with a mandate to promote good health. VicHealth is a pioneer in health promotion – the process of enabling people to increase control over and improve their health.

VicHealth is an independent statutory authority, operating under a Board that includes three Victorian Members of Parliament. Our funding comes from the Victorian Government via the Department of Health and Human Services, and we report to Parliament through the Minister for Health.

Our primary focus is promoting good health and preventing chronic disease. We work with individuals, communities, organisations and governments within Victoria, nationally and internationally, with VicHealth designated as the World Health Organization Collaborating Centre for Leadership in Health Promotion.

We recognise that the Terms of Reference indicate that the Royal Commission is focused on family violence, which is in the main committed by men against female partners and ex-partners. However VicHealth's work is aligned to the United Nations definition of violence against women (VAW), which includes family violence as well as intimate partner violence, sexual assault, sexual harassment and stalking.[7]

The rationale for this is that international and local evidence demonstrates that there is significant overlap in the underlying social determinants of all of these forms of violence, namely unequal power between women and men.

While this submission discusses VAW in its broader sense, there is significant opportunity to work towards the elimination of family violence by applying the methodologies that have shown early potential in relation to eliminating VAW.

All policy, research and leadership issues described in this submission in the reduction of violence against women are directly applicable to the reduction of family violence.

[7] United Nations General Assembly 1993, *Declaration on the Elimination of Violence against Women*, United Nations, Geneva.

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2. VAW: Prevalence, health burden and economic costs

2.1 Violence against women

For the past decade VicHealth has had a leadership role in the primary prevention of VAW. We have focused on VAW because it is prevalent, serious and preventable.

More than one in three women in Australia (39 per cent) aged over 18 has experienced violence at the hands of a man since the age of 15.[8] VAW is a contributor to ill health, particularly as a risk factor for two of the most common forms of mental illness, depression and anxiety. It is more damaging to the health of Victorian women aged 15 to 44 years than any other well-known risk factors for chronic disease, including high blood pressure, obesity and smoking (see Figure 1 and 2).[9]

Figure 1: Health outcomes contributing to the disease burden of intimate partner violence women, Victoria 2001

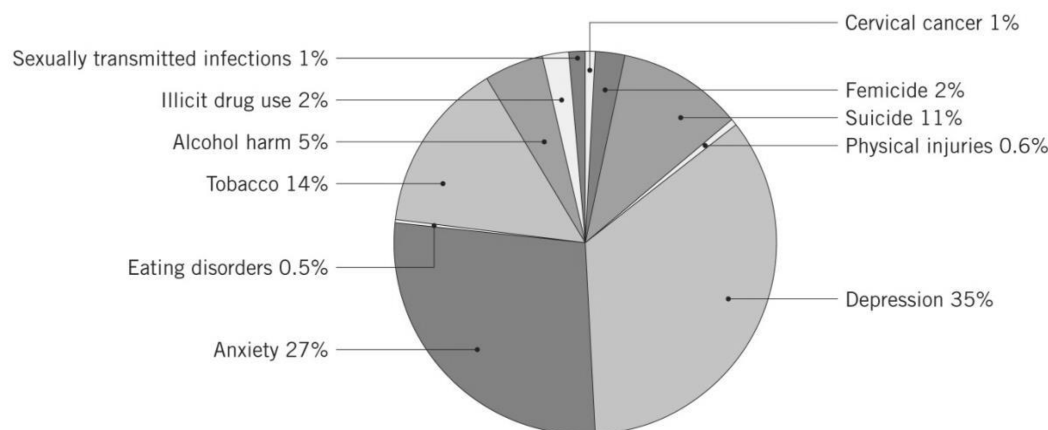
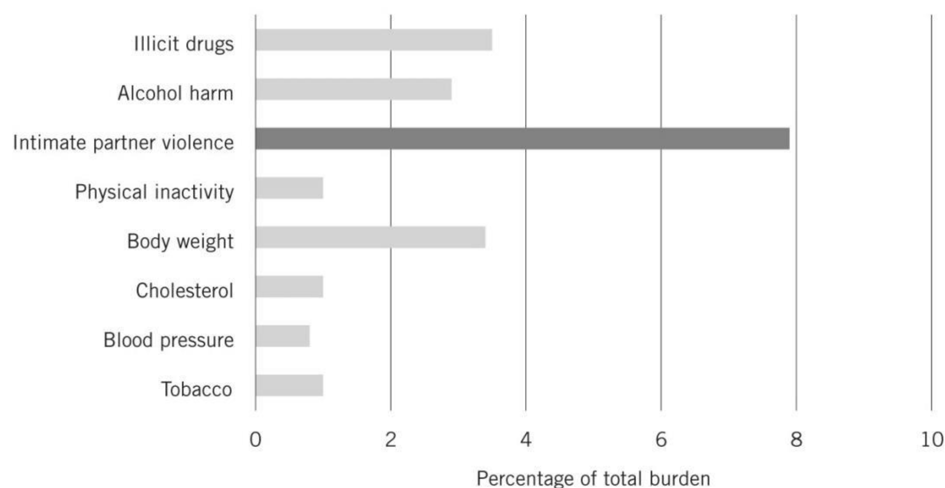


Figure 2: Top 8 risk factors contributing to the disease burden in women aged 15–44 years, Victoria 2001



[8] ABS (Australian Bureau of Statistics) 2013, *Personal Safety Survey, Australia, 2012*, cat. no. 4906.0, www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0

[9] VicHealth 2004, *The health costs of violence: Measuring the burden of disease caused by intimate partner violence,* Victorian Health Promotion Foundation, Melbourne.

The Australian National Research Organisation for Women's Safety (ANROWS) is currently undertaking a burden of disease study to assess the impact of intimate partner violence across Australia. Findings are expected to be available in 2016.[10]

In 2009 the National Council to Reduce Violence against Women and their Children found that violence against women and their children costs the Australian economy an estimated $13.6 billion that year. Without concerted action to reduce violence, the Council estimated that the annual cost will rise to $15 billion by 2021.[11]

The National Council also established that for every woman whose experience of violence could be avoided, over $20,000 in costs could also be avoided. These costs included:

- pain, suffering and premature mortality costs associated with the victims'/survivors' experience of violence
- health costs including public and private health system costs associated with treating the effects of VAW
- production-related costs, including the cost of being absent from work, and employer administrative costs (for example, employee replacement)
- consumption-related costs, including replacing damaged property, defaulting on bad debts, and the costs of moving
- second generation costs are the costs of children witnessing and living with violence, including child protection services and increased juvenile and adult crime
- administrative and other costs, including police, incarceration, court system costs, counselling, and violence prevention programs
- transfer costs, which are the inefficiencies associated with the payment of government benefits.[12]

However, at present there are no formalised models to estimate the cost savings that can be achieved from investment in reducing VAW at the state or national level.

Section 3 describes the most recent evidence about the underlying social determinants of violence and how these can be addressed through coordinated action.

2.2 Violence against men

It is well-recognised that men can also be victims of violence from partners and ex-partners; however, far greater numbers of men are victims of violence from strangers in public settings.

All violence is unacceptable and requires appropriate responses and support for victims. While there are commonalities in the determinants of all forms of violence, for example men being by far the most common perpetrators of all forms, there are unique determinants of men's violence against women.

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[10] ANROWS 2014, 'Research program', Australia's National Research Organisation for Women's Safety, www.anrows.org.au/research-program/research-program-2014-16

[11] National Council to Reduce Violence against Women and their Children 2009, *The cost of violence against women and their children,* Commonwealth of Australia, Canberra.

[12] National Council to Reduce Violence against Women and their Children 2009, *The cost of violence against women and their children,* Commonwealth of Australia, Canberra.

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Initiatives therefore need to be tailored to address the particular causal factors and the very different contexts in which these kinds of violence occur.[13]

In Victoria, crime statistics demonstrate that family violence is most likely to be perpetrated by males against a female partner or ex-partner. While under-reporting is a problem for monitoring all forms of violence, Victoria Police data state that for the period 2013/14, men were identified as offenders in 83.9 per cent of family incident reports and women were identified as victims in 75.3 per cent of family incident reports.[14]

International evidence indicates that women are three times more likely than men to be injured through intimate partner violence, five times more likely to require medical attention or hospitalisation as a result, and five times more likely to report fearing for their lives.[15] Women are also more likely than men to be subjected to controlling and abusive behaviours[16] and to experience violence as a continuing pattern of repeated behaviour compared to a single incident.[17]

It is important to note that the increasing recognition and policy responses to men's perpetration of family violence has triggered critical responses from men's rights organisations, also referred to as fathers' rights and men's health groups.[18] Policy responses to men's experiences of violence (as victims) are important and necessary but are most likely to succeed if they are tailored to the types of violence that men are most likely to experience; that is, one-off incidences of violence from other men in public places.

In the context of family violence, policy responses to male victims should not detract from the resources or focus on ending VAW, as this is the strategy that is most likely to lead to a reduction in the health and economic burden associated with family violence.

[13] VicHealth 2014, *Australians' attitudes to violence against women: Findings from the 2013 National Community Attitudes towards Violence Against Women Survey*, Victorian Health Promotion Foundation, Melbourne.
[14] Victoria Police 2014, *Victoria Police Crime Statistics 2013/14,* Victoria Police, Melbourne.
[15] Statistics Canada 2003, *Family Violence in Canada: A Statistical Profile 2003*, Canadian Centre for Justice Statistics, Ministry of Industry, Ottawa, Canada.
[16] Wangmann J 2011, *Different types of Intimate Partner Violence – An Exploration of the Literature*, Australian Domestic and Family Violence Clearinghouse, University of New South Wales, Sydney.
[17] ABS (Australian Bureau of Statistics) 2013b, Personal Safety Survey 2012, cat. No. 4906.0, viewed 29 April 2014 <www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0>
[18] For further illustration of this issue, see Kelly, RT 2013, 'The masculine mystique', *The Daily Beast,* 20 October 2013, http://www.thedailybeast.com/articles/2013/10/20/the-masculine-mystique-inside-the-men-s-rights-movement-mrm.html, or McKenzie-Murray, M 2015, 'Inside men's rights groups', *The Saturday Paper,* 21 March 2015, http://www.thesaturdaypaper.com.au/news/law-crime/2015/03/21/inside-mens-rights-groups/14268564001653#.VVVtPdWUdo8

3. What are the social determinants of VAW?

The purpose of this section is to describe research findings and theoretical models conceptualising the social determinants of VAW. We illustrate how this knowledge has been applied to research, policy and programming in population- and community-level primary prevention of VAW, and the implications arising for future policy and investment decision-making.

Primary prevention is often conceptualised as being on a spectrum of action, as per the table below.[19]

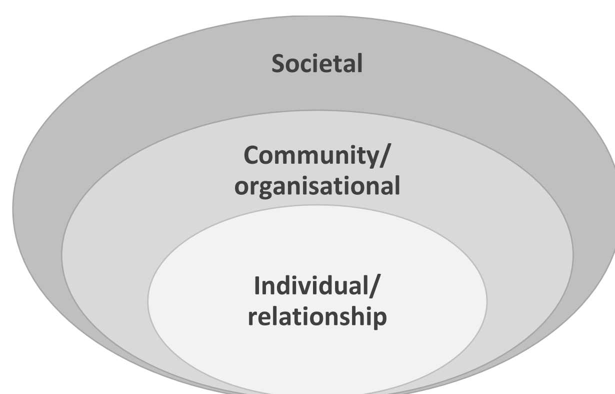
Level of prevention	Aim
Primary	Widespread changes that reduce the average risk in the whole population. Reduction of particular exposures among identified higher risk groups or individuals.
Secondary	Prevent progression to disease through early detection and intervention.
Tertiary	Reduce the consequences of established disease through effective management of the patient to reduce the progress or complications of established disease and improve patient wellbeing and quality of life.

3.1 An ecological framework for understanding VAW

There is no simple, single explanation of why some men use violence and control against women. Over the past few decades diverse theories have been advanced to explain this violence, many emphasising the gendered nature of this form of abuse and the impact of social and economic influences operating at the national or community level.

VAW can be understood as the result of a complex interaction of influences at population, organisational/institutional, community, family and individual levels that ultimately shape individual behaviour. This has led to the application of ecological frameworks to improve understanding of violence affecting women in relationships, as illustrated in Figure 3 below.

Figure 3: Ecological framework



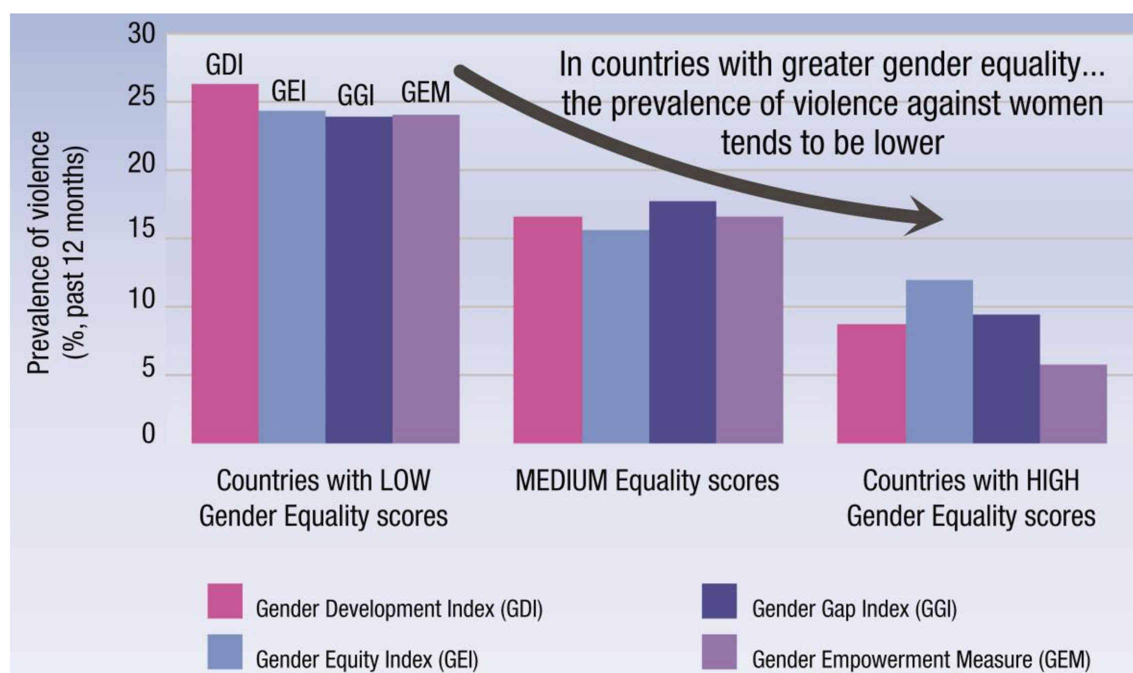
[19] Adapted from National Public Health Partnership 2006, *The language of prevention,* NPHP, Melbourne.

Since 2002 the World Health Organization has adopted this ecological framework as a basis for research and program activity to prevent all forms of interpersonal violence, including physical and sexual VAW. Subsequently, the emphasis on the social and structural influences on behaviour have featured in the development of other research and modelling to establish the social determinants of VAW.

3.2 The role of gender inequality as social determinant of VAW

International and Australian evidence shows that societies with higher levels of gender inequality – that is, unequal distribution of power and resources between women and men – also have higher rates of VAW. The diagram below, developed by the United Nations Development Fund for Women, demonstrates the relationship between the prevalence of VAW and gender equality. Data based on global indices of gender equality shows that as equality decreases, prevalence of VAW increases.

Figure 4: Physical and/or sexual intimate partner violence and measures of gender equality[20]



It is important to note that no country in the world has, as yet, undertaken a rigorous program of applying and testing gender equality strategies as a means to achieve a reduction in levels of VAW. Therefore, at this time, conceptualisations of drivers and influences on violence are put forward as illustrative models to understand the nature of the problem and provide guidance in the development of programs and practices.

A framework developed by VicHealth in 2007 (and updated in 2014) on the basis of commissioned research, proposes that violence can best be understood through three inter-related clusters of influence.[21]

[20] United Nations Development Fund for Women (UNIFEM) 2010, *Investing in gender equality: Ending violence against women and girls*, UN, Geneva. Prevalence data based on 56 countries drawn from leading international surveys on VAW: World Health Organization; International Violence Against Women Survey; MEASURE Demographic and Health Surveys (DHS) and the World Bank Domestic Violence Dataset and is based on physical and/or sexual violence by an intimate partner in the 12 months prior.
[21] VicHealth 2007, *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria,* Victorian Health Promotion Foundation, Melbourne; VicHealth 2014, *Australians' attitudes to violence against women: Findings from the 2013 National Community Attitudes towards Violence Against Women Survey*, Victorian Health Promotion Foundation, Melbourne.

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Illustrated in Figure 5 (see page 8), the most significant drivers of VAW are:

- structures and cultures supportive of gender inequality
- factors facilitating learning and support of violence
- other intersecting, contextual and behavioural factors.[22]

The recent analysis of research, an excerpt of which is presented in Box 1 below, confirmed international modelling suggesting that unequal power and resources between women and men, and the structural and cultural practices that sustain those inequalities, are key influences in the prevalence and perpetration of VAW. All other related drivers and factors intersect with this leading driver in their influence on the prevalence of violence, as follows:

- *Factors facilitating learning and support of violence*: Men are more likely to perpetrate VAW if they are exposed to attitudes and behaviours that are supportive of violence broadly, for example through male–dominated organisational environments such as the military, college fraternities and certain sporting clubs, or when they have witnessed or used violence in other contexts.
- *Other intersecting, contextual and behavioural factors*: Situational and individual-level risk factors associated with increased likelihood of VAW include alcohol misuse, marital/relationship separation, pregnancy, individual anger management and alcohol consumption. There is also evidence to suggest that VAW may increase in the context of broader social and economic conditions being compromised, such as through natural disasters and entrenched disadvantage.[22]

Interventions targeting family- and individual-level factors associated with VAW are important. However, where risk is widely spread, as it is with VAW, population- and community-level interventions focusing on social determinants of behaviour, such as gender equality, can be highly effective and comparatively efficient ways to reduce the greatest burden of harm.

Action to address these intersecting factors is in the very early stages of development. The sections below focus on areas where there has been a stronger history of investment and program development, that is in reducing the structures and cultures that are supportive of gender inequality.

VicHealth is currently working in partnership with Our Watch and ANROWS to develop the new national prevention framework, which is due for release in late 2015 and will provide further conceptual modelling to explain the social determinants and dynamics of violence and the actions required to address them.

3.3 Evidence on the key social determinants of VAW

Box 1: What are the causes of violence against women?
Source: VicHealth 2014, *Australians' attitudes to violence against women: Findings from the 2013 National Community Attitudes towards Violence Against Women Survey*, Victorian Health Promotion Foundation, Melbourne, pp. 32–35. Please see www.vichealth.vic.gov.au/ncas for the full document and references.
Population-level research suggests that there is no single, simple cause of VAW. Rather, violence is best understood as the product of an inter-play between the characteristics of individuals, and influences in

[22] VicHealth 2014, *Australians' attitudes to violence against women: Findings from the 2013 National Community Attitudes towards Violence Against Women Survey*, Victorian Health Promotion Foundation, Melbourne.

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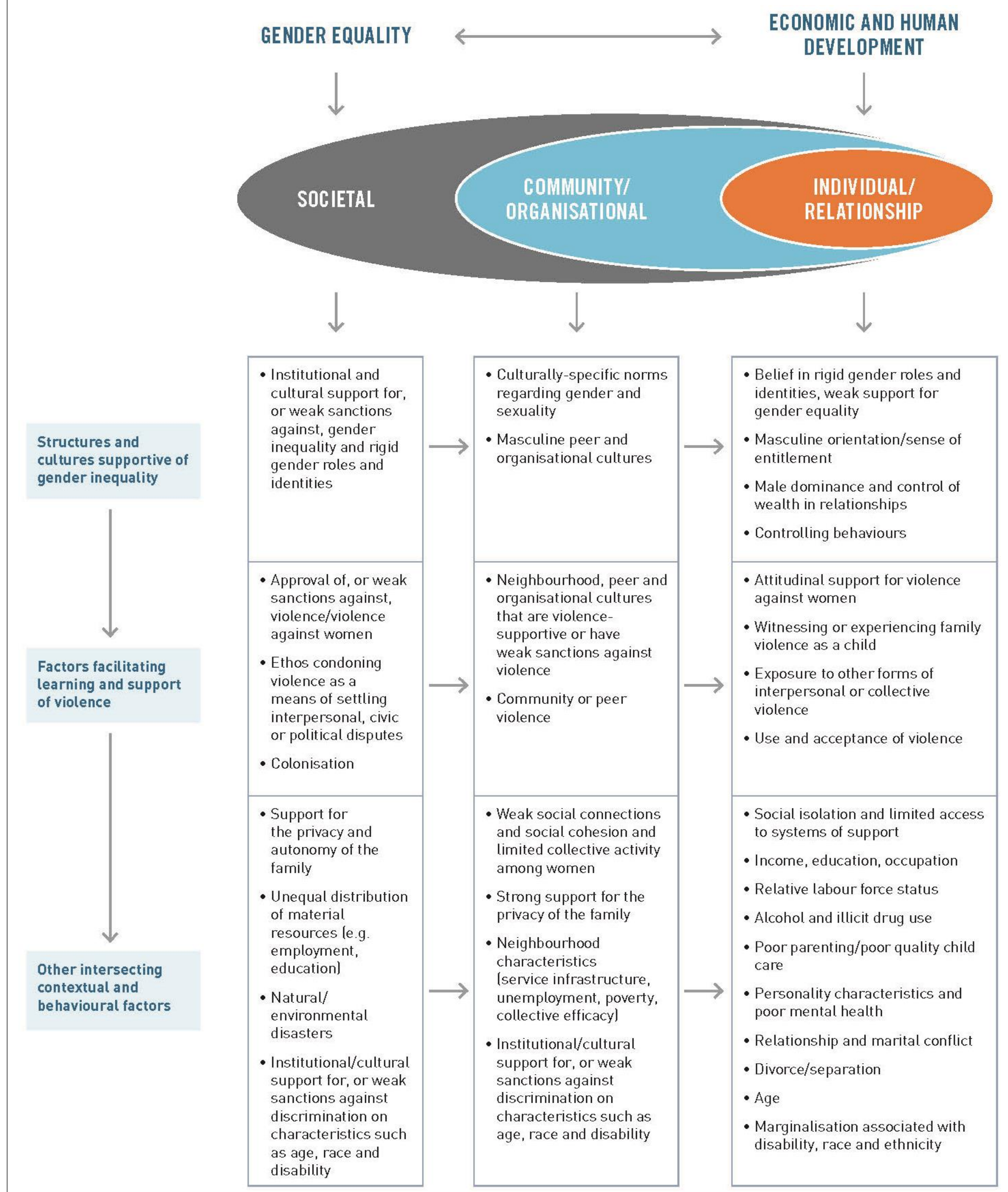
their families, the communities they live in, the organisations they interact with in the course of education, work and leisure, and broader societal influences, such as the media, laws and social norms and beliefs. Commonly called an ecological approach, this is illustrated in Figure 5. This is an approach advocated by a number of expert bodies (European Commission 2010b; UN 2006, 2012c; UNICEF et al. 2013; WHO 2002, 2010; WHO & London School of Hygiene and Tropical Medicine 2010).

Figure 5: Understanding violence against women – an ecological model to guide primary prevention



A common feature of ecological models developed to inform the primary prevention of VAW is the understanding that a key factor is the unequal distribution of power and resources between men and women, referred to as gender inequality (UN 2006, 2012c; WHO 2010; WHO & London School of Hygiene and Tropical Medicine 2010). These frameworks also note the important role of economic and human development, owing to the inter-relations between these forms of development and gender equality and gender relations.

Structures and cultures supportive of gender inequality

Gender inequality involves power and resources being unequally distributed between men and women in public and private life. For example, the under-representation of women in parliament or men making all the key decisions in a relationship. Such inequality can result from laws or structures that constrain opportunities for women. However it is also supported through gender role divisions (i.e. distinctions being made between what are appropriate roles for men as opposed to those for women) and through distinctive male and female gender identities (i.e. what it means to be masculine or feminine). In most societies these roles and identities are hierarchically organised such that masculine roles and identities are typically seen to be superior and are associated with greater power and authority (UN 2006). Some of the ways in which these inequalities and distinctions can contribute to violence are outlined in Figure 4. They can occur at each level of the ecological model described above (i.e. in individual relationships, in organisations and communities and at the societal level) and are supported by social practices, cultures and norms (WHO & London School of Hygiene and Tropical Medicine 2010).

There is a large and complex body of research on the relationship between VAW and the different dimensions described above (inequality in power and resources, gender roles and gender identities) and the levels at which they manifest (from individual through to societal). Taken together the studies indicate a strong relationship between the various markers of gender inequality and VAW (True 2012; UN 2006; VicHealth 2007; WHO 2010; WHO & London School of Hygiene and Tropical Medicine 2010).

For example, at the societal and community levels, the risks of VAW have been found to be higher when resources such as education and income are distributed unequally between men and women (True 2012; Yodanis & Carrie 2004); when women's economic, social and political rights are poorly protected (UN Women 2011 p. 34); and/or when there are more rigid distinctions between the roles of men and women and between masculine and feminine identities (Flood & Pease 2006; Sanday 1981; VicHealth 2007).

Violence is also more common in families and relationships in which men control decision making (Gage 2005; Vézina & Hébert 2007) and less so in those relationships in which women have a greater level of independence (Gage 2005; Vyas & Watts 2009).

Among the most consistent predictors of the perpetration of VAW at the individual level are traditional views about gender roles and relationships, attitudes that support male dominance in relationships and attitudes that reflect sexual hostility towards women (Foshee et al. 2008; Grubb & Turner 2012; Nabors & Jasinski 2009; Robertson & Murachver 2007; VicHealth 2007).

Motivations and reasons for violence often reflect adherence to these attitudes. Men who use violence report more opposite sex jealousy (Foran & O'Leary 2008; Gage 2005; Garcia-Moreno et al. 2006; VicHealth 2007). Similarly, the use of behaviours to exercise power and control in relationships has been

found to be a consistent predictor in studies across time and place (Antai 2011; Dalal & Lindqvist 2012; Gage 2005; Garcia-Moreno et al. 2005, 2006; Graham-Kevin & Archer 2008; Heise 2012; Kiss et al. 2012), including Australia (Mouzos & Makkai 2004). Other studies have shown that men who are hostile towards women's non-conformity to gender roles and to challenges to male authority have a particular proclivity for violence (Heise 2012; Reidy et al. 2009; Robertson & Murachver 2007).

Why is there a relationship between gender inequality and violence against women?

- The emphasis on aggression and conquest in male socialisation may lead to a greater proclivity and support for violence among some men, and a greater social acceptance of men's use of violence (Flood & Pease 2006, 2009).
- The sense of entitlement associated with the traditional masculine gender role may result in the use of force by some men to secure their will (particularly in intimate relationships), and its acceptance and legitimation in the wider community and by key institutions (Gilgun & McLeod 1999; Hill & Fischer 2001).
- Violence, or the threat of violence, may be used to re-establish the perceived natural 'gender order', with men's violence towards women often occurring and more likely to be supported in circumstances where women have, or are perceived to have breached, socially defined feminine roles (Reidy et al. 2009). For example, VAW has been found to increase in societies undergoing rapid economic change where women have begun to play a more prominent role in paid work and civic society (Chon 2013; Jewkes 2002; Simister & Mehta 2010; Xie et al. 2012). Similarly, studies show that people are more likely to justify rape in circumstances where women transgress standards of 'moral purity' (Whatley 2005).
- The importance attached to masculinity may result in the use of violence as a means of restoring masculine identity when it is under threat (Gallagher & Parrott 2011). For example, VAW has been found to increase when economic conditions compromise men's role as breadwinner (True 2012; Weissman 2007). Some researchers attribute this to men's sense of entitlement and their desire to dominate women, while others see it as evidence of the fragility of masculine identity (see, for example, Carrington & Hogg 2007).
- The lower social standing accorded to women may mean that women are perceived by some men, by people witnessing violence or by victims themselves as justified targets of violence, hostility, exploitation and abuse (Forbes et al. 2004; Masser et al. 2006; Ryan & Kanjorski 1998; Sakalh 2001).
- Some aspects of feminine gender identities may involve the denigration, objectification and sexualisation of women, again potentially casting women as targets for hostility and exploitation (American Psychological Association 2010; Papadopoulos 2010).
- Gender inequalities in access to power and resources may increase women's risk of violence and compromise their capacity to seek safety once violence has occurred. This makes them vulnerable to repeated and escalating violence (Humphreys 2007).

International and Australian research has established that a critical strategy to eliminate VAW is to address the underlying social determinants of violence.[23] While strategies to improve perpetrator accountability and victim support and safety services are also essential, they alone will not enable society to achieve an actual reduction in levels of VAW – including intimate partner violence, sexual assault, stalking and sexual harassment.

In Victoria, where there is currently the most investment and significant progress in primary prevention in the country, we are testing the application of this modelling to the design of programs and practices to reduce levels of VAW. This activity is yielding some promising results in relation to the outcomes and indicators described in sections 4 and 5. However, further investment and coordinated activity is required to strengthen understanding of what action can be taken to address the determinants of violence against women.

[23] WHO 2010, *Violence prevention: The evidence*, World Health Organization, Geneva; UN 2012, *Report of the Expert Group Meeting on Prevention of Violence against Women and Girls*, viewed 20 May 2014, http://www.unwomen.org/~/media/Headquarters/Attachments/Sections/Library/Publications/2012/11/Report-of-the-EGM-on-Prevention-of-Violence-against-Women-and-Girls.pdf

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4. Progress on gender equality in Victoria

4.1 Applying our understanding of the link between VAW and gender equality

There have been significant achievements in Victoria in applying an understanding of this causal link to responses to VAW. Concepts related to gender equality have been incorporated into workforce development and training initiatives and enabled professionals from a range of disciplines to test them through research and practice. Importantly, this has increased the resources dedicated to address the determinants of violence

In addition, the concepts have been explored and translated into plain language in order to increase engagement in non-specialist organisations and sectors. This extends to explanations of 'gender' and 'equity', which has enabled multiple sectors to develop an understanding of how VAW is connected to industries such as sport and local government, and also how practices in those industries can be altered to support an overall reduction in VAW.

An example of the translation of complex concepts is a publication that VicHealth is currently developing, called *Equal Footing: A practical toolkit to promote gender equality and respect in your workplace.* We have provided an excerpt of this resource in Appendix 1 to demonstrate the ways in which primary prevention resources can be made relevant to key non-specialist sectors and support their activity.

4.2 Current levels of gender equality in Australia

Despite our knowledge of the role of gender equality in improving health and societal outcomes, Australia still has some way to go in creating true gender equality. The Global Gender Gap Index examines the gap between men and women in four fundamental categories (subindices): economic participation and opportunity, educational attainment, health and survival, and political empowerment.[24]

In 2013 Australia was ranked 24, nine places below our 2006 position. We are currently below similar countries such as New Zealand, the UK and the USA, and also behind developing countries such as the Philippines, Nicaragua and Burundi.

The subindices give a fuller picture. Australia is equal-first for educational attainment (with 24 other countries). We are ranked 14 for economic participation and opportunity, 53 for political empowerment, and 70 for health and survival. The strategies proposed in this report to advance gender equality are similar to those discussed in sections below to advance the reduction of VAW, for example creating policies that provide women and men with equal access to opportunities, and mobilising civil society, educators and media in empowering women and engaging men in these processes.

4.3 Current prevention approaches in Australia

To address gender inequality and prevent VAW, the World Health Organization has recommended a 'primary prevention' approach to save lives, prevent ill health and reduce social and economic costs.[25] Previously, action in the area of VAW has been largely focused on secondary prevention (e.g. immediate

[24] Hausmann, R, Tyson, LD, Bekhouce, Y & Zahidi, S 2014, *The Global Gender Gap Report 2014*, World Economic Forum, Geneva.
[25] World Health Organization/London School of Hygiene and Tropical Medicine 2010, *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*, World Health Organization, Geneva.

responses to VAW such as emergency services and medical care) and tertiary prevention (e.g. long-term care after VAW has occurred, such as rehabilitation/reintegration or counselling).

VicHealth has been implementing a primary prevention approach for the past decade, using a public health model that addresses the social determinants of VAW, risk and protective factors influencing its prevalence and severity. This shift to include a more substantial focus on primary prevention is essential to effectively address the social determinants of VAW and reduce its prevalence across Victoria, and while it complements secondary and tertiary responses, it requires separate strategies and investment.

5. Responding to VAW: Models of future investment

In this section we describe the models of investment that have potential for application to reduce levels of VAW. We point to other achievements in reducing health and economic burdens that have been progressed through the application of public health approaches.

Victoria currently holds a national leadership role in the primary prevention of VAW and, with continued investment and activity utilising the models below, is well-positioned to achieve a world-first reduction in levels of VAW in the foreseeable future.

5.1 Using public health approaches to address complex social issues

Public health approaches to primary prevention use coordinated, evidence-based and mutually reinforcing strategies. They aim to work across multiple settings with partners from a wide range of sectors. Action focuses across all areas of the ecological model – individuals, relationships/families, organisations, communities and societies.

Successful public health approaches also have had long-term, bipartisan support with significant investment, supported by a whole-of-government approach. They benefit from a model that allows for an iterative learning process – identifying new and innovative ways of working, testing them and sharing the results, and integrating promising findings into the broader sector.

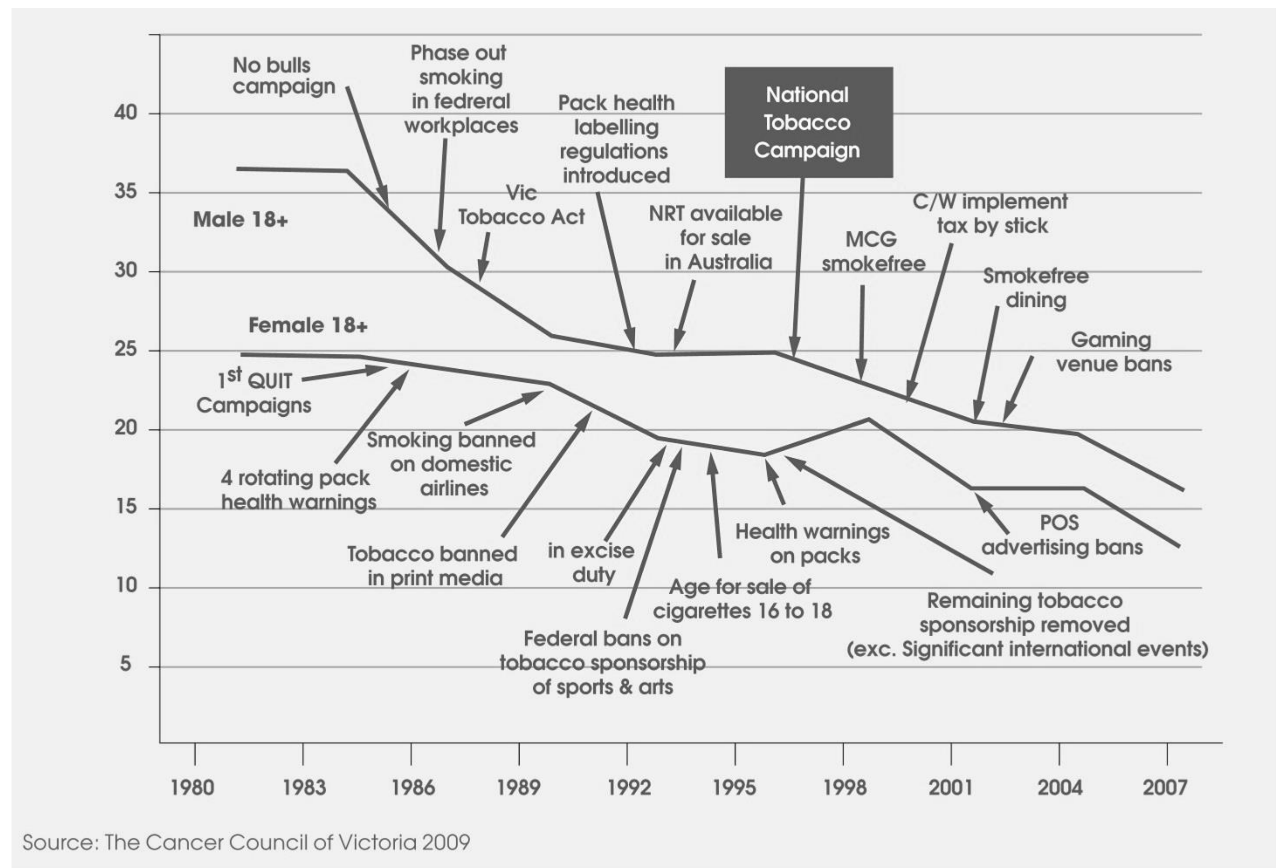
This kind of multifaceted public health approach has been successful in reducing smoking and motor vehicle accidents and their associated social and economic costs. The case studies below illustrate this approach. With sustained, long-term investment it is possible to undertake multifaceted strategies with proven methodologies that could have an unprecedented impact on of the levels of VAW in Victoria.

Case study 1: Tobacco control
Since the 1980s, tobacco control activity in Victoria has included a combination of public education, taxation, legislation, regulation, cessation support, rigorous monitoring, research and evaluation of activity.[26] This was supported by long-term bipartisan commitment and the local, state and federal levels, and dedicated bodies to coordinate action such as Quit Victoria. Tobacco control in Victoria has also received significant ongoing investment, by government, health organisations and non-government/community organisations. For example, in 2013/14 Quit Victoria received over $10 million from VicHealth, the Department of Health, Cancer Council Victoria and the Heart Foundation, as well as funding from the Commonwealth Government for social marketing. This approach has resulted in an all-time low smoking rate of 13.3 per cent in Victoria, with rates almost halved since 1980.[27] The decrease in the smoking rate from 2008 to 2013 (16.5 to 13.8 per cent) was estimated to save the Victorian economy $1.85 billion.[28]

[26] National Preventative Health Taskforce 2009, *Australia: The healthiest country by 2020. National Preventative Health Strategy – the roadmap for action,* Australian Government, Canberra.
[27] Quit Victoria 2015, *Smoking rates,* Quit Victoria, accessed 5 May 2015, http://www.quit.org.au/resource-centre/facts-evidence/fact-sheets/smoking-rates
[28] Collins, DJ & Lapsley, HM, 2011 *The social costs of smoking in Victoria in 2008/09 and the social benefits of public policy measures to reduce smoking*, Quit Victoria and the VicHealth Centre for Tobacco Control, Melbourne.

In 2009 the National Preventative Health Taskforce mapped the success of the approach in Australia, indicating the progressive, long-term and iterative processes required to achieve change (see Figure 5). Since that time strategies such as plain packaging have created further reductions in smoking rates.[29]

Figure 5: Milestones in reducing smoking in Australia 1980–2007[23]



Source: The Cancer Council of Victoria 2009

Case study 2: Road trauma

A similar approach has been used to prevent road trauma. Since the 1980s the Transport Accident Commission (TAC), Victoria Police, the Department of Justice and Regulation, VicRoads and other key partners have worked closely to develop a multifaceted public health approach to road trauma prevention. This approach includes strategies such as legislative change targeting high-risk behaviour, law enforcement and policing, research and evaluation, road network improvements, and awareness-raising and behavioural change campaigns.[30]

Investment in this area has also been long-term and significant; for example, the TAC spent over $59 million in 2013/14 on marketing and road safety.[31]

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[29] Wakefield, M, Coomber, K, Zacher, M, Durkin, S, Brennan, E & Scollo, M 2015, 'Australian adult smokers' responses to plain packaging with larger graphic health warnings 1 year after implementation: results from a national cross-sectional tracking survey', *Tobacco Control,* vol. 24, pp.ii17–ii25.

[30] Transport Accident Commission 2015, 'What we do', Transport Accident Commission, accessed 1 May 2015, http://www.tac.vic.gov.au/about-the-tac/our-organisation/what-we-do; Department of Justice and Regulation 2015, 'Road safety', State Government of Victoria, accessed 6 May 2015, http://www.justice.vic.gov.au/home/safer+communities/road+safety/

[31] Transport Accident Commission 2014, *Getting lives back on track: 2013–14 Annual Report,* TAC, Melbourne.

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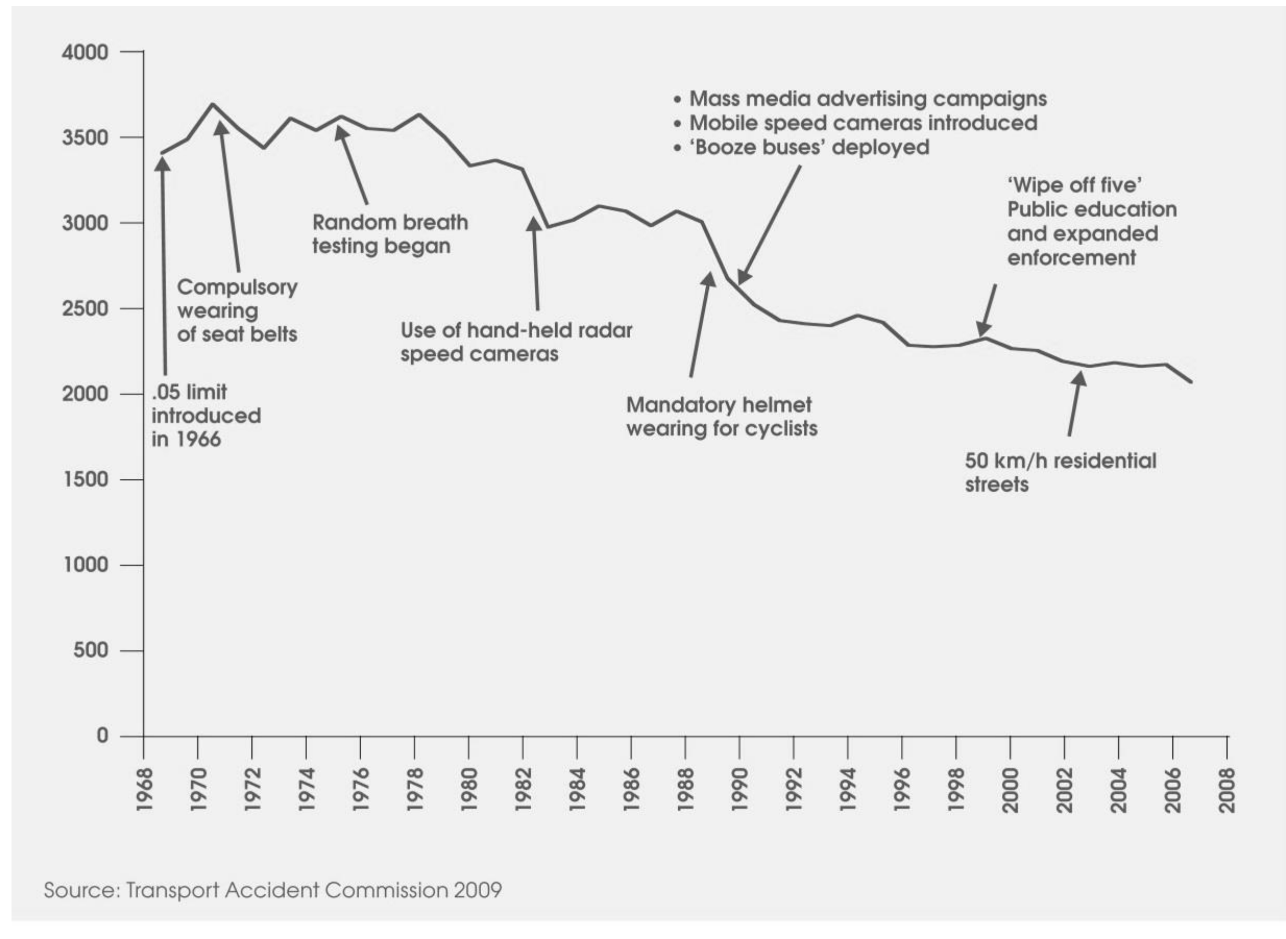
This long-term, coordinated activity at the local, state and federal level has resulted in the Victorian road in 2013 being lowest since records began in 1952, and one of the best road safety records in the world.[32]

Figure 6: Road fatalities in Australia 1968–2008[33]



Considering the success of these approaches in such complex social issues, there would be significant benefit in considering a similar approach to VAW in terms of the breadth of resources, cross-sectoral reform and cultural change required. Currently, there is a burgeoning prevention evidence base in Victoria, and there is a high level of readiness and commitment across sectors.

There is a clear opportunity now to activate and coordinate across several key proven methodologies in relation to health and social policy, as detailed in section 6.

[32] Department of Justice and Regulation 2015, 'Road safety', State Government of Victoria, accessed 6 May 2015, http://www.justice.vic.gov.au/home/safer+communities/road+safety/

[33] National Preventative Health Taskforce 2009, *Australia: The healthiest country by 2020. National Preventative Health Strategy – the roadmap for action,* Australian Government, Canberra, p. 36.

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6. Applying public health approaches to VAW – methodologies, achievements and gaps

6.1 Overview

The World Health Organization has documented the considerable potential to reduce VAW using a multifaceted health promotion approach.[34] This issue requires new approaches that complement existing knowledge and practice in behavioural change with knowledge of changing environments, communities, individuals and policies to create greater gender equality, respectful relationships and safer environments.

Based on VicHealth's work and that of our partners and the broader sector, we have identified key aspects of this approach, methodologies, achievements and potential gaps and opportunities for the Commission to consider.

6.2 Achieving optimal reach through universal and targeted approaches

The case studies outlined in section 5 were effective in reaching a range of sub-populations across the Victorian community. This level of reach and engagement is essential in the reduction of VAW and will require universal, population-wide strategies combined with tailored approaches for specific sub-populations. This combination is essential because while not all those in priority sub-populations are considered 'at-risk' in relation to violence, many in the mainstream population are 'at-risk' and will experience violence. Priority populations in relation to reducing VAW are listed in Appendix 2.

The development of inclusive approaches will require further research and program testing, as equity assessment tools and tailored approaches in the reduction of VAW are under-developed in Victoria.

VicHealth is committed to promoting the health and wellbeing of all Victorians. We have recently adapted and applied the work of the World Health Organization Commission on the Social Determinants of Health to the Australian context, and produced an action-oriented framework to guide health promotion. *Fair Foundations: The VicHealth framework for health equity*[35] outlines and describes the social determinants of health inequities and provides practical entry points for action. It is designed for application to any health issue and this includes the reduction of VAW.

6.3 Timeframes and the need for long-term commitment

The success stories of tobacco control, road trauma and other public health approaches are encouraging, yet they also indicate the length of time and depth of activity that is required for prevention investment to create a population-level impact. It is important this timeframe is considered when undertaking activity to prevent VAW. In Victoria, investment has not yet been sustained at a significant level and program activity has only been occurring for around a decade (see table 1 for further details of some of this action), so we are in the very early stages of establishing best practice and can add to this in future years.

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[34] World Health Organization 2002, *Work report on violence and health,* World Health Organization, Geneva.

[35] See www.vichealth.vic.gov.au/media-and-resources/publications/the-vichealth-framework-for-health-equity

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6.4 Methodologies

There are seven key methodologies identified in public health literature as being effective to create population-level impact. As described in section 5, these methodologies have proven effective in addressing other significant health and social issues, in particular where they have been executed simultaneously across the community and with a sustained base of investment.

These methodologies can be applied to the primary prevention of VAW in the following ways[36]:

Direct participation programs

These programs can be targeted at men, women and children at the individual, relationship or group level to build the knowledge and skills required to establish and sustain equal, respectful, non-violent gender relationships; build individuals' access to the resources required for such relationships (such as effective early parenting and connections to social networks and institutions); or to seek to prevent or address the impacts of other factors linked to VAW (for example, child abuse).

Organisational and workforce development

This methodology is based on the understanding that organisations and organisational cultures have a powerful role in influencing the behaviours of individuals and groups and so can play a role in violence reduction by modelling non-violent, equitable and respectful gender relations. Workforce development involves building the skills of relevant workforces to implement primary prevention activity either informally and opportunistically or at a more formal level.

Community strengthening

This methodology aims to mobilise and support communities to address VAW and the social norms that make it acceptable. These strategies can also be used to increase community access to the resources required for action and to address broader community-level risk factors for VAW, such as high rates of early school leaving or localised violent peer cultures.

Communications and social marketing

These methodologies aim to use a range of communication media to raise awareness of VAW and address attitudes, behaviours and social norms that contribute to this problem. This includes mainstream television, radio and print media as well as the internet and other social media, community forums, community arts and so on.

Advocacy

Advocacy involves building collective activity and mobilisations to raise awareness of the issue of VAW and to encourage governments, organisations, corporations and communities to take action on factors contributing to the problem.

Legislative and policy reform

This involves the development of legislation, policies and programs that seek to address the factors underlying or contributing to VAW.

[36] VicHealth 2007, *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria,* Victorian Health Promotion Foundation, Melbourne.

Research, monitoring and evaluation

Research and evaluation underpin activity in the other six areas by informing action, improving the evidence and knowledge base for future planning and enabling efforts to be both effectively targeted and monitored. Research findings are also important for advocacy and awareness-raising activity.

6.5 Achievements and gaps

Over last decade VicHealth and partners have led the design and delivery of a range of initiatives to reduce VAW using these methodologies. This work has led to some achievements and generated an early evidence base, and also highlighted the gaps in knowledge and opportunities to consolidate the evidence base in the near future.

An overview of these achievements and gaps is presented in table 1. In summary:

- There are several streams of activity that have been initiated in primary prevention, involving sectors and resources that are separate to activity in secondary/tertiary prevention; however, there is not yet a sustained investment base for primary prevention activity.
- There is strong take-up across sectors in applying determinants-focused design to programming; however, there is not yet a coordinated monitoring framework to assess the impact of this design against the prevalence of VAW or the progress towards gender equality.
- There is a significant range of programs engaging individuals, organisations and communities in the reduction of VAW; however, there is not yet a coordinated monitoring framework to assess the coverage, reach or access to prevention programs across Victorian communities nor the impact of programs on attitudes or behaviours.
- There is a significant range of resources and tools available for non-specialist sectors to engage in the reduction of VAW; however there is not yet clear data to indicate take-up of these resources. In addition there is inconsistency in application of tools and implementation due to gaps in coordination of activity, limited availability of technical assistance, and gaps in statewide workforce development.

Table 1: VicHealth's achievements in primary prevention and opportunities for future action

Methodology	Achievements – VicHealth and partners	Gaps and opportunities
Direct participation programs	• **Single setting design** – e.g. Baby Makes 3 program in maternal and child health, *Equal Footing*[37] in the workplace, Everyone Wins in sports. • **Multi-setting design** – e.g. Respect, Responsibility and Equality Program 2007–2015 and the current Generating Equality and Respect Program (see Appendix 3). • **Training and education –** for workplace leaders, faith leaders, bystanders to sexism and cross-sector professionals.	• **Reach** – Strategies and investment to increase access to direct participation programs across regions and population groups. • **Consistency and coordination –** Strategies and resources, such as standards and guidelines, to enable best practice across programs and settings. • **Impact –** Evaluation frameworks to monitor the cumulative impact of direct participation programs statewide. • **Evaluation of multi-setting design** – Currently being undertaken in relation to the Generating Equality and Respect Program (available in 2016).
Organisational and workforce development	**Organisational development – evidence reviews** • Workplace, local government, schools/education, media. • Ethnic/CALD communities, faith leaders, bystanders. **Organisational development – programs and resources** • Workplace, local government, sports clubs/associations, schools/education, maternal and child health, community health. • Bystander action in communities and workplaces. **Workforce development** • Prevention training and capacity-building – e.g. PVAW Short Course, PVAW Leaders' Course. • Communities of Practice and networks/hubs – e.g. Advanced Practitioners' Forum, Partners in Prevention.	**Organisational development – evidence reviews** • Sports and recreation, arts/entertainment. • Aboriginal communities, disability sector, youth sector. **Organisational development – programs and resources** • Standards/guidelines for consistent practice in organisational development within and across settings. • Coordination of activity to enable best practice and avoid duplication. **Workforce development** • Evidence review regarding skill development and capacity-building strategies. • Coordinated strategy to strengthen prevention skill base across specialist and non-specialist services.

[37] Due for release in mid-2015

Methodology	Achievements – VicHealth and partners	Gaps and opportunities
Community strengthening	• **Community mobilisation strategies** – e.g. Not1More Community Walk/Event, Gippsland Aboriginal CommUNITY Walk Against Family Violence. • **Place-based approaches** – e.g. Generating Equality and Respect Program (see Appendix 3). • **Priority population groups –** e.g. *The Roadmap: Understanding and taking action to prevent VAW in CALD communities*[38].	• **Reach** – Strategies and investment to increase access to community strengthening programs across regions and population groups. • **Consistency and coordination –** Strategies and resources, such as standards and guidelines, to enable best practice across regions and communities. • **Impact –** Evaluation frameworks to monitor the cumulative impact of community mobilisation statewide.
Communications and social marketing	**Evidence reviews** • Review of communication components of social marketing/public education campaigns focusing on violence against women. • Victorian print media coverage of violence against women: A longitudinal study.	• **Updated evidence** – Contemporary evidence reviews addressing new and emerging communication mediums. • **Consistency and coordination –** Standards and guidelines to enable delivery of communication/social marketing initiatives as a component of direct participation programs, organisational development and policy and legislative reform. • **Impact –** Evaluation frameworks to monitor the cumulative impact of communications and awareness-raising on attitudes to violence and public support for policy and programming.
Advocacy	• Strengthening the voices of survivors in public dialogue – e.g. Media Advocates Project 2007–2015. • Strengthening the visibility of research in public dialogue – e.g. opinion piece by Luke Ablett on VicHealth's NCAS report. • Strengthening the visibility of the drivers of violence in public dialogue – e.g. opinion piece by Jerril Rechter.	• **Consistency and coordination –** Strategies and resources, such as standards and guidelines, to strengthen advocacy across regions and communities.

[38] Due for release in 2015

Methodology	Achievements – VicHealth and partners	Gaps and opportunities
Legislative and policy reform	• **Planning framework** to guide prevention policy and planning in Victoria – e.g. Preventing violence before it occurs 2007. • Application of planning framework to **grants/program design and funding –** e.g. Victorian Department of Justice Reducing Violence Against Women and their Children program 2012–2015. • **Legislative reform** in Victoria that has strengthened community awareness of the definition and dynamics of gender-based violence – e.g. *Family Violence Act 2008, Crimes (Rape) Act 1991*.	• Planning framework to guide prevention policy and planning across Australia (Our Watch, in development). • Policy and regulatory frameworks to address the emerging challenges in relation to reducing VAW – e.g. sexualisation of children, pornography, discriminatory portrayals of girls and young women in advertising.
Research, monitoring and evaluation	• **Evidence of the prevalence, dynamics and impact of VAW** – e.g. Burden of disease study 2004, community attitudes surveys 2006, 2009, 2014, youth attitudes survey (forthcoming) . • **Evidence of the scope of primary prevention** – e.g. Preventing violence before it occurs framework 2007, More than ready bystander survey 2012. • Development of **evaluation guides** for programs and projects – e.g. Respect Responsibility and Equality Program report 2012, Trends in evaluation: Preventing violence against women practice papers 2012, *A short guide for evaluation: Victorian primary prevention projects* (forthcoming).	• Cross-disciplinary models to predict the cost reductions arising from investment in primary prevention. • Whole-of-government framework for monitoring that links datasets with justice, health and other government portfolios. • Meta-evaluation framework to monitor progress in primary prevention corresponding to cross-sector indicators and community-level outcomes. • Linking and coordination of family violence index/indicators and gender equality indicators at the population level. • Evidence base relating to the dynamics and impact of the emerging challenges in relation to reducing VAW – e.g. sexualisation of children, pornography, discriminatory portrayals of girls and young women in advertising. • Map investment by geographic area to measure and monitor effectiveness.

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7. Outcomes

Supporting equitable and respectful gender relations, reducing exposure to all forms of violence and violence-supportive cultural norms, and improving access to resources and systems of support through actions at these levels is likely to help prevent VAW from occurring and to reap associated long-term benefits, as shown in table 2.

The intermediate outcomes are the conditions it is anticipated can be achieved in the short term with a view to achieving these long-term benefits. They provide a useful basis against which progress can be measured and monitored as well as for evaluating the effectiveness of individual programs and interventions. They have been identified on the basis of evidence of factors underlying and contributing to violence.

VicHealth is currently working in partnership with Our Watch and ANROWS to develop the national prevention framework, which is due for release in late 2015 and will further articulate the achievable outcomes for primary prevention of VAW in the short, medium and long term.

Table 2: Intermediate outcomes and long-term benefits of primary prevention of VAW[39]

Intermediate outcomes			
Individual/relationship	**Organisational**	**Community**	**Societal**
Individuals and relationships with: – improved connections to resources and support – respectful and equitable gender relations – improved attitudes toward gender equality, gender roles and violence and/or VAW – improved skills in nonviolent means of resolving interpersonal conflict – responsible alcohol use.	Organisations that: – model, promote and facilitate equal, respectful and nonviolent gender relations – work in partnerships across sectors to address violence – implement evidence-based violence prevention activities – are accessible to and safe and supportive for women.	Environments that: – value and support norms that are non-violent and build respectful and equitable gender relations – build connections between people and sources of formal and informal support – take action to address violence.	A society in which there are strong legislative and regulatory frameworks and appropriate resource allocation for supporting: – gender equality – the prevention and prohibition of violence – the positive portrayal of women (e.g. in advertising) – the development of healthy relationships between men and women.

[39] VicHealth 2007, *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria,* Victorian Health Promotion Foundation, Melbourne.

Long-term benefits			
Individual/relationship	**Organisational**	**Community**	**Societal**
– Reduction in violence-related health problems and mortality – Improved interpersonal skills and family and gender relations – Reduced intergenerational transmission of violence and its impacts	– Violence prevention resources and activities integrated across sectors and settings – Organisations that value and promote respectful gender relations – Improved access to resources and systems of support	– Communities that value gender equality and respectful relationships between men and women – Reduced social isolation and improved community connections	– Reduced gender inequality – Improved quality of life for men and women – Reduced levels of violence and/or VAW – Improved productivity

8. VicHealth's future focus

Following VicHealth's investment and leadership in programs to prevent VAW over the last ten years, it's time for primary prevention activity to be scaled up and expanded across Australia. We have worked with our partners to build practical resources and programs to bring more workplaces, sports bodies, local governments and community organisations on board.

We have formalised a partnership with Our Watch and will continue to work closely with their team to consolidate and integrate our work to help improve the health and wellbeing of women and their children across the Victorian community and across the country.

We have invested significantly in the reduction of VAW over many years at an average of $2 million per annum. We are continuing with our current program partners and investments, which will conclude in 2016.

VicHealth is currently considering its future role in primary prevention, which will take into account the recommendations of the Royal Commission. We will continue to lead new, high quality research in the area of preventing VAW beyond 2016, including investigating fresh areas for research which can further our understanding and underpin further solutions to this important health issue.

9. Recommendations

Based on the above, VicHealth recommends that the Royal Commission:

1. Ensures **sustained investment with bipartisan commitment** at all levels of government in order to achieve coordination across the spectrum of responses to family violence – including crisis response, early intervention and primary prevention – and to achieve coordination across government and non-government sectors.

2. Considers the introduction of a **new statewide mechanism** to coordinate policy and programmatic responses to the issue across Victoria. In relation to the reduction of family violence, a new statewide mechanism could have mandate to:
   - coordinate activity across crisis response, early intervention and primary prevention
   - drive and/or assist whole-of-government policy and activity
   - lead primary prevention, using the public health approach outlined below.

3. Ensure that the new statewide mechanism has capacity to drive **primary prevention** responses to family violence utilising a public health approach as the basis to coordinate delivery of proven methodologies:*
   - *Direct participation programs* – to increase individuals' skills, attitudes and knowledge of respectful and equitable relationships.
   - *Organisational and workforce development* – to create environments that model, promote and facilitate respectful and equitable gender relations.
   - *Community strengthening* – to mobilise and support communities to address VAW and the social norms that make it acceptable.
   - *Communications and social marketing* – to raise awareness of VAW and address attitudes, behaviours and social norms that contribute to this problem.
   - *Advocacy* – to build collective activity and mobilisations to raise awareness and to encourage governments, organisations, corporations and communities to take action.
   - *Legislative and policy reform* – to ensure laws and regulations complement strategies to build equitable gender relations, and to reorient policy approaches across government to address the social determinants of violence.
   - *Research, monitoring and evaluation* – to underpin activity in the areas above by informing action, improving the evidence and knowledge base for future planning and enabling efforts to be both effectively targeted and monitored.

** For an example of coordinated delivery of proven methodologies see the case study in Appendix 3 on VicHealth's Generating Equality and Respect Program.*

Appendix 1: Example of VicHealth's translation of resources for practitioners – *Equal Footing* excerpt

What is 'gender'?

Source: VicHealth (in press), *Equal Footing: A practical toolkit to promote gender equality and respect in your workplace*, Victorian Health Promotion Foundation, Melbourne.

VicHealth acknowledges the support of the Victorian Government in developing this resource.

The word 'gender' is often mistakenly used when referring to a person's 'sex' – so it's understandable if you're confused about its meaning. Although the terms are related and are often used interchangeably, they are actually two very distinct things. Someone's 'sex' is the biology that defines whether they are male or female, while their 'gender' refers to society's expectations about how they should think and behave as boys and girls, and then as men and women.

As the writer, philosopher and feminist Simone de Beauvoir once wrote, 'one is not born, but rather becomes, a woman' – and the same is equally true of men. Gender is a social construct: something that is taught to us by the society or culture we live in. We are introduced to the concepts of 'masculinity' and 'femininity' from birth and these tell us who we are supposed to be, what kind of roles we can and can't perform, how we should act and respond to whatever life throws at us, even how we should dress.

Societal expectations about gender are reinforced every day of our lives – whether it's in the media, by our family, in our community, in the workplace – and sometimes in very subtle ways. This has resulted in the creation of gender stereotypes that we're all expected to fit into – even though most of us realise they are overly simplistic, don't reflect our individuality, and help perpetuate unfairness and inequality between the two sexes.

Gender stereotyping incorporates things like personality traits (the assumption that men are confident and aggressive, women are submissive and nurturing), behaviours and skills (women are better carers for children, men are more adept at household repairs and mowing the lawn), career paths (construction workers are men, secretaries are women), even how we should look (women are short and petite, men are tall and imposing). Problems can arise when sticking to gender stereotypes means some people start to have power or control over others –specifically, that men should be 'in charge' of households, organisation or our society as a whole.

Even though we know these stereotypes are wildly inaccurate, they are also very hard to fight, as they are so engrained in our culture. In fact, members of both sexes who don't follow gender stereotypes are often punished (for example, assertive or strong women can be labelled 'bitches', and men who lack physical strength seen as 'wimps').

What's the difference between 'equality' and 'equity'?

It's been said that 'equity is the process; equality is the outcome' – but what does this mean, exactly?

'Equity' is making sure people have what they need to achieve their best. This means providing access to the resources, opportunities, power and responsibility they need to reach their full potential. Equity is all

about fairness and justice, and recognising that some people are disadvantaged and may require additional help to reach the same level as the majority.

‘Equality’, on the other hand, aims to level the playing field and make sure everybody is at the same place and needs the same things. Within the context of gender, this means treating both men and women equally in society, the workplace, and in regards to the law, without allowing gender stereotyping to affect or restrict their rights and choices.

A useful analogy to demonstrate the difference between the two terms is to imagine being in the MCG’s standing room area on Grand Final Day. Equality is providing everybody with a milk crate, regardless of their height, so they can stand on it and watch the game with an uninterrupted view. Equity is recognising that some people are shorter than others – through no fault of their own – so they’ll require an additional crate to see properly and be on the same level as everybody else.

Appendix 2: Priority population groups

Universal approaches need to be supported by interventions targeting 'priority' population groups, including:

- those who are at higher risk of perpetrating or being subject to violence
- those who are particularly vulnerable to the impacts of violence once it has occurred
- those for whom whole-of-community or universal interventions are likely to have limited reach or impact
- those who are at a stage of the lifecycle when the factors influencing violence are amenable to intervention.

Research has found that in Australia, the following population groups are most at risk:

- Young women.
- Pregnant women.
- Aboriginal and Torres Strait Islander women.
- Women from culturally and linguistically diverse communities.
- Women with disabilities.
- Women from rural and remote areas.

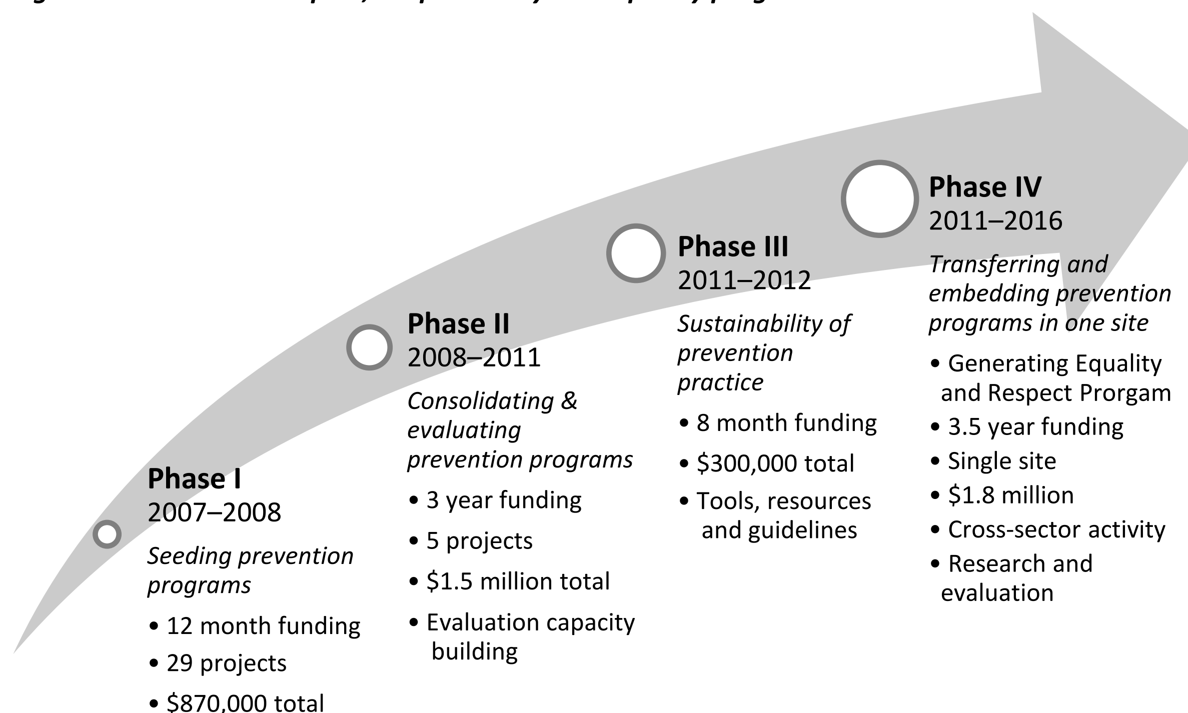
A review of evidence regarding priority population groups can be found in: VicHealth 2011, *Preventing violence against women in Australia: Research summary,* Victorian Health Promotion Foundation, Melbourne.

Appendix 3: Case study – Generating Equality and Respect

VicHealth's site-based saturation approach, the Generating Equality and Respect program, provides an example of our investment in the primary prevention of VAW.

This investment of $1.8 million represents the fourth phase of a decade-long $4.4 million funding stream in preventing VAW, called *Respect, Responsibility and Equality* (see Figure 7 below). Each phase of this investment has been designed to maximise learning and build the evidence base for the emerging field of primary prevention of VAW.

Figure 7: VicHealth's Respect, Responsibility and Equality program 2007-2016

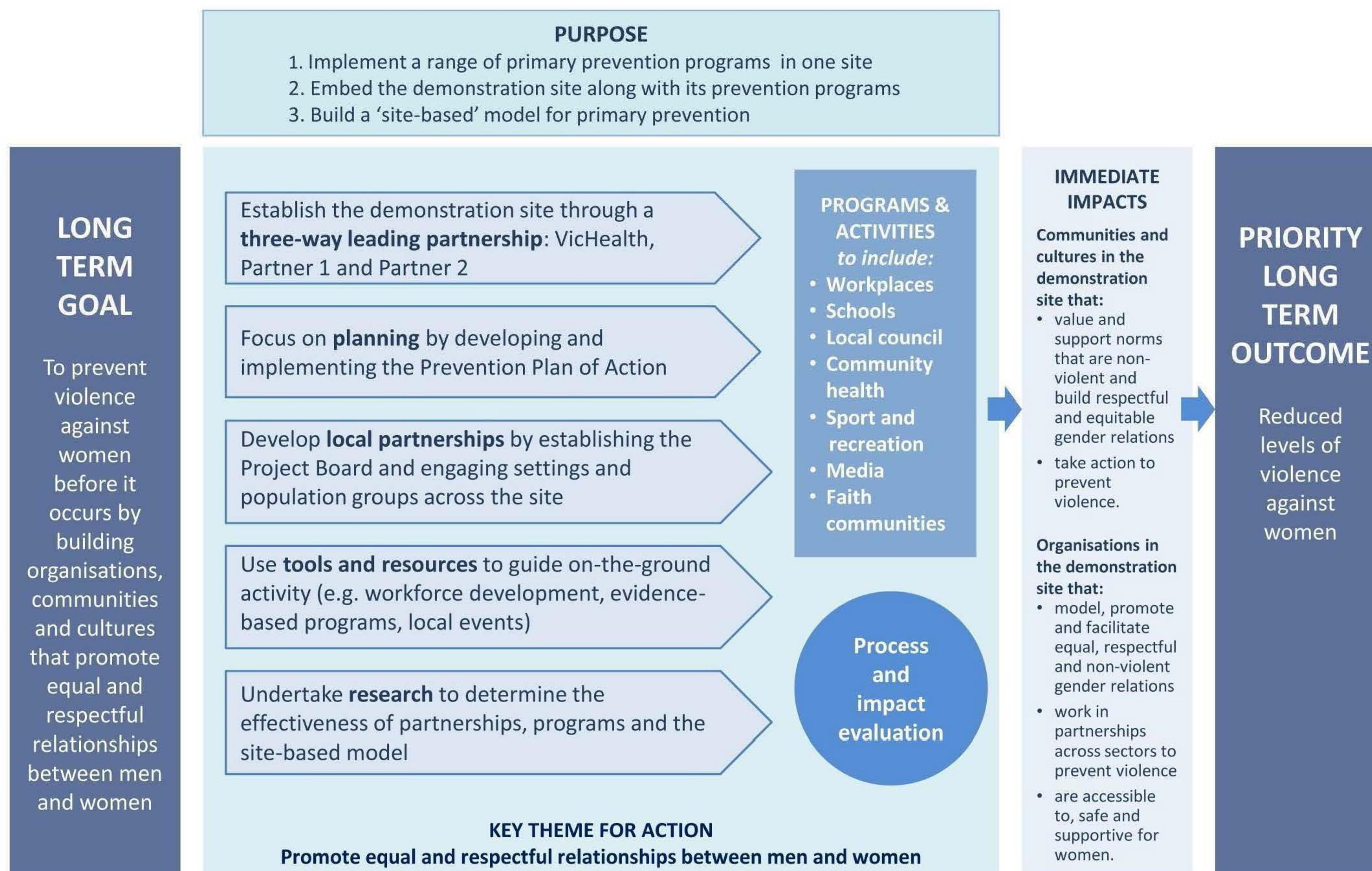


Trialling a new approach: One Community, Many Programs

As the fourth phase of this work, Generating Equality and Respect trials an innovative design for the prevention of VAW. This design focuses on depth of intervention as well as breadth, providing one community with many mutually reinforcing program activities.

Previous VicHealth investments have focused on breadth or single settings, where many communities have received the same program activity, such as the Baby Makes 3 program. However central to the concept behind the Generating Equality and Respect Program is that it engages as many settings and population groups as afforded by partners involved in the initiative (breadth) with the strategic intent of both establishing and embedding the demonstration site and its programs so they continue well beyond the initial funding period that 'seeds' it (depth).This is illustrated in Figure 8.

Figure 8: Generating Equality and Respect Program 2012–15 – Program model



Program summary

Drawing from VicHealth's decade of research and activity in preventing VAW, the Generating Equality and Respect Program is a world-first program funded by VicHealth and led by a strong and collaborative partnership. Trialling a site-based, saturation approach to primary prevention in Melbourne's south-east, it strives to reach people where they live, work, study and play.

The program is delivered through a partnership between VicHealth, Monash City Council and MonashLink Community Health Service. Monash City Council and MonashLink are receiving $1.079 million of funding.

The Generating Equality and Respect Program runs over three and a half years and aims to:

- build communities, cultures and organisations that are gender equitable and that value and support non-violent norms
- foster respectful and equal relationships between men and women
- realise sustainable primary prevention through strong collaboration with established and new partners
- pilot an innovative model for the primary prevention of VAW that is transferable and informs practice.

Distinguishing features are the three-way partnership illustrated through a cross-organisation project team, whole-of-workplace organisational change activities and embedded sustainability.

Across the life of the program activities have taken place in five settings with a focus on the suburb Clayton as the program site. Initiatives include:

- the Baby Makes 3 program, for first time parents delivered through Maternal Child Health Services
- an organisational change program at MonashLink Community Health Service and Monash City Council to promote respect and equality within the workplace, which will be extended into the broader community through the programs and services they deliver
- a suite of training has been delivered to more than 700 participants including the VicHealth Preventing Violence Against Women Short Course and Leaders' Masterclass
- a local Monash Partners in Prevention Network to actively support youth practitioners to deliver good practice respectful relationships education and promote gender equality through their programs and services. Network members include local teachers, police, school nurses, youth services and community organisations.
- Robert Bosch Australia, a significant employer in Clayton, is a partner in the program and has joined forces with Monash Council, MonashLink Community Health Service and VicHealth to raise awareness of family violence and respectful relationships for its male and female employees. The Clayton headquarters of Robert Bosch Australia is a home for awareness raising and training activities integrated into existing staff health and HR programs over the next six months.

Evaluation is built into every step of Generating Equality and Respect using a participatory and learning-oriented approach to evaluation, which involves evaluation capacity building strategies to resource and support project workers as key evaluators of their own programs. This is led by the VicHealth Research

Practice Leader and builds on the approach used in VicHealth's previous program, *Respect, Responsibility and Equality*, to evaluate the processes and impacts of the program activity.[40]

For more information on the program, see www.vichealth.vic.gov.au/generating-equality-and-respect

Relevance to the Commission

The Generating Equality and Respect Program focus is addressing the social determinants of VAW by promoting gender equality and respectful relationships between men and women.

It is important to note that the investment is designed to intensely resource the partners to establish a solid foundation to sustain activities well beyond the 3.5 year funding period. It has started the community and partners on a journey of embedding this work in their key institutions and services including community health services, local government, schools, youth services, maternal child health services and workplaces.

To effect change in the long term, multi-level mutually reinforcing strategies are required across multiple settings and sectors. Importantly, resources, whether they are externally or internally funded, must be sustained, as preventive efforts need generational change, with results potentially not visible for several decades.

VicHealth and Generating Equality and Respect Program partners are currently preparing the research and evaluation components of the program to establish impact and best practice principles. In the meantime, the single-site modelling described lends itself to consideration for expansion and scaling up across Victoria as part of government-led activity to prevent VAW.

[40] Kwok, WL 2013, *Evaluating preventing violence against women initiatives: A participatory and learning-oriented approach for primary prevention in Victoria*, Victorian Health Promotion Foundation, Melbourne.