Submission to Victoria's Royal Commission into Family Violence

May 2015

Contents

1. Background

This submission is a joint contribution from four Victorian community-based organisations funded to support people living with human immunodeficiency virus (HIV). Together we provide a range of health promotion, support and other services to people living with HIV, their families and friends and the broader community. The four agencies are:

Positive Women Victoria

Positive Women Victoria (PWV) is the only community-based organisation specifically funded to support women living with HIV in Australia.

PWV provides health promotion, peer support, information and advocacy for women living with HIV in Victoria. For over twenty five years PWV has responded to the changing needs of women living with HIV, recognising the impact gender has on the way women experience HIV and addressing the specific needs and emerging issues that affect women and HIV in Victoria.

Straight Arrows

Straight Arrows is the lead agency for heterosexual people living with HIV in Victoria. It is a membership based support service for heterosexual men, women, their partners and families who are living with or affected by HIV. Our philosophy is that HIV affects not only the individual but their whole family. We believe that an individual's needs are best met within that context, providing support not only to individuals living with HIV but their partners and families. Straight Arrows is cognisant of the changing nature of the HIV epidemic in Victoria and responsive to the changing needs of its membership base and work collaboratively with our partners to ensure that all people living with HIV have equitable access to services and are able to realise their full potential to live a healthy, fulfilling life.

Living Positive Victoria

Living Positive Victoria is a not for profit, community-based organisation representing all people living with HIV in Victoria. Since 1988 Living Positive Victoria has been committed to the advancement of human rights and wellbeing of all people living with HIV. Living Positive Victoria works closely in partnership with a range of HIV-sector and other organisations to deliver a comprehensive and coordinated response to the needs of people living with HIV in Victoria, nationally and internationally.

Victorian AIDS Council

The Victorian AIDS Council (VAC) was formed in 1983 as a central part of the Victorian community response to the HIV/AIDS epidemic. VAC continues to lead the response by providing a range of services which include prevention, education, treatment, counselling, and care for people living with HIV. We continue to evolve in our response with continuing dedication to our vision and service philanthropy. Working together with all our community partners, we adhere to a social model of health that is aligned with the Ottawa Charter for Health Promotion which determines that all people have a right to increase control over and improve their health. A consequence of this is that

care and support, health promotion, and the prevention of the spread of HIV is integral to our work requiring continual community input and participation.

2. Family Violence

'I first visualised in rapt childish ecstasy a world in which women would no longer be the second-rate, unimportant creatures that they were now considered, but the equal and respected companions of men.'

Vera Brittain
Testament of Youth, 1933

Family violence is the most pervasive form of violence perpetrated against women in Victoria. Whilst both men and women can be perpetrators or victims of family violence, overwhelmingly, the majority of perpetrators are men and victims are women and children. The consequences of family violence are profound, not only for the victims, for whom the consequences can be catastrophic, but for the economic and social wellbeing of our community as a whole.

The alarming statistics on the extent of family violence and the cost of family violence to the community are well documented by organisations such as the Victorian Council of Social Services, The Women's Health Association of Victoria, Victorian Women's Health Services, VicHealth and Domestic Violence Victoria (who will be detailing these statistics in their independent submissions to the Royal Commission). Of specific concern is the evidence on the cost to the Victorian community of intimate partner violence through ill-health, disability and death in Victorian women aged 15-44[1], the rising numbers of family violence intervention orders and the number of women and children who die each year due to family violence – in 2013 in Victoria there were 44 deaths directly attributable to family violence, 29 of which were of women and eight of children[2].

A significant proportion of women who experience physical and/or sexual violence do not seek help. Violence against women and the related health consequences is a significant public health concern and an unacceptable violation of women's rights.

In recent decades, substantial evidence has emerged that supports the key drivers of violence perpetrated against women by men as being structural and normative expressions of gender inequality exacerbated by other factors such as alcohol abuse and childhood exposure to violence[3]. The contribution of prevailing community attitudes to family violence is also well documented, specifically those influences within Australian culture that encourage a tolerance of violence against women and discourage men from taking responsibility for their violence[4].

Family and intimate partner violence does not occur exclusively in heterosexual relationships. It is increasingly acknowledged that intimate partner sexual violence occurs at a similar rate in same sex

[1] Vic Health, *The health costs of violence; Measuring the burden of disease caused by intimate partner violence,* 2004.
[2] K Lay, Changing the Culture, Changing the System; an edited extract from speech to the May 2014 VCOSS Summit, *Insight 11*, October 2014.
[3] Joint statement on family violence from Victorian Centres Against Sexual Assault, Domestic Violence Victoria, No to Violence, Our Watch, Women's Health Association of Victoria, Women's Health Victoria, Victorian Equal Opportunity and Human Rights Commission *Getting serious about change: the building blocks for effective primary prevention of men's violence against women in Victoria* 2015
[4] Victorian Health Promotion Foundation *The Health Costs of Violence: Measuring the Burden of Disease Caused by Intimate Partner Violence.* VicHealth, Melbourne 2004

relationships as heterosexual intimate partner sexual violence. Transgender people (who may identify as gay/lesbian, bisexual, heterosexual or other sexualities) and bisexual people may experience family violence in the context of same-gender or opposite gender relationships[5].

Social attitudes to individuals (and communities of people) who challenge the dominant norms around sex, gender, and sexuality can lead to significant levels of violence and abuse of both a physical and sexual nature. Although less well documented than the drivers of violence perpetrated against women by men in heterosexual relationships, these social attitudes may exacerbate intimate partner violence in same-sex relationships when an abusive partner exploits these broader societal attitudes around homophobia and heterosexism as a mechanism to prevent their victim from disclosing the abuse[6].

3. Women, violence and HIV

'We must take action to end violence against women and girls and ensure that they have the sexual and reproductive health and rights that they deserve. Violence has a drastic impact on the health of women and children and is inextricably linked to a higher prevalence of HIV.'

Ban Ki-moon,
United Nations Secretary-General, 2014

Despite the fact that women comprise around ten percent of the population of people living with HIV in Australia, women are not recognised as a priority population under the most recent national HIV strategy[7]. The low participation rates of women and limited reporting of gender disaggregated data in the HIV surveillance and wellbeing reports[8,9] results in a limitation in organisations' capacity to develop evidence-based policy advice or service delivery for women living with HIV.

From the limited data available, we know that women living with HIV in Victoria are most likely to contract the virus through heterosexual sex or because they come from high prevalence countries in Sub-Saharan Africa or Asia. We also know that women living with HIV face major challenges and issues around reproduction and child rearing and are more likely than men to experience discrimination by health services including disclosure of their HIV status without their consent[16].

The small numbers and diverse characteristics of the population of women living with HIV in Australia mean that many live in isolation from other women living with HIV. Their geographic and social isolation can further exacerbate the vulnerability they experience as a result of their gender

[5] ACON (AIDS Council of NSW) *Homelessness and Same Sex Domestic Violence in the Supported Accommodation Assistance Program*, October 2004.<http://www.facs.gov.au/internet/facsinternet.nsf/vIA/saap/$File/Homelessness_DV_October.pdf>

[6] Fileborn, B *Sexual violence and gay, lesbian, bisexual, trans, intersex, and queer communities* Australian Centre for the Study of Sexual Assault, March 2012

[7] Australian Government Department of Health. (2014). *Seventh National HIV Strategy 2014–2017*. Commonwealth of Australia, Canberra.

[8] The Kirby Institute.(2014). *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2014*. The Kirby Institute for infection and immunity in society, University of New South Wales, Sydney

[9] Grierson J, Pitts M, Koelmeyer R, 2013 *HIV Futures Seven: The health and wellbeing of HIV positive people in Australia* Australian Research Centre in Sex, Health and Society, May 2013

and HIV status. An alarmingly high number of women living with HIV are estimated to be living below the poverty line[10].

Violence is a key risk factor for HIV among women. Globally, women who experience sexual assault or intimate partner violence are at much greater risk of contracting HIV, particularly in high prevalence countries.[11] Furthermore, the imbalance in power relationships between men and women means that many women have difficulties negotiating safe sex and condom use. This heightens women's risk of exposure to HIV and other blood borne viruses and sexually transmitted infections. Women diagnosed with HIV subsequently experience higher levels of gender-based violence.

In the United Kingdom, one study found that over half of the women attending an East London HIV outpatient department had experienced intimate partner violence in their lifetime and one in seven had experienced intimate partner violence in the previous year[12]. In South Africa, young women 15-24 years old who are married are most likely to experience physical or sexual violence from a partner.[13] Young women who experienced intimate partner violence were 50% more likely to have acquired HIV than women who had not experienced violence.[14]

In a study examining cross-sectional data from ten countries in sub-Saharan Africa the findings indicated that male controlling behaviour in its own right, or as an indicator of ongoing or severe violence, puts women at risk of HIV infection[15]. Women from sub-Saharan Africa and Asia are disproportionately represented in the cohort of women in Victoria who are newly diagnosed with HIV[16].

Whilst we do not have gender disaggregated data that supports a causal association between women's disclosure of HIV status and experience of family violence in Australia, we know anecdotally that several women living with HIV have been clients in Victorian women's refuges over the past year. We know that both men and women living with HIV are at heightened risk of family and interpersonal violence due to a complex range of intersecting health, lifestyle and socioeconomic factors.

The known drivers of violence perpetrated against women by men are mediated differently across cultural communities and are implicated differently in lived experience when they intersect with other forms of structural discrimination such as systemic racism and institutionalised discrimination based on disability or chronic illness. Women with disabilities, women who inject drugs, women who have been trafficked, and sex workers are more vulnerable to sexual violence and are at disproportionately higher risk of HIV.

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[10] Koelmeyer, R., McDonald, K., Grierson, J. (2012). Beyond the data: Distinct features and experiences of women living with HIV in Australia. *HIV Australia Vol. 9,* no. 4, 8–10.

[11] World Health Organization, 2005 *Multi-country study on women's health and domestic violence against women.* <http://www.who.int/gender/violence/who_multicountry_study/summary_report/en/>

[12] Dhairyawan R, Tariq S, Scourse R and Coyne KM Intimate partner violence in women living with HIV attending an inner city clinic in the UK: prevalence and associated factors *HIV Medicine* 2013 **14** 303-310

[13] *Demographic and Health Surveys.* 2010–2012. <http://www.dhsprogram.com/>

[14] Jewkes R, Dunkle K, Nduna M, Shai N, 2010. Intimate partner violence, relationship power inequity and incidence of HIV infection in young women in South Africa: a cohort study. *Lancet* 376(9734):41–48.

[15] Durevall D, Lindskog A, Intimate partner violence and HIV in ten sub-Saharan African countries: what do the Demographic and Health Surveys tell us? *Lancet Glob Health* 2015; 3: e34–43

[16] Centre for Population Health, Burnet Institute *New HIV diagnoses and people living with HIV in Victoria: Targeted Report 2013 (Women and men who did not report male-to-male sexual exposure to HIV)* Melbourne 2014

4. Stigma, violence and HIV

'Stigma's power lies in silence. The silence that persists when discussion and action should be taking place. The silence one imposes on another for speaking up on a taboo subject, branding them with a label until they are rendered mute or preferably unheard.'

M.B. Dallocchio
Quixote in Ramadi, 2013

In Australia, HIV is a highly stigmatised chronic illness.[17] While the virus itself can be medically suppressed, the personal impacts of HIV infection are far reaching. HIV stigma manifests both internally, as an expression of self-rejection causing feelings of worthlessness and low self-esteem, fear of unwanted disclosure, and externally, through direct violence, rejection or discrimination.[18]

Stigma is used to assert power over others and to justify and normalise inequalities that structure our society. Stigma is a broad and pervasive social process that is difficult to measure. However, the impacts of stigma are clear. We know that stigma has a direct impact on the mental and physical health and wellbeing of people living with HIV, causing shame, diminishing social connectedness, intensifying social disadvantage, creating chronic self-doubt and increasing stress. These factors can contribute enormously to the risk of an individual being subject to or perpetrating violence within a family context. Violence can be defined in extremes or by subtle expressions of shame, all of which need to be recognised as limiting the ability of the HIV positive person to maintain mental and physical health.

Although levels of stigma may decrease or change over time in society, this change might not be reflected readily in the family situation. The family unit is often seen or appears to be incubated against the changing nature of stigma. This results in the family sometimes being a false place of safety for HIV disclosure, which can then be used as a tool to leverage or perpetrate acts of violence.

Stigma, violence and the fear of violence deters women and girls from seeking access to treatment and support services and thus undermines Australia's public health response to HIV. As co-signatories of the Melbourne declaration[19], Australia has an obligation to ensure we do everything we can to end the discrimination and inequities that remain key drivers of the HIV epidemic. Supporting women to seek safe access to treatment and support services is therefore incumbent upon us.

[17] Slavin S, Brener L, Callander D, de Wit J, 2012. *The HIV Stigma Audit Community Report* National Association of People Living with HIV/National Centre for Sex and Health Research, p. 4-5
[18] Link BG, Phelan JC., 2001. Conceptualising Stigma *Annual Review of Sociology* vol 27 p. 363-385
[19] AIDS 2014 *Melbourne Declaration: Nobody left behind* < http://www.aids2014.org/declaration.aspx>

5. Unique forms of family violence related to HIV

'HIV/AIDS is related to inequality between the sexes, it's related to social development, to security. It has links with everything we do in life'

Purnima Mane
Director, UNAIDS, 2006

People living with HIV have a higher than usual reliance on access to medical and pharmaceutical services outside the home, and essential access to medications in the home. Between these settings there are opportunities for violence to manifest that are unique to medicalised people.

The HIV Power and Control Wheel[20] effectively shows the extended range of potential risk areas relating to HIV. These are recorded in the following key areas:

- Medical Abuse: interfering with HIV treatment access or regiments
- Psychological: fear of violence or using psychological means to abuse
- Emotional Abuse: using degrading or humiliating language about HIV and AIDS
- Privilege: using a person's HIV status to guilt them into action or non-action
- Using children: using HIV status as proof that a person is unfit for parenting
- Isolation: not allowing the person living with HIV to be socially connected
- Economic abuse: withdrawing monetary support for access to HIV treatment
- Coercion and threats: using HIV to manipulate the individual into action or non-action

In our organisations we have come across many examples of acts of family violence towards people living with HIV. These include:

1. Family members exercising power over a person living with HIV through not allowing them to attend their medical appointments, disposing of valuable medications or interrupting their treatment regimens
2. People living with HIV being subjected to sexual violence, coercion or threats as a result of either their or their partner's HIV status
3. Unwanted disclosure of a person's HIV status to their children.

Victims of same-sex domestic violence who are living with HIV may feel they have no other support apart from their abusive partner. If the abusive partner is living with HIV, the victim may feel guilty about reporting the abusive partner to the police as this may be perceived as betraying the gay community.

Out of fear of family violence, some people living with HIV will hide their medications from family, flatmates or visitors to the home. Some will transfer treatments into unmarked or mislabelled container units to hide their condition and its management. This extends to the act of collecting treatments from the pharmacy and transporting medicines openly.

[20] Dochrey D, *HIV Power and Control Wheel* Alabama Coalition Against Domestic Violence & Montgomery AIDS Outreach < http://nnedv.org/resources/dv-hiv-aids-toolkit/168-dv-hiv-aids-handouts/4316-hiv-power-control-wheel.html>

6. Primary prevention of men's violence against women

'I do not wish them (women) to have power over men; but over themselves'

Mary Wolstonecroft

A vindication of the rights of women, 1792

Primary prevention refers to activities and interventions that seek to prevent violence before it occurs. The overall goal of primary prevention is to reduce the actual incidence of violence experienced within the population. More than that, primary prevention aims to challenge the underlying causes of violence, by identifying and modifying the factors that produce or perpetuate the conditions for gender-based violence, in order to influence behaviour.

Primary prevention strategies are universal strategies directed at the whole population (though sometimes requiring tailored approaches for different groups) with the aim of addressing the social determinants or root violence including:

- Belief in and adherence to rigid gender roles and stereotypes,
- A wider context of gender inequity where there is unequal distribution of power and resources between men and women
- Violence supportive attitudes.

Primary prevention requires a specific set of expertise and a universal approach focused on challenging commonly held attitudes and behaviours. Primary prevention means evolving strategies to readjust structural power imbalances and adopt more nuanced approaches to changing the conditions which support gender inequality and violence. In addition to achieving change on the individual/relationship level, primary prevention strategies target the structural, cultural and societal inequalities which enable violence against women to occur.

7. Response to family violence

Whilst the ultimate aim of our society should be preventing violence before it occurs, until this goal is a reality, effective family violence response strategies are critical. The most urgent areas of family violence response have been identified by the No More Deaths Coalition[21] and include:

- Keeping women and children safe and housed
- Making the justice system safe and supportive
- Holding violence perpetrators to account.

Australian society continues to develop and expand its traditional definition of family to encompass the various realties of modern relationships.[22] Family rejection of people living with HIV due to

[21] The members of the *No More Deaths* coalition are: Domestic Violence Victoria, Federation of Community Legal Centres, No To Violence, Women's Legal Service Victoria, Domestic Violence Resource Centre Victoria, Women's Domestic Violence Crisis Service, Women with Disabilities Victoria. Together they represent most statewide and local organisations working with women and children, community legal services and men's behaviour change programs across Victoria.

societal, religious or cultural attitudes and beliefs, means that new models of family or supportive relationships that substitute the traditional family network are relied on to provide support and stability. Traditional notions of family, definition and language, need to be carefully considered so as not to exclude or dissuade individuals from accessing services or support.

The lack of full and equal legal recognition of same sex relationships and rainbow families means that family violence incidents occurring in these families are not always reported or recorded as such. As a result, the handling of family violence in this context often occurs outside established frameworks which can be to the detriment of the victims in these situations.

8. Recommendations from the HIV sector community agencies

Policy

1. Detailed reporting of HIV wellbeing and surveillance data should be gender disaggregated to enhance organisations' capacity to develop evidence-based policy advice and service delivery for women living with HIV
2. Women should be recognised as a key population in the state and national HIV strategies

Funding of services and programs

3. HIV community services continue to be funded and delivered through a gender equity lens, including preserving dedicated funding for the delivery of community services to women living with HIV
4. In recognition of the health impacts of stigma and discrimination for people living with HIV, funding for community HIV services to deliver broad-based education and anti-HIV stigma campaigns will be maintained
5. Continuation and involvement of police liaison officers with HIV sensitivity training
6. Continuation and expansion of alcohol and other drug programs and other harm reduction strategies with the aim of enhancing engagement with individuals more at risk of family violence
7. Funding is prioritised to address the areas that have been identified as the most urgent areas of family violence response including:
    - Keeping women and children safe and housed
    - Making the justice system safe and supportive
    - Holding violence perpetrators to account

Education and awareness

8. In consultation with the community HIV agencies, develop and fund a broad-based population-wide education campaign aimed at reducing HIV stigma and discrimination
9. Ensure workers in the family violence sector are made aware of the links between violence and HIV and of the support services available to women diagnosed as HIV-positive.

[22] Robyn Hartley and Peter McDonald, *The many faces of families: Diversity among Australian families and its implications* Australian Government Australian Institute of Family Studies < https://aifs.gov.au/publications/family-matters/issue-37/many-faces-families>

10. Create stronger links between domestic violence services and peer support organisations for women living with HIV
11. Ensure that family violence services are aware of the issue of confidentiality for women living with HIV, and that they have processes in place to ensure that accidental disclosure of HIV status does not occur.
12. Advocate for the legal recognition of same sex relationships and broaden the definition of family to include those non-traditional family units
13. Comprehensive and universal sex and relationship education is mandatory in schools. Topics to be covered include respect and consent. These programs should be developed and delivered through a culture and gender lens.

Prevention of family violence

14. Strategies to address and reduce men's violence against women (including primary prevention) should employ a clear and consistent acknowledgement of the causes of men's violence against women:
    - Belief in and adherence to rigid gender roles and stereotypes,
    - A wider context of gender inequity where there is unequal distribution of power and resources between men and women
    - Violence supportive attitudes