PREVENTING VIOLENCE TOGETHER

Western Region Action Plan to Prevent Violence Against Women

PREVENTING VIOLENCE TOGETHER

Five-year Retrospective Process Evaluation and Report

2010-2015

Contents

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Executive summary

Preventing Violence Together (PVT) is Melbourne's western region partnership and action plan to prevent violence against women before it occurs. Led by Women's Health West, PVT's vision is of communities, cultures and organisations in Melbourne's west that are non-violent, non-discriminatory and gender equitable, and that promote respectful relationships between women and men. The partnership currently comprises eighteen partner organisations, including all community health services, primary care partnerships and local governments in the west, and a number of response sector services.

Since its launch in 2010, PVT has functioned as a mechanism for realising its vision by offering signatories an enabling and coordinating context to undertake primary prevention actions in and across the region. The achievements of PVT have been many, not least being the implementation of the United project, as one of eight regional projects funded through the Victorian Department of Justice and Regulation's Reducing Violence against Women and their Children (RVAWC) grants program, from 2012–2015.

PVT's progress and the United project's implementation have coincided with significant developments in primary prevention at the national and state levels, alongside ever-increasing community and public awareness of the problem of violence against women and growing momentum to do something about it. Developments include:

- The establishment, in 2013, of Our Watch, which exists to drive nationwide change in the culture, behaviours and power imbalances that lead to violence against women and their children

- The launch, in 2015, of Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia, by Our Watch, ANROWS and the Victorian Health Promotion Foundation (VicHealth)

- The announcement, in 2015, of the proposed terms of reference for a Royal Commission into Family Violence, by the Victorian Government. The extensive work of the Royal Commission was completed in the following months, with a final report and 227 recommendations – a number of which relate squarely to primary prevention – delivered to the Victorian Government on 29 March 2016. Implementation of the recommendations has since commenced

The completion of United in December 2015, alongside these major developments in primary prevention and public awareness, makes it timely for partners in Melbourne's west to reflect upon where PVT has come from, what its main achievements and successes have been, and, more importantly, how the region's primary prevention partnership and action plan might look and operate in the coming years. Such reflection is the purpose of this five-year retrospective process evaluation and review.

This report presents the findings and recommendations arising from the evaluation commissioned by PVT's Executive Governance Group (EGG) and undertaken from April to August 2016. While the evaluation's intended users are PVT's partners, its findings will be used in the first instance by the EGG, in its strategic leadership and oversight function, to set the tone for the development of an effective and sustainable western region partnership and action plan as the next iteration of PVT.

Core evaluation activities included focus groups, interviews, an online survey, and a review of relevant PVT and United documentation, with 38 participants recruited to the study. The study produced a number of findings and considerations related to the lead agency partnership model, the roles and responsibilities of partners, the structures and processes that govern and support the work of the partnership, and the evaluation of regional prevention efforts.

The findings are summarised as follows.

- While the lead agency partnership model, with Women's Health West as the lead partner, has been in place in the west for some time and has been successfully replicated across Victoria, and while there are words that describe Women's Health West as the lead partner in the current PVT partnership and action plan document (Preventing Violence Together: Western Region Action Plan to Prevent Violence Against Women), this model has never been properly enshrined in any binding partnership document.

- There is a need to ensure that the lead agency partnership model, which has Women's Health West as the lead partner, as well as the expectations, roles and responsibilities of all partners, are uniformly understood by all partners as the underpinning approach to primary prevention in the region. A degree of confusion about the partnership model and the role of Women's Health West was found to exist among some partners during implementation of the United project.

- Clarity and consistency in understandings of the role of Women's Health West as the lead partner and the role of other partners will be especially critical going forward, as momentum for primary prevention continues to build following the release of the report and recommendations arising from the Royal Commission into Family Violence, and with a more diverse range of organisations – some relatively new to primary prevention work – likely to come on board in the near future.

- While the EGG's membership has been expanded in recent years to include executive or senior management representation of all partner organisations, there exists an uneven level of engagement with this structure, which means the work of Implementation Committee (IC) members is not always supported (i.e. authorised) within their organisations – the very reason for a broadened EGG in the first place.

- The PVT action plan has been useful as a higher-order strategy for partners to advocate for primary prevention actions within their organisations and/or for shared regional endeavours. However, there is a need to introduce an annual action planning process that can support partners to identify concrete actions and have these endorsed by organisational decision makers at the same time, so that an authorising environment for implementation is generated and agreed upon from the outset, rather than being continuously sought.

- All of the partnership's structures should stay and will need to continue to meet the governance and implementation needs of the western region partnership and action plan – which can be considered to have reached a phase of maturity and is no longer fledgling or developing – by adapting specific areas of their functioning or operations as appropriate. This is particularly so of the EGG, which is required to evolve into a much more dynamic structure with an annual strategic work plan to execute that includes some urgent external advocacy activity.

- While PVT as a document has been useful as a higher-order strategy for partners to advocate for primary prevention actions, there is a weakness in relying upon it as a 'stand-alone' document for implementing regional actions: it makes it difficult for partners to plan for evaluation and agree to markers of success (indicators) in an integrated and coordinated way.

- Evaluation of the region's prevention efforts could be greatly strengthened through the introduction of an annual action planning process, which would have evaluation planning tethered to actions identified and endorsed by each organisational partner for any given twelve-month period. As with the primary prevention actions, activities identified through evaluation planning would be endorsed by organisational partners at the start of each twelve-month cycle, with a commitment from partners to undertake agreed evaluation activities and pool their data as part of their accountability to the partnership.

The considerations focus on a new partnership instrument, two different membership tiers, an annual action planning process, a higher-order strategy, priority settings and techniques, an annual strategic work plan for the EGG, refreshed terms of reference for the EGG and IC, evaluation planning as part of action planning, and options for monitoring regional progress.

The following four recommendations are drawn from these considerations. They are put to the partnership as a whole, but to the EGG in particular as it makes its start in setting the tone for the development of the next iteration of PVT.

Recommendation 1: Develop a partnership agreement

That the EGG immediately implements a process for developing a partnership agreement for the region's primary prevention partnership. The partnership agreement must enshrine the lead agency partnership model, and Women's Health West as the lead partner, as the approach for primary prevention in Melbourne's western region. The partnership agreement must explain the expectations, roles and responsibilities of full implementing partners within the partnership model; in particular, their accountability to the partnership and the actions they have agreed to. The partnership agreement must also explain the expectations of associate partners.

That the partnership agreement is finalised in time to be signed at the inaugural full-day planning forum of the partnership (Recommendation 3). From there, the partnership agreement should be reviewed every twelve months as a living partnership document.

Recommendation 2: Develop a higher-order strategy

That the EGG immediately approves the development of a higher-order strategy that is similar to the existing PVT action plan document, but revised as the region's interpretation of Change the Story, the new evidence-informed framework for a shared national framework for primary prevention. The higher-order strategy should align with the framework's themes, settings and techniques for action, injected with a regional flavour. The higher-order strategy should have a ten-year horizon.

That the development of the strategy should be led by Women's Health West and involve all (or as many as possible) of the region's partners, through the EGG and IC structures. The strategy should be ideally completed within three months of the EGG receiving this report of PVT's retrospective process evaluation and review.

Recommendation 3: Hold an inaugural action-planning forum

That the EGG immediately develops a process and plan for bringing together executive/senior manager-level and officer/worker-level representatives of the partnership, for an inaugural full-day planning forum, including the communications and engagements needed for this; and that coordination and resources for the forum are secured so it can be held between four and six months of the EGG receiving this report.

Further, that the agenda for the full-day planning forum includes (but not be limited to):

- Selecting one or two priority settings and/or techniques for which the partnership can saturate its efforts over the next twelve months
- Identifying organisational partners' actions for the next twelve months
- Identifying the pieces of strategic work required of the EGG to oversee the partnership and its prevention actions over the next twelve months
- Nominating executive or senior manager representatives who can best contribute to the EGG's strategic work plan for the next twelve months
- Gaining partners' commitment to all the work identified, and endorsing an annual operational primary prevention plan that contains that work (to be finalised within one month of the forum by Women's Health West as the lead partner)
- Gaining partners' endorsement and commitment to an evaluation plan to be developed within four months of finalising the operational primary prevention plan (coordinated by Women's Health West as the lead partner)
- Signing the partnership agreement

The higher-order strategy for the partnership (Recommendation 2) is a key framing device to hold conversations and support decisions at this forum.

Recommendation 4: Convene EGG and IC meetings with refreshed terms of reference

That meetings of the EGG and IC are held as soon as practicable after the inaugural full-day planning forum, and their terms of reference are refreshed to reflect their evolved functioning and operations; and:

- That the meeting of the EGG nominates its chair for the year
- That the nominated chair is Women's Health West
- That the meeting of the IC identifies the smaller working groups that need to be convened for the next twelve months to progress the year's operational primary prevention plan

In conclusion, this report shows that the western region partnership and action plan rest upon sound operational and functional features that have evolved over the past five years, and that improvements to structures and/or processes across the domains of governance, planning, implementation and evaluation – particularly in following the recommendations of this report – should see primary prevention continue to flourish and deliver strong outcomes in Melbourne's west for the years ahead.

This report now presents the findings and considerations in detail.

Background and context

Preventing Violence Together: Western Region Action Plan to Prevent Violence against Women

Preventing Violence Together (PVT) is Melbourne's western region partnership and action plan to prevent violence against women before it occurs. Led by Women's Health West, PVT's vision is of communities, cultures and organisations in Melbourne's west that are non-violent, non-discriminatory and gender equitable, and that promote respectful relationships between women and men. Since its launch in 2010, PVT has functioned as a mechanism for realising its vision by offering signatories an enabling and coordinating context to undertake primary prevention actions in and across the region. PVT's seven action areas have been broad enough to ensure a range of mutually reinforcing primary prevention activities occur in a comprehensive yet flexible fashion, depending on the organisational mandates, priorities, readiness and capacities of partner agencies.

The PVT partnership currently comprises eighteen partner organisations, including all community health services, primary care partnerships and local governments in the west, and a number of response sector services. The partner organisations (in alphabetical order) are:

- Brimbank City Council
- cohealth
- Department of Justice and Regulation
- Djerriwarrh Health Services
- HealthWest Primary Care Partnership
- Hobsons Bay City Council
- Inner North West Primary Care Partnership
- ISIS Primary Care
- Maribyrnong City Council
- Melbourne City Council
- Melton City Council
- Moonee Valley City Council
- Victoria Police
- Western Region Centre Against Sexual Assault
- Western Integrated Family Violence Committee
- West Metro Indigenous Family Violence Regional Action Group
- Women's Health West
- Wyndham City Council

As a regional partnership and action plan, PVT was the first of its kind in Victoria, with many other regions adopting similar partnership approaches to primary prevention in the following years.

Recent developments in primary prevention

The achievements of PVT since 2010 have been many, not least the implementation of the United project, as one of eight regional projects funded through the Victorian Department of Justice and Regulation's Reducing Violence against Women and their Children (RVAWC) grants program, from 2012–2015.[1] The United project focused on supporting and resourcing the capacity development needs of PVT's partners to undertake sustainable, evidence-based strategies for gender equity and primary prevention, whether within their organisations, with the diverse communities served by them, or through joint regional endeavours. With this focus, United furthered the role of PVT as an integrating force for primary prevention in the west.

PVT's progress and United's implementation have coincided with significant developments in primary

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prevention at the national and state levels, alongside ever-increasing community and public awareness of the problem of violence against women and growing momentum to do something about it. A snapshot of recent highlights follows (see Our Watch 2016, pp. 14–15).

- Nationally, in 2013, the first action plan of the National Plan to Reduce Violence against Women and their Children 2010–2020 saw the establishment of two new organisations to advance the agenda for reducing and preventing violence:
    - Australia's National Research Organisation for Women's Safety (ANROWS), which exists to build, translate and lead the uptake of evidence in work towards significant and sustained reduction in violence against women and their children
    - Our Watch, which exists to drive nationwide change in the culture, behaviours and power imbalances that lead to violence against women and their children.

- In 2015, Our Watch, ANROWS and the Victorian Health Promotion Foundation (VicHealth) launched Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia (Our Watch, ANROWS & VicHealth 2015). The framework:
    - Presents up-to-date evidence and a sound conceptual approach for preventing violence against women before it occurs
    - Is designed to support shared understanding and collaborative action among governments and their partners for primary prevention.

The framework contributes to the second action plan of the National Plan to Reduce Violence against Women and their Children 2010–2020.[2]

- In 2015, the National Australia Day Board Council selected Victorian Rosie Batty as Australian of the Year, in recognition of her advocacy for women and children living with family violence following the tragic murder in 2014 of her son, Luke, at the hands of her estranged husband.

- At the state level, in 2015, the newly-elected Victorian Government appointed Fiona Richardson MP as Minister for the Prevention of Family violence, a first for any Australian ministerial portfolio.

- In 2015, the Victorian Government also announced the proposed terms of reference for a Royal Commission into Family Violence, another first for Australia. The extensive work of the Royal Commission was completed in the following months, with a final report and 227 recommendations – a number of which relate squarely to primary prevention – delivered to the Victorian Government on 29 March 2016 (State of Victoria 2016). Implementation of the recommendations has since commenced.

2 The National Plan to Reduce Violence against Women and their Children 2010–2022 was endorsed by the Council of Australian Governments and released in February 2011. The plan aims to connect all work being done by Australian governments, community organisations and individuals to reduce and prevent violence.

Retrospective process evaluation and review

The completion of United in December 2015, alongside the major developments in primary prevention and public awareness described above, makes it timely for partners in Melbourne's west to reflect upon where PVT has come from, what its main achievements and successes have been, and, more importantly, how the region's primary prevention partnership and action plan might look and operate in the coming years.

In recognition of such timeliness, PVT's partners commissioned a retrospective process evaluation and review covering the period 2010–2015. This report presents the findings from the evaluation, undertaken from April to August 2016, and is structured as follows:

- **About the evaluation**, which describes the evaluation's purpose, its intended use and intended users, the overarching questions guiding the study, how and when the data collection occurred, and data collection limitations

- **Thematic presentation of findings**, which provides a discussion of the findings yielded through the study's investigations into the functioning and operations of the partnership and action plan. These multiple findings are clustered into three thematic areas related to:

    - The lead agency partnership model/roles and responsibilities of partners
    - Structures and processes that govern the partnership and support its work
    - Collecting shared impacts and sharing collective impacts

  This chapter also presents proposed next steps for the partnership and action plan, as they emerge in the context of the findings

- **Listing of key considerations**, which brings together the proposed next steps of the preceding chapter

- **Recommendations and conclusion**, which formulates the considerations as recommendations for PVT's partners and the next iteration of their regional partnership and action plan to prevent violence against women

About the evaluation

Evaluation purpose

Process evaluation, by definition, is concerned with exploring the operations of a program, project or initiative – in this case a regional partnership and action plan – in order to improve them. A review of PVT and United documents, undertaken in April 2016, uncovered four domains of PVT that are amenable to process evaluation.

1. Governance: This domain refers to the composition and functioning of PVT's strategic leadership and oversight structure, the Executive Governance Group (EGG).

2. Planning: This domain has two aspects:

- PVT's own development as a partnership and action plan
- The use of the action plan by partners for coordinating, integrating and planning their primary prevention actions, whether within their individual organisations, with the communities served by them, or through joint regional endeavours

3. Implementation: This domain refers to primary prevention actions undertaken within and across the region, and how these are supported or enabled through PVT's two main implementation features:

- The pairing of the EGG with the partnership's second main structure, the Implementation Committee (IC), so that work happening 'on the ground' has the high-level support needed for it to happen
- The work of the lead partner with organisational expertise, core business and ongoing commitments in gender equity, Women's Health West, in coordinating and implementing PVT's planned actions, so that these actions are evidence informed, mutually reinforcing and integrated

It is noted that a third implementation feature emerged through the United project, and that this is fast becoming a core component of how the region undertakes its primary prevention work. This feature comprises the smaller working groups formed from the IC of partners with a shared interest in agreed joint initiatives or work related to specific settings (e.g. executive leaders' forum, gender equity for community health services initiative).

4. Evaluation: This domain refers to the approaches taken by partners to evaluate their efforts. It also refers to the extent to which such data are pooled to build a regional picture of how the partnership and action plan is tracking with respect to PVT's longer-term vision, and whether or not PVT is contributing to the evidence base of primary prevention in this way.

The purpose of this retrospective process evaluation, therefore, is to examine these four operational domains of the western region partnership and action plan from as many angles as possible and within the timelines and resources available for the study, to discover what has worked well, anything that might have been done differently, and what has been learned or can be applied to the western region partnership and action plan in the future.

Intended use and intended users

This evaluation has been commissioned by PVT's partners to support their thinking on the future operations and directions of the western region partnership and action plan, especially following the completion of the United project in 2015 and in the context of the developments in primary prevention described above (with the Victorian Government's implementation of the recommendations from the Royal Commission into Family Violence being particularly relevant).

While the evaluation's intended users are PVT's partners, its findings will be used in the first instance by the EGG, in its strategic leadership and oversight function, to set the tone for the development of an effective and sustainable western region partnership and action plan as the next iteration of PVT.

Overarching evaluation questions

In preparing for the evaluation, the evaluator developed six overarching questions to guide the study. The first four questions related in turn to each of the operational domains described above. A fifth question covered the broader policy, programming and practice context within which PVT has operated thus far and is likely to operate to the future. A sixth and final question linked together the previous questions by asking, 'What should happen next?'.

The overarching questions were:

1. How has PVT been governed over the years (i.e. changes, strengths and weaknesses)? Which features of the governance structure should be taken forward?

2. How was PVT developed? And how has PVT worked as a planning mechanism for integrated and collaborative action across the region and/or for individual partner organisations? Lessons learned? Planning features that should be taken forward?

3. How has PVT gone about enabling a supportive environment for action to occur across the region and/or for individual partner organisation activity? Lessons learned? Implementation features that should be taken forward?

4. How have partners gone about evaluating the efforts of PVT and United? Lessons learned? Evaluation features that should be taken forward?

5. What is PVT's contribution to or legacy for Victorian primary prevention? What are the main practice, policy or programming contexts for regional partnership and action plans in the current environment?

6. What are the key considerations for a relevant, effective and sustainable regional prevention partnership and action plan for Melbourne's west from 2016 and beyond?

During May 2016, the evaluator consulted with a working group of the EGG to confirm the six overarching questions and identify the data sources that could help in answering them. The consultation also identified the most appropriate methods for collecting data from the sources, and when the data collection would need to occur to fit within the evaluation's timelines.

The evaluator then drafted an evaluation framework and developed a set of data collection instruments for the work. Feedback was sought from the whole EGG before finalising the evaluation framework and data collection instruments, with formal endorsement by the EGG working group by the end of May 2016.

Details of the data sources and methods of data collection can be found at Appendix 1.

Data collection methods and phases

Data collection took place in June and July 2016 and used a mix of methods as follows:

- Focus group with current EGG members
- Focus group with current IC members
- Abridged questions by email for those not able to attend focus groups
- Face-to-face interviews or abridged questions by email for those connected to PVT in the past, recently or currently (e.g. PVT or United project workers, people involved in developing and/or implementing PVT in the early days)
- Face-to-face or telephone interviews with informants in the region and beyond
- Online survey administered to all those contributing to the evaluation via focus groups, interviews or abridged questions by email (excluding informants beyond the region)
- Document review of relevant PVT, United and primary prevention materials provided at the commencement of the study and gathered along the way

Phase 1

Data collection occurred in two interlinked phases, with the first phase encompassing the focus groups, interviews and abridged questions by email. Instruments developed for these data collection methods can be found at Appendix 2.

A total of 61 people were invited to participate in the evaluation during this first phase of data collection. Those invited were:

- 20 people on the EGG's current email list
- 21 people on the IC's current email list
- 12 people connected to PVT in the past
- 3 regional informants
- 5 external informants

This invitation process resulted in 38 people (or 62 per cent of those invited) electing to participate in the evaluation. A breakdown of participants is shown Table 1.

Data Collection Method	Participants
Focus group: EGG	7
Focus group: IC	14
Abridged questions by email: EGG [3]	3
Abridged questions by email: IC	3
Abridged questions by email: People connected to PVT in the past or recently	2
Face-to-face interviews: People connected to PVT in the past or recently	3
Face-to-face interview: Current PVT worker	1
Face-to-face or telephone interviews: Regional informants	2
Face-to-face interviews: External informants	3
Total	**38**

3 One EGG member requested (and was granted) a telephone interview rather than responding to the questions by email.

The evaluator made sure that all those involved in the focus groups and interviews, and all those responding to the abridged questions by email, were fully aware of the purpose of the evaluation and how the data they were providing would be used. The evaluator also explained how the confidentiality of their data would be maintained, and the steps she would take to protect their anonymity in products arising from the evaluation (i.e. interim and final reports).

The evaluator obtained verbal permission from participants in the focus groups and face-to-face interviews to audio-record their responses to the questions, to support her note-taking and analysis of their data. Focus groups were around 90 minutes in length, and interviews were between 30 and 90 minutes in length. During this first phase of data collection, the evaluator amassed over nine hours of audio.

Phase 2

The second phase of data collection comprised the online survey. The online survey was designed and administered to test the strength of different viewpoints that arose during the first phase of data collection. As such, the online survey was open only to those who had actually contributed to the evaluation via a focus group, interview or responding to abridged questions by email. Because of the 'internal' focus of the online survey, informants recruited to the evaluation from beyond Melbourne's western region (n = 3) were excluded from this part of the data collection phase.

The online survey consisted of fourteen statements related to PVT's partners, actions and structures. These statements can be found at Appendix 3. The survey asked respondents to rate each statement along a scale ('Strongly disagree', 'Disagree', 'Neither disagree or agree', 'Agree', 'Strongly agree'). Respondents who felt unable to rate a statement, for whatever reason, were able to select an 'Other' option. Respondents were also given the opportunity to provide comments on why they gave the ratings they did, to facilitate interpretation of the quantitative data being gathered.

The fourteen statements were developed in consultation with the EGG working group, following a progress meeting in early July 2016, at which the study's interim findings were presented. The online survey was then tested before being administered over a one-week period in mid-July.

Of the evaluation's 35 participants who were invited to complete the online survey, a total of 23 responded, reflecting a response rate of 66 per cent. No information was collected about the demographics of survey respondents to ensure their ratings remained de-identified.

Report review process

The evaluator brought together the study's early findings as an interim report, and presented it to the working group of the EGG for their review in early July 2016. This report included emerging themes from the first phase of the data collection, the qualitative component. As noted above, the online survey was still in its development phase at the time of the interim report's submission.

Once the online survey closed, the evaluator then integrated the results from the quantitative component of the study with the emerging themes of the interim report, developing all findings as a whole and bringing everything together into a first draft of a more complete report. This draft was submitted to the EGG working group for feedback in early August 2016, with the EGG working group providing their comments within a one-week period.

The evaluator then prepared a penultimate draft of the evaluation report for review by the EGG working group, with the report of PVT's retrospective process evaluation and review finalised shortly thereafter.

Limitations to the study

Limitations to the study relate to the recruitment of participants to two data collection activities. As expected, it was challenging to engage those connected to PVT from the past, especially people who worked on (or with) PVT during its early development days. People had moved on from the partner organisations that connected them to PVT, and some had even left the region or primary prevention work for opportunities elsewhere.

The evaluation framework specified a focus group of past and present IC members, PVT and United project workers, and others connected to PVT in the early days, in addition to the focus groups for the current EGG and IC. This mixed focus group did not eventuate due to a low response rate from those targeted. Of the small number of people who indicated a willingness and availability to be involved in the study, some were offered face-to-face interviews (at times and locations convenient to them) using the same questions for the non-eventuating focus group, while others were involved in the evaluation by issuing via email an abridged version of the focus group questions, with answers returned to the evaluator in confidence.

The EGG focus group posed a second – and more serious – participant recruitment challenge. This focus group was held during a scheduled meeting of the EGG. Yet, out of PVT's eighteen organisational partners, only seven were represented at the focus group. Immediately following the focus group, those not present were invited to respond to an abbreviated version of the focus group questions via email. This generated the participation of one EGG member. Members were then given an extension to the original closing date for their responses to the questions, and sent reminders to respond. Out of this additional process, two further EGG members provided responses to the email questions; however, both of these members were from organisations that had already participated in the evaluation through their colleagues attending the initial focus group.

In the end, just eight of the eighteen organisational partners participated in the evaluation at the EGG level. Of the organisational partners not represented, five were local governments and two were community health services. With so many critical partners notably absent, it has to be stated that the views and perspectives offered by EGG members during the course of the study cannot be taken as fully reflective of the partnership at the governance level.

By contrast, all organisational partners across the region's local government, community health and primary care partnership sectors were represented in the evaluation through the IC focus group, conducted as part of a scheduled IC meeting, or via the abridged version of the questions sent to IC members not able to attend that meeting. The views and perspectives provided by IC members to this evaluation can therefore be said to be fully reflective of the partnership at the implementation level.

As it happens, the difficulties in recruiting EGG members to the evaluation can be explained by one of the study's main findings: the patchy level of engagement of PVT's organisational partners with the partnership's governance structure. This unevenness, and the reasons for it, are unpacked in this report's presentation of findings, to which the discussion now turns.

A note on the presentation of findings

It was previously mentioned that the evaluator developed six overarching questions to guide PVT's retrospective process evaluation and review. As the evaluation progressed, the evaluator discovered that findings arising from the investigations of one question were often connected to findings arising from the explorations of others. For instance:

- Investigations of PVT's development (overarching question 2) led to findings about the lead agency partnership model and the roles and responsibilities of partners. These findings were also revealed through explorations of:
    - PVT as a supportive environment for implementing primary prevention actions in the west (overarching question 3)
    - PVT's contribution to or legacy for Victorian primary prevention (overarching question 5)

- Investigations of PVT's governance structure (overarching question 1) led to findings about the endorsement of identified actions and how this occurs. These findings were also revealed through explorations of:
    - PVT as a planning mechanism for integrated and collaborative action across the region and/or for individual partner organisations (overarching question 2)
    - PVT as a supportive environment for implementing primary prevention actions in the west (overarching question 3)

For these reasons, the presentation of findings in the next chapter is approached thematically, rather than being organised under the six overarching questions. Thematically, the multiple findings yielded by the study are sectioned as follows:

1. The lead agency partnership model and the roles and responsibilities of partners
2. Structures and processes that govern the partnership and support its work
3. Collecting shared impacts and sharing collective impacts

Each section opens with a snapshot of the main findings related to the theme being discussed, before providing evidence for the claims being made. Related next steps or considerations for the region's partnership and action plan going forward, many of which also emerged as findings through the study's investigations (overarching question 6), are proposed in the sections that comprise the following chapter as well.

Thematic presentation of findings

The lead agency partnership model and the roles and responsibilities of partners

PVT's partnership currently comprises eighteen partner organisations, including all seven local governments in Melbourne's west, the three community health services and two primary care partnerships with catchments in the region, and a number of response sector services (see 'Background and context' in this report for a full list of partner organisations). Since its inception, PVT has adopted a lead agency partnership model, with Women's Health West, the western region's women's health service, as the lead partner among the signatories.

The evaluation's investigations of PVT's development as a partnership and action plan, the contribution to or legacy of PVT for Victorian primary prevention, and the work of Women's Health West as lead agency in the implementation of partners' identified prevention actions, yielded a number of findings related to the lead agency partnership model, with implications for how partner accountability – especially the roles and responsibilities of partners as implementing agencies – can be strengthened in the future.

The findings in snapshot

- While the lead agency partnership model, with Women's Health West as the lead partner, has been in place in the west for some time and has been successfully replicated across Victoria, and while there are words that describe Women's Health West as the lead partner in the current PVT partnership and action plan document, this model has never been properly enshrined in any binding partnership document.

- There is a need to ensure that the lead agency partnership model, which has Women's Health West as the lead partner, as well as the expectations, roles and responsibilities of all partners, are uniformly understood by all partners as the underpinning approach to primary prevention in the region, as a degree of confusion about the partnership model and the role of Women's Health West was found to exist among some partners during implementation of the United project.

- Clarity and consistency in understandings of the role of Women's Health West as the lead partner and the role of other partners will be especially critical going forward, as momentum for primary prevention continues to build following the release of the report and recommendations arising from the Royal Commission into Family Violence, and with a more diverse range of organisations – some relatively new to primary prevention work – likely to come on board in the near future.

Origins of the partnership model

History has a place in going forward. Specific questions were put to evaluation participants about the development of PVT, with a view to distilling any insights or lessons learned for the development of the next iteration of the region's primary prevention partnership and action plan. Answers illuminated the significance of the lead agency partnership model to PVT's development, and that the origins of this model can be traced as far back as ten years ago, beyond this five-year retrospective process evaluation and review, when the Victorian primary prevention context was vastly different to that of today.

Around 2006, Women's Health West had just convened a conference – believed to be a first for Victoria – on the links between health promotion and preventing violence against women, and what primary prevention actions could look like in local area contexts. The conference attracted around 200

delegates from across the state, even though it was intended as a regional event (Women's Health West 2006). VicHealth was represented on the conference plenary, and was just about to publish a new evidence-informed framework for the primary prevention of violence against women, *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria* (VicHealth 2007). Over the next few years, this framework would become the 'go-to' resource for partnerships, strategies, projects and programs, and a world-first public policy in *A Right to Respect: Victoria's Plan to Prevent Violence against Women 2010–2020* (Office of Women's Policy 2009; Michau et al. 2015).

Around 2007, Maribyrnong City Council was midway through its partnership with the Faculty of Architecture, Building and Planning at the University of Melbourne, as a case study for the Gender, Local Governance and Violence Prevention (GLOVE) project. Through the GLOVE partnership, the council produced an action plan to prevent violence against women for the municipality, bolstered by twelve months of funding from VicHealth's Respect, Responsibility and Equality program (Kwok 2008).[1] Meanwhile, Women's Health West was busy advocating to the region's primary care partnerships, and through them their member agencies, to have the prevention of violence against women prioritised in their integrated health promotion plans for their next funding cycle. Staff were attending as many committees of the region's community health services and local governments as they could, to put forward a primary prevention agenda that was not always welcome at the time.

> *It's hard to go back and remember that this is what it was like. People actively campaigned against primary prevention as a priority. They didn't get it. They couldn't see anything that could be done about violence against women within health promotion. They said it was too big; and not a good use of funds. (Interviewee)*

Women's Health West was also about to commence an innovative action research project that built the capacity of six organisational partners, recruited via expressions of interest, to plan and implement local actions to prevent violence against women, with the women's health service in a lead role in this process.[2]

In 2009, HealthWest Primary Care Partnership became the first of the region's primary care partnerships to name the prevention of violence against women as an integrated health promotion priority. Women's Health West immediately stepped up as the lead partner for the work, in keeping with the lead partnership model being used for all other named integrated health promotion priorities during that time. The main piece of primary prevention work in the integrated health promotion plan was to develop a strategy for the HealthWest catchment and the western region. Led by Women's Health West, this work was to be achieved through a working group of partners, comprising the region's local governments, community health services and primary care partnerships, and the Western Integrated Family Violence Committee, with input from an expert advisory group of academics and others.

Herein lay the beginnings of PVT, with its lead agency partnership model squarely in place. History tells us that PVT was not invented from scratch in 2010: rather, there was important work being undertaken by Women's Health West beforehand and behind the scenes to get primary prevention on the region's agenda in the first place, in order to have a strategy for the west. Core staff time and resources went into such advocacy, which was unequivocally prioritised as the agency's core business.

Such commitment and leadership was entirely in keeping with a strong body of international research, which points out that the progressive social policy changes required to end violence against women must necessarily be led by a strong autonomous feminist movement (Htun & Weldon 2012). With their core business in the social determinants of women's health, and years of primary prevention and gender equity expertise as their core business, history shows that Women's Health West has been (and

1 Maribyrnong City Council went on to be further funded by VicHealth from 2008–2009 to 'scale up' its local government primary prevention activities. The organisation continued its work from there as the lead local government of a western metropolitan 'cluster' (with Brimbank City Council and Wyndham City Council) for the Preventing Violence against Women in our Community project, 2011–2014, funded by the (then) Office of Women's Affairs.

2 The action research project resulted in a series of eight fact sheets published by Women's Health West, available online at <http://whwest.org.au/resource/building-capacity-organisations-western-region-prevent-violence-women/>.

will continue to be) a critical component of work to end violence against women, as the lead agency in regional primary prevention efforts in Melbourne's west.

PVT as a Victorian first and its influence in historical perspective

Questions put to evaluation participants about PVT's contribution to or legacy for Victorian primary prevention generated further findings about the lead agency partnership model by placing it in historical perspective.

The western region's strategy acquired its final form as the PVT partnership and action plan from the latter part of 2009, especially on the Victorian Government's release of *A Right to Respect. A Right to Respect* applied VicHealth's *Preventing violence before it occurs* framework to statewide policy, the first attempt of this kind anywhere in the world (Michau et al. 2015). In expressing VicHealth's framework as policy, *A Right to Respect* gave Women's Health West and the working group the strategic parameters within which to shape their regional strategy as a local interpretation of higher-level direction. The result was an action plan that was clearly aligned with *A Right to Respect's* seven strategies, expressed as regional objectives with suggested actions.

> *It was really exciting. We wanted to align with the statewide plan. That's why PVT looks the way it does. It's modelled on the plan, the seven action areas. It re-imagines what these look like at the local level. It gives really clear ideas about what primary prevention can look like at the local level across these action areas. (Interviewee)*

> *PVT added a western flavour to the statewide plan, and that's what enabled buy-in from partner organisations in the region. (Interviewee)*

Once finalised, PVT was launched at a sign-on event in December 2010, with hundreds in attendance and fourteen agencies signing on as partners.

Through its launch, PVT established itself as the first regional primary prevention partnership and action plan for Victoria. Victoria's other regions were soon to follow, by adopting similar partnership approaches led by their regional women's health services. At the current time, just a few years since PVT's launch, nearly all of Victoria's regions have in place a primary prevention strategy developed through the leadership of their women's health services (Women's Health West 2015a).

> *We showed that it can be done. Getting a regional strategy in primary prevention was trailblazing for other regions and women's health services in the state. It's been great for the women's health sector too, a great demonstration of women's services leadership and capacity to lead massive partnerships. (Interviewee)*

> *The United project undertaken by PVT has been epic. It has been great in terms of identifying and then demonstrating how a disparate but unified group of partners can work together to effectively tackle a complex issue. Its achievements have been significant ... But it has had greater value as an exemplar for the way this work can be done. This is where the greatest achievement probably lies. (Respondent to questions by email)*

The leadership of Victoria's women's health services has not gone unrecognised. By way of acknowledging the primary prevention infrastructures generated through the proliferation of regional partnerships and action plans, the (former) Office of Women's Affairs funded the Women's Health Association of Victoria for the Leading Regional Action project, 2014–2016, to resource a community of practice (and develop practice-based tools) for the women's health services. This community of practice went on to effectively facilitate connection and learning among women's health services as lead partners of their respective regional strategies (Springtech Services 2016).

Earlier this year, when bringing together the findings from its work, the Royal Commission into Family

Violence noted the leadership role of Victoria's women's health services in fostering collaborations and networks for primary prevention partnerships and action at the regional level, calling their efforts 'substantial' (State of Victoria 2016). It is highly likely that regional primary prevention approaches will continue to feature across Victoria in the future – with a modest amount of resourcing having already been allocated to women's health services for this purpose (but with much more needed) – as the Victorian Government implements the primary prevention recommendations of the Royal Commission into Family Violence.[3]

These points demonstrate the historical significance of the western region partnership and action plan – and the leadership of the region's women's health service – in establishing a lead agency partnership approach to primary prevention that was immediately replicable (and replicated) across the state. They show that in the evolution of Victorian primary prevention, the west's approach can be considered tried and tested or best practice as far as mobilising and coordinating regional efforts to prevent violence against women before it occurs.

Some arising confusions about the partnership model

Given the historical importance of the lead agency partnership model to PVT's development, and its significance in advancing other regional strategies, it was somewhat surprising for this evaluation to discover that the model has never been formalised or elaborated upon in any PVT document to date.

The final form of the PVT partnership and action plan does state that women's health services, such as Women's Health West, 'have significant expertise and capacity to advise on the prevention of violence against women and build the capacity of other organisations' (Women's Health West 2013, p. 10). Furthermore, because ending violence against women is core business for women's health services, this makes them 'well placed to play a central role' in the regional partnership and action plan (Women's Health West 2013, p. 10). The background document also asks those signing onto the partnership and action plan 'to outline how your organisation will begin the process of implementing your chosen actions in 2011 and beyond' (Women's Health West 2010, p. 4). However, these documents do not include words of any kind that would bind partners together through their accountability to the partnership in implementing their chosen actions; nor do they include any words about the lead agency partnership model, and the roles and responsibilities of all partners – lead or otherwise – within that model. To what extent, if any, have these omissions in wording impinged upon regional primary prevention in practice?

Questions were put to evaluation participants about the work of Women's Health West as the lead agency in the implementation of identified prevention actions. Answers showed some confusion exists about the partnership model and the roles and responsibilities of partner organisations within it, particularly as the work of the region's partnership and action plan progressed through United. During their interviews, for example, PVT and United project workers, both past and present, felt they have needed to communicate to the partnership at different stages – but especially during the implementation of United, when funding was held by Women's Health West as the lead partner – the message that organisational partners are the ones required to implement their identified primary prevention actions and not Women's Health West, whose role it is to contribute expertise and build capacity for coordinated and integrated regional effort.

> *We talked about gender audits and gender-responsive budgeting for United. The idea was to build the capacity of the partners in order to do that work in their own organisations, not for Women's Health West to go around to all partners and do it. That was not at all what had been discussed. But some partners thought that was what was going to happen. (Interviewee)*

> *Having secured funding for United, $600,000 or whatever it was, some agencies thought,*

3 For example, the Victorian Government has already further invested in the leading regional action capacities of the women's health services with funding to continue the community of practice for another twelve months.

'Well my name is on that plan, why don't we get [a fraction] of that pie?' Notwithstanding the fact that the lead partner was there for a reason, and that was the whole point of [PVT]. (Interviewee)

The United project was huge, and it asked for a lot. We asked for gender audits and so on. We needed partners to be really clear that they are doing the work, that it's not Women's Health West doing it for them. How can Women's Health West do their organisational gender audits? Women's Health West doesn't have access to organisational processes; it doesn't sit in the organisations where the work is happening. (Interviewee)

During their focus group, two IC members spoke of a lack of clarity when they first joined the group regarding the position of Women's Health West in the partnership.

When I first started, I wasn't sure whether [Women's Health West staff] were PVT IC employees housed at Women's Health West or whether they were Women's Health West employees who were members of this group, if you know what I mean. (Focus group discussant)

Yeah … it took me a little while too. I remember reading the Inner North West website to understand how the [United] funding had been allocated and the positioning or responsibility of Women's Health West having a representative role for PVT and all the partners. I had to clarify that. (Focus group discussant)

During her interview, a regional informant offered observations that some partners tend to view Women's Health West as PVT's auspice agency, in the same way that the organisation auspices the Western Integrated Family Violence Committee, rather than thinking of Women's Health West in the context of quite a different partnership model (and quite a different system). This regional informant felt there were emerging risks to the women's health service of its lead partner role becoming invisible or devalued, a perspective shared by PVT and United project workers who were also interviewed (although for slightly different reasons).

One of my concerns is that as prevention has become more mainstream, the work of the women's health service is becoming more invisible … We need to be loud and proud of the work of the women's health service, its role as the lead partner back then [before PVT] and the role that it continues to play through PVT. (Interviewee)

Partners now have good capacity and there's a risk they might not see as much value in having a women's health service as the lead; but that's because the work of the women's health service is 'invisible' and behind the scenes. There's an irony there in the devaluing of women's work, and this being replicated in the partnership. It's something for the partnership to consider, the legitimising and recognition of the work of the women's health service, the significant decades of work to end violence against women that our partnership stands on. (Interviewee)

On the other hand, there is data to support the interpretation that while some confusion over the lead agency partnership model has arisen in recent times, this is a minor (or at least manageable) communication problem, and not in any way suggestive of a poorly functioning partnership and action plan. In fact, the multiple achievements of PVT and United suggest the opposite: that the region's lead agency partnership model is well understood among partners, and well supported by them, as critical to progressing their work of primary prevention.[4]

4 The achievements of PVT and United are well documented in annual progress briefs, project reports and evaluation reports, and will not be discussed at length in this report. Specific achievements will, however, be mentioned where they provide relevant evidence for the findings in this current report, e.g. Gender Equity for Community Health Services Working Group, Leading Gender Equity Executive Leaders' Forum Working Group, regional initiatives for the 16 Days of Activism against Gender-based Violence, and United's Gender Equity Staff Attitudes surveys.

Women's Health West has delivered leadership that's been critical for focusing the actions and capacities of the partnership. (Focus group discussant)

This part of the model is thoroughly endorsed. There's only one women's health service. It's independent; and its commitment to the work is embedded in its core business. Other partners have a commitment to prevention, but they also have a dispersed commitment to other issues … There's a need for a lead agency, and one with independence creates a much smoother ride. (Focus group discussant)

Individually, from IC members, we get positive feedback a lot. 'We'd be lost without your expertise and leadership in this. We didn't know where to start.' (Interviewee)

We have a prevention system in Melbourne's west, a workforce that is skilled for the work and shares what it knows. Conversations are much more sophisticated now than in 2012, when United started. It used to be, 'How do we do a White Ribbon Day?' Now there are informed critiques of White Ribbon, informed comments about prevention. The leadership of Women's Health West has been critical to this. (Focus group discussant)

It's essential to the model, absolutely important. Women's Health West have done a marvellous job at getting us together, coordinating all the responses. A great resource, individually and collectively. Their strength is knowledge and background. (Focus group discussant)

Evaluation participants also recognised the importance of the lead agency partnership model for continued primary prevention successes in the region, as evidenced by their responses to a statement in the online survey. The survey asked respondents to rate the statement, 'The lead agency partnership model, with Women's Health West as the lead partner, will remain central to the success of our region's primary prevention efforts in the coming years'. Results show that:

- A resounding majority of respondents (91 per cent) strongly agreed/agreed
- Only 5 per cent disagreed, while 5 per cent felt unable to rate the statement[5]

A selection of respondent quotes adds further depth to these online survey results:

In this political climate and increasing recognition of violence against women and the need for prevention, we need a lead organisation [that] will undertake strong advocacy on behalf of the partnership and will always have primary prevention of violence against women and gender equity as core business and expertise. Women's Health West fulfils these criteria. (Survey respondent)

Leadership and coordination for this work should remain with Women's Health West. (Survey respondent)

Regional women's health services coordinate primary prevention strategies across the state and have infrastructure to support this work. There would have to be a heavy rationale to change this for the western region. (Survey respondent)

Definitely agree that Women's Health West should remaining as lead agency; however, I wonder if we need to consider a co-lead to share the workload? (Survey respondent)

Women's Health West should be better resourced for the work they do to support and contribute to the partnership. (Survey respondent)

5 Full results from respondent ratings for all fourteen statements of the online survey have been collated and can be found in the table at Appendix 3.

It is really important to have a committed, knowledgeable and informed lead agency … Apart from the obvious central steering and coordination that agency can offer, there is added value in having an organisation that can pull together the will and voice of the partnership, such as has been done with various submissions and grant applications. That becomes even more important in the current climate wherein there are many new policies, frameworks and resources (which add complexity, especially to those partners who come from generalist backgrounds). (Survey respondent)

Considerations moving forward

Two considerations for the next iteration of the western region partnership and action plan are now suggested to PVT's partners based on the findings presented above.

Consideration 1: A new partnership instrument

It is proposed that PVT's partners develop an appropriate partnership instrument that can:

- Enshrine the western region's lead agency partnership model as the approach for its partnership and action plan

- Explain the expectations, roles and responsibilities of all partners within the partnership model, and in particular the accountability of each and every partner to the partnership in implementing the actions to which they, as partners, whether lead or otherwise, have agreed

The introduction of such a partnership instrument would support the western region's primary prevention efforts in ways that have not thus far existed, by giving clear expression to the lead agency partnership model and what is required of all partners in that model.

The introduction of such an instrument would also be warmly supported by PVT's partners, as demonstrated through data collected by this evaluation. During this study, the idea of such an instrument was put forward to evaluation participants and found to be favourable among focus group discussants and interviewees alike. The idea was also put to respondents of the online survey, who were asked to rate the statement, 'A signed formal agreement between all organisations involved in the regional partnership and action plan would help clarify partner expectations, roles and responsibilities'. Results show that:

- Around three-quarters of all respondents (74 per cent) strongly agreed/agreed
- 22 per cent neither disagreed or agreed with the statement
- Importantly, no respondents were in disagreement with the statement

The specific type of partnership instrument would, of course, need to be settled among PVT's partners, but it could be a memorandum of understanding (MoU) or (more strongly) a partnership agreement.[1] It would need to include (but not be limited to):

- A statement of the partnership and its model
- The different types of partners and what they bring to the partnership
- The partnership goals and objectives in relation to primary prevention in the west
- The principles of partnering (and expectations to observe these)
- The roles and responsibilities of the lead and other partners
- The structures through which work of the partnership is governed, supported or related (e.g. EGG, IC, working groups, other relevant structures within the region or beyond)

It is proposed that PVT's partners also consider building into their partnership instrument the fundamental principles of primary prevention to which all signatories to the partnership adhere. Such fundamentals were identified through the evaluation as desirable yet absent in existing partnership documents.

Consideration 2: Two different membership tiers

It is proposed that PVT's partners consider introducing an option for organisational partners to join the partnership at two different membership tiers:

1 A recent example of a primary prevention partnership that developed an effective partnership agreement is Generating Equality and Respect, 2012–2015. The full evaluation report is available online at <https://www.vichealth.vic.gov.au/media-and-resources/publications/generating-equality-and-respect-resources>.

- Full implementing partners committed to undertaking primary prevention actions, with voting rights at the EGG or other decision making forums

- Associate partners who are part of the primary prevention system but not in a position to be implementing primary prevention actions, and who would therefore be without voting rights to decisions affecting the partnership until such time as they can progress to becoming full implementing partners

This consideration is proposed in light of developments in primary prevention over the last few years, especially the recommendations of the Royal Commission into Family Violence and the Victorian Government's commencement of their full implementation (State of Victoria 2016). Four recommendations have particularly strong implications for shaping the Victorian primary prevention landscape over the coming years. These are that the Victorian Government:

- Develops a ten-year Statewide Family Violence Action Plan (Chapter 38) that includes a primary prevention strategy supported by dedicated funding and implemented through three-year action cycles (Recommendation 187)

- Mandates the introduction of whole-of-school respectful relationship education into government schools in Victoria from prep to year 12 (Recommendation 189)

- Begins implementing best-practice workplace programs in all public sector workplaces in order to enable them to:

    - Build respectful and gender equitable cultures
    - Build skills and support staff in taking bystander action (Recommendation 192)

- Gives priority to providing adequate funding in Aboriginal community controlled organisations for prevention actions (Recommendation 146)

The implementation of these recommendations means Victoria will see an unprecedented level of coordinated and resourced primary prevention policy and programming into the next decade. For partnerships and action plans like those in Melbourne's west (and indeed for partnerships and action plans of any scale) it is likely that many new partners will be targeted as the breadth of primary prevention is expanded in programmatic, planned and sustained ways into an ever-widening range of settings or sectors.

Some of these partners will be new or inexperienced in primary prevention work, and perhaps not able to commit quite yet to implementing any agreed actions as part of the region's efforts. A two-tiered membership option would accommodate their involvement in the partnership and keep it broad and inclusive, as any prevention partnership ought to be, while allowing the partnership and action plan to be meaningfully governed and supported by and for those participating as full implementing partners.

It is noted that such two-tiered membership arrangements have been utilised by prevention partnerships in other Victorian regions, and appear to be operating well (Women's Health West 2015a; Crinall, McRae & Laming 2015).

Adding new partners to the partnership and action plan in the near future was certainly a consideration of evaluation participants who, in their focus groups and interviews, favourably discussed the partnership's potential to be more inclusive of partners from settings and/or sectors not currently engaged, including workplaces other than local government or community health.

> *One challenge for all of us still is … to try and move into settings that we're not working in enough. I think workplaces, education … I think PVT has been great in terms of us having a sense of what other partners are doing, and that's always quite influential ... But relatively speaking we're preaching to the converted around the table to some extent …*

It would be really good if we could, you know, work out how we can make an imprint or influence on other settings … The things we've done … have worked really well, but it's how you extend the sphere of influence to more sectors … If you take big employers as one example, in terms of reach, some strategic work could be done around who are the key large employers in the region, who are the potential champions. I think it could extend our reach more. (Focus group discussant)

The online survey also asked respondents to rate the statement, 'It will be important in the coming years to bring new partners to the regional partnership and action plan to reflect the increasing breadth of primary prevention work'. Results show that:

- A resounding majority (96 per cent) strongly agreed/agreed with the statement
- Less than 5 per cent disagreed with the statement

Respondents were asked to rate the counter-statement, 'Our partnership has too many organisations involved'. Results show that:

- Almost three-quarters (74 per cent) strongly disagreed/disagreed with the statement
- 26 per cent selected 'neither disagree or agree' in response to the statement

More partners, more momentum, more reach, more impact. (Survey respondent)

We need to ensure that by bringing on new partners we don't create simply an information [network] as the strength of PVT is that it produces tangible gender equity outcomes. MOUs or agreements will further strengthen our regional approach and ensure that we have the mechanisms and processes needed for a partnership of this maturity. (Survey respondent)

Meanwhile, the idea of a two-tiered membership was put to those participating in the focus groups and interviews, and was well received by discussants and interviewees. Respondents were also asked via the online survey to rate the statement, 'Other regional partnerships have adopted a two-tiered membership that differentiates between full implementing partners and associate partners. I'd like to see something like this introduced for our regional partnership and action plan'. Respondents produced a rather more mixed reception to the idea:

- Nearly half of all respondents (48 per cent) strongly agreed/agreed
- 39 per cent selected 'neither disagree or agree', while 13 per cent strongly disagreed/disagreed

Should PVT's partners go forward with a two-tiered membership for the partnership, its rationale and benefits would need to be clearly communicated to all partners.

I'm not convinced in regard to a two-tiered membership … The notion of shared commitment to a common purpose is crucial to partnership effectiveness and I'm not sure two tiers of membership gives a good message. (Survey respondent)

Structures and processes that govern the partnership and support its work

The work of PVT and United has progressed via three interlinked partnership structures that have shown flexibility and responsiveness to the governance and implementation needs of the partnership and action plan since 2010. The EGG acts as the partnership's principal governance structure, and the IC and (more recently) the smaller working groups formed from the IC – comprising members with an interest in agreed joint initiatives or work related to specific settings – act as the partnership's implementation structures.[2]

The evaluation's investigations of the EGG, IC and working groups, and the ways in which PVT has provided an enabling environment for integrated planning and the implementation of identified primary prevention actions, yielded a number of findings related to the endorsement of actions and how this occurs, with implications for the structures and processes that govern the partnership and support its work into the future.

The findings in snapshot

- While the EGG's membership has expanded in recent years to include executive or senior management representatives from all partner organisations, there exists an uneven level of engagement with this structure, which means the work of IC members is not always supported (i.e. authorised) within their organisations – the very reason for a broadened EGG in the first place.

- PVT as a document has been useful as a higher-order strategy for partners to advocate for primary prevention actions within their organisations and/or for shared regional endeavours. However, there is a need to introduce an annual action planning process that can support partners to identify concrete actions and have these endorsed by organisational decision makers at the same time, so that an authorising environment for implementation is generated and agreed upon from the outset, rather than being continuously sought.

- All three partnership structures should stay and will need to continue to meet the governance and implementation needs of the western region partnership and action plan – which can be considered to have reached a phase of maturity and is no longer fledgling or developing – by adapting specific areas of their functioning or operations. This is particularly so of the EGG, which is required to evolve into a much more dynamic structure with an annual strategic work plan that includes some urgent external advocacy activity.

Flexible and responsive partnership structures

The evaluation learned a great deal about the EGG, IC and working groups as interlinked partnership structures through conversations with participants in focus groups and interviews, and in its review of relevant PVT and United documents.

The IC has existed since the early days of PVT, and initially consisted of a mix of senior- and officer-level staff of partner organisations. Funding for United brought the EGG into existence, which engaged the chief executive officers of the region's two primary care partnerships (representing their member agencies) and Women's Health West (as the lead partner). While the EGG structure in this initial incarnation did provide the partnership with broad strategic oversight of United, new needs were soon to emerge. Given that much of United's focus was on partner agencies undertaking evidence-based strategies for gender equity and primary prevention within their own organisations as priority settings, many partners felt more could be done at the EGG level to build an authorising environment for such

2 An Expert Advisory Group (EAG) was also established as a structure for the work of the partnership and action plan in the early days of PVT. The EAG consisted of representatives from organisations with expertise on violence against women and its prevention, such as VicHealth, Deakin University, the Municipal Association of Victoria, Women with Disabilities Victoria, Melbourne Business School's Centre for Ethical Leadership, and the Victorian Immigrant and Refugee Women's Coalition. Members of the EAG were available to the PVT partnership on an as-needs basis for support on substantive content matters relating to prevention practice. It is understood that contact has been infrequent.

work.

> *The idea of the expanded EGG was about bringing in people we needed to have at the table to help us really tackle primary prevention in the west. There was a recognition that there were people missing, and if we were going to be as effective as possible we needed to have a larger group, a more representative group of people needed to take action … There was a targeting of people who were quite senior in their organisations and who could create influence and internal action [for United]. We needed to generate that authorising environment within the organisations … And while primary care partnerships do represent their members, they don't have the authority to make their members do anything. So, we needed to have the people within the organisations who are the movers and the shakers and influencers ... (Focus group discussant)*

In 2014, following a partnership survey, membership of the EGG was consequently expanded to include executive and/or senior manager representation from all eighteen partner organisations. The EGG's revised terms of reference clearly show the strategic advocacy and leadership role of its members to authorise United activities in their own organisations as well as across the partnership more broadly, as a reinforcing structure for the IC.

The expansion of the EGG was later identified as one of the biggest factors contributing to the successes of United, as documented in the project's final report to the Department of Justice and Regulation (Women's Health West 2015b) and captured in the words of participants of this current evaluation:

> *The EGG was really small at first. This was the biggest challenge for the first part of United, the biggest lesson learned, and the biggest enabler for the second part. (Interviewee)*

> *An end-of-project survey asked IC members for the three biggest enablers to their work. So many said the expansion of the EGG, and getting their managers onto that committee. (Focus group discussant)*

The EGG's expansion midway through United saw a parallel development in the IC, which evolved into a structure specifically for officer- or worker-level staff: those tasked with the 'doing' of organisational and/or shared regional primary prevention actions, and who came to the partnership with the requisite skills and content knowledge (whether actual or aspiring) to undertake the work. As with the EGG, this adapted IC drew its members from all organisations across the partnership, and continues to be well represented in this regard.

The smaller working groups emerged organically from the IC, to progress the work of organisational partners in implementing primary prevention actions. Working groups have formed for shared regional initiatives as well as for specific organisational activities common to a few (but not all) partners, and are time-specific to the initiatives for which they have been convened. When asked about the success of PVT and United, evaluation participants often noted the significant outputs of working groups such as:

- Gender Equity for Community Health Services Working Group, established to develop resources for building the organisational capacity of community health services to embed gender equity into planning and practices

- Leading Gender Equity Executive Leaders' Forum Working Group, established to plan and coordinate a forum for executive leaders of PVT's partners on their role in advancing gender equity for preventing violence against women

The expansion of the EGG, evolution of the IC, and emergence of the smaller working groups demonstrate the flexibility of the partnership's structures and their responsiveness to PVT or United's

governance and implementation needs that have arisen over time. All three structures are definitely assets for the partnership going forward; however, there is room to improve their operations and functioning – and for the EGG, to refine its governance purpose.

Getting the most out of the EGG

Questions put to evaluation participants about the functioning and operations of the EGG revealed strengths and weaknesses in this governance structure. Concerning strengths, as previously discussed, it is well documented that the expanded EGG made a positive difference to IC members over the second half of United insofar as it enhanced the authorising environment for prevention work to progress. However, for some partner organisations, senior manager or executive representation at the EGG has been rather more elusive, reflecting a weakness of the partnership's principal governance structure to engage organisational partners evenly and at times consistently.

> *I would say for three-quarters of the partners there's very high representation from senior managers, but there are certain partners who continually are the ones who often don't have an EGG representative there. (Focus group discussant)*

> *One of the challenges for us as an organisation will always be getting consistency in representation at these meetings. Our roles are so dynamic, there might not be the same person in any given role in two years' time, so getting continuity in one person attending these meetings is difficult. (Focus group discussant)*

With the United project complete, it is observed that consistent and/or even representation at the EGG has further diminished. There were significant challenges, for instance, in engaging the EGG members with the activities of this retrospective evaluation and review, with less than half of PVT's partners represented at the EGG scheduled meeting at which the EGG focus group took place. Among those absent in this part of the evaluation process were five local government and two community health service partners (see 'Limitations to the study').

For IC members who do not have regularly attending EGG counterparts, or no executive or senior manager representation at the EGG, the work of primary prevention can be hard going. During the evaluation, some IC members reflected on the challenges of getting organisational leadership to attend the EGG, and the frustrations of constantly having to advocate for primary prevention work in their organisations because internal endorsement is poor or non-existent. Meanwhile, for IC members with senior managers or executives who regularly attend the EGG, there can be other unique problems, with regular briefings difficult to arrange because of busy schedules.

> *How many of this group's senior manager or executive representatives attend the EGG? I know ours don't attend very often. So I'm not getting a whole lot of information coming from that level … Sometimes there's a bit of a disconnect between the members from there and here. (Focus group discussant)*

> *I've found it really hard to get our leadership represented. We've been trying, it's been 18 months and we haven't really succeeded. I mean the work has progressed … but it's frustrating, we're constantly having to advocate for the work internally. I'm not sure what the answer is. (Focus group discussant)*

> *While membership and participation within the IC have remained consistent, from my organisation's point of view, participation in the EGG has been inconsistent, which has had some impact on achieving buy-in across the organisation. (Respondent to questions by email)*

> *It would be good to find out what's happening, but sometimes there's not enough time to meet with them [EGG member]. (Focus group discussant)*

Reasons offered by IC and EGG members for the inconsistent or non-existent leadership representation at PVT's governance level varied, and included:

- Senior managers or executives being too busy to attend, with primary prevention being just one of several competing priorities in their portfolios

- Nominated EGG representatives feeling they are not sufficiently across primary prevention from a content perspective to contribute meaningfully to the meetings

- Senior managers or executives not being properly briefed about the EGG and the role of organisational partners represented on it (e.g. local governments are very 'layered' organisations and detailed briefings are often needed for any degree of leadership involvement)

- Organisational leadership feeling there is already sufficient endorsement of primary prevention actions having signed onto PVT in the first place, so having an EGG representative is duplication

These findings pose interesting questions in terms of engaging organisational leadership with the EGG and their reasons for being there, post-United. Senior managers or executives are always going to be busy with multiple priorities to juggle, and people in their roles are always going to change, which means EGG representation is never going to be entirely even among partners or consistent among people attending other than over shorter periods of time.

Is there a way of creating an authorising environment to progress the primary prevention work of IC members without having to rely solely on the EGG and its members attending meetings? Is there a way of thereby making the EGG's governance focus 'bigger picture', more strategic and perhaps more appealing to those who might otherwise not be attending? Is there a way, in short, to get the most out of the EGG so it is reflective of the partnership and responsive to its governance needs for the future – a partnership that is far more mature now than it was five years ago or even midway through United? The considerations moving forward (below) provide some answers.

Getting the most out of the IC and working groups

Questions put to evaluation participants about the IC and working groups revealed strengths and weakness in these structures too. On strengths, the IC has clearly been able to maintain itself as an effective implementation structure for the partnership and action plan, with solid engagement of officer- and worker-level staff among partners. The evaluation's focus group for the IC, for instance, was well attended by representatives of most organisational partners across the region's local government, community health and primary care partnership sectors. Those unable to attend submitted responses to the abridged version of the questions, and the end result was 100 per cent of the region's local governments, community health services and primary care partnerships represented in the evaluation at the IC level.

Another strength of the IC has been its ability to maintain itself as a community of practice that is highly valued among its members. Communities of practice are defined in the literature as:

> *…groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis. […] These people don't necessarily work together on a day-to-day basis, but they get together because they find value in their interactions, as they spend time together, they typically share information, insight, and advice. They solve problems. They think about common issues. They explore ideas and act as sounding boards to each other (Wenger, McDermott & Snyder 2002).*

In Victoria, communities of practice have been identified as an important factor in developing the

workforce capabilities of the primary prevention sector, as they enable the exchange of tacit or situational knowledge – or knowledge derived from experience and which very rapidly accumulates among those who are immersed in practice – without having to wait for the latest in evidence-based practice on the release of project or evaluation reports or other publications (VicHealth 2014).

The evaluation found that the IC is a place for members to get together on a regular basis, to hear about primary prevention developments in policy or research, share information and resources, learn from one another, provide support to one another (especially important to IC members who are the sole primary prevention practitioners in their organisations), and grow professionally as the region's primary prevention workforce. This implementation structure was described as 'bigger than the sum of its parts', in that it adds more to the partnership than what each individual member brings in representing their organisations at the meetings.

> *It's been a great learning opportunity, hearing from others and where they are at … You have the privilege of hearing others' experiences and taking those on, including them in your work, instead of repeating issues or errors. (Focus group discussant)*

> *When I came to this role, my individual training and knowledge in relation to primary prevention was weak. Also, I felt somewhat 'subdued', especially early on, as I was the only man in the room. But PVT became a positive learning environment for me that built my knowledge, capacity and confidence in ways that undoubtedly led to better and more rigorous outcomes for my council. In addition, the very nature of violence against women makes it a confronting and erosive issue. I found that being within the PVT partnership created a helpful and supportive environment that made dealing with this confronting issue seem just a little easier. (Respondent to questions by email)*

> *The size of the group has been good. The size has helped from my perspective, being relatively new as well. Because if it was any bigger, it could have potentially been just purely information sharing, you know. We've been able to include reflective practice and things like that in these meetings, which have been really helpful. (Focus group discussant)*

> *When Change the Story came out, the IC was a forum talk about it. So there's a need for this kind of learning. A meeting that's called for that kind of thing. We got to explore the new framework in that meeting. (Interviewee)*

> *I see PVT … as a source of knowledge where we come together, we learn about new things and we have a common and shared understanding about certain things; for example, last year when we had the [regional] forum. We all learned about … structural change within our organisations. Or the initiatives for the 16 Days of Activism against Gender-based Violence, which were shared by all of us and benefited our own organisations. Secondly, I see PVT as a place for networking and partnership, where we can come together and do a project together. My organisation benefits from PVT through this networking and partnership. (Focus group discussant)*

The evaluation found the working groups to be highly successful implementation structures for the region's partnership and action plan. The working groups have given great flexibility to IC members in implementing primary prevention actions, by offering a structure to those focusing on similar activities or settings, or those with more time to commit to shared endeavours, to innovate and/or progress their efforts. Learning and capacity building are intensified through the smaller working groups, too, as opposed to the larger IC with members working on a more diverse range of activities and with different learning needs around these.

> *The working groups for specific areas have been a better model potentially than a larger IC. There's more 'like with like'. With different goals, different wants and different capacities in the one meeting, sometimes it felt like even if we were trying to reach*

agreements ... we were trying to get all the scheduling things in that space, versus when people work on one concept or area … (Interviewee)

We've got some community health services doing really sophisticated work on gender and transgender and developing a whole-of-organisational change strategy, sitting next to others in the working group who can't even get a White Ribbon action day together … They can ask, 'How did you get that up?' Without that structure those conversations might not happen. (Interviewee)

The Community Health Services Working Group is still going. They've all said, 'This has been the best capacity building I've had; this is the place where my confidence has grown'. (Interviewee)

It feels like our partnership is saying it's ready to go, it's ready to work on particular things and that's where we've gotten the biggest bang for buck over the last few years, when they've come together on certain things, and when they've contributed financially to it too. That creates internal buy in and got things happening. (Interviewee)

The flexibility to have working groups … that's been a big one, just the flexibility to accommodate that. (Focus group discussant)

The online survey explored the views of evaluation participants regarding the IC as a space for sharing, learning and reflecting, and the working groups as places where prevention action, especially initiatives or activities that are jointly undertaken by partners or common to them, are best progressed. Respondents were first asked to rate the statement, 'The implementation of joint partner initiatives of a regional action plan is best progressed through specifically convened smaller working groups rather than a whole-of-group IC'. Results show that:

- The majority of respondents (62 per cent) strongly agreed/agreed with the statement
- 24 per cent neither disagreed/agreed, while 5 per cent disagreed

Respondents were then asked to rate the statement, 'The IC is important for the partnership's work, but it is better suited as a community of practice with a focus on information sharing, learning and reflection, rather than a place to go through the "nuts and bolts" of implementation'. Results show that:

- Just over half the respondents (52 per cent) strongly agreed/agreed with the statement
- 14 per cent neither disagreed/agreed, while around one-quarter (24 per cent) disagreed

While the IC has increasingly incorporated the features of a community of practice over time, these results suggest a desire to maintain some scope for members to work on implementing primary prevention actions in this whole-of-group forum.

One area for improvement identified by the evaluation related to the safety of members in the IC as a learning forum. During the IC focus group, some members talked about how primary prevention is a learning curve for everyone, and that there are always going to be new things to reflect on and discuss. Safety to do this is paramount to quality reflection, new learning and ultimately collaboration; but safety is where the group has at times let itself down.

When new members join PVT who may work in health promotion, be given three priority areas, have been employed for their strengths and expertise in areas that aren't primary prevention, I'm not sure that this is the safest space for new members. It's so easy to say the wrong thing when you're talking about gender and prevention. I really do feel for new members when it's hard for them to contribute and when they say the wrong thing. (Focus group discussant)

The changes that have been put in place on reflective practice are crucial and important.

I think, being honest, there are examples where we let ourselves down sometimes in terms of a safe space. Whether you're a new member or very aware of your levels of expertise or familiarity in the content, there's continually emerging things in this area. It's not saying we're all across it either … I just think … we've really learned this lesson. The participation of all members, the valuing of having their voices, their safety will only strengthen the work we do collectively. That's what I believe. (Focus group discussant)

In moving into the next iteration of the region's partnership and action plan, PVT's partners would do well to ensure the IC and working groups as structures for advancing the region's primary prevention actions continue to be strengthened, and that any weaknesses are redressed.

Considerations moving forward

Five further considerations for the next iteration of the western region partnership and action plan are now suggested to PVT's partners based on the findings presented above.

Consideration 3: An annual action planning process

It is proposed that PVT's partners consider introducing an annual action planning process that can support partners to identify concrete primary prevention actions and have these endorsed by necessary organisational decision makers at the same time. This process could be a full-day planning forum that brings together relevant executive and/or senior management people and all officer- or worker-level primary prevention staff, so that an authorising environment for each and every partner's chosen actions over any given twelve-month period is generated and agreed upon from the outset. This is because:

- The output resulting from the all-day planning forum would be an operational primary prevention plan rather than a higher-order strategy document (the current form of PVT's action plan), and the participation of decision makers in this full day would reflect the necessary level of authorisation required of each organisational partner for the resourcing and implementation of their respective actions contained in the operational primary prevention plan

- By achieving formal 'sign off' in this way, endorsement of primary prevention activities for any given twelve-month period would not need to be further sought by IC members, either through their own internal advocacy and/or by reliance upon their EGG counterparts to reinforce the work for them organisationally

This concept of an annual action planning process was put to evaluation participants, and was favourably received by focus group discussants and interviewees alike. It generated lively discussion among IC focus group members in particular:

Currently, we go to the EGG to authorise regional collaborations and the like, but if we already had these through a planning process, agreed and signed off, we could progress the work. We don't have this at the moment ... (Focus group discussant)

If we had an alternative arrangement, the annual action planning would be really good. We could do our organisational endorsement process annually, do it once, so that there's an agreement, a commitment from the organisation. (Focus group discussant)

Engaging leaders is a strategy for PVT no matter what. We always have to do this. I'm not sure that attending EGG meetings works for us. But that sort of joint planning day might work because they see they are able to do something that day and it's useful and they sign it off. (Focus group discussant)

There's no reason why you couldn't, for a lot of things over the course of a year, as part of an annual planning process, have leaders sign off on them, have them say they have a

commitment to these … They'd be signing off on these at the beginning, and so then we'd have the freedom to activate or implement. (Focus group discussant)

An annual action plan that gets endorsed would include all the themes, settings, whatever has been agreed on. You've then got structure and time, you can budget. The one thing we've struggled with is in relation to timing of our shared actions. Some might want to roll out something, others might not be ready. If we all agree to particular initiatives for the coming year, allocate budgets through our processes or whatever, then we've planned ahead. It's not haphazard. It would strengthen the collaborative work we do. (Focus group discussant)

The concept of an annual action planning process was also put to evaluation participants through the online survey, where respondents were asked to rate the statement, 'An annual action plan is great in theory, but I'm concerned about adding a layer of planning for my organisation'. Results show that:

- Over half of all respondents (59 per cent) strongly disagreed/disagreed
- 5 per cent neither disagreed/agreed
- Almost one third (32 per cent) strongly agreed/agreed

These results indicate that should PVT's partners introduce an annual action planning process, there will need to be strong communication about the benefits to organisational partners.

I don't see this as another layer of planning but rather actions that I would incorporate into my own annual planning and feed up to the regional plan. (Survey respondent)

Annual action planning will have significant time and resource implications, and may see organisations caught in the cycle of 'too much time planning, too little time to implement'. (Survey respondent)

Consideration 4: A higher-order strategy

It is proposed that PVT's partners consider retaining something like the existing PVT action plan document as a higher-order strategy, but revised so it is consistent with *Change the Story*, the new evidence-informed framework for a shared national approach to primary prevention. The rationale for holding onto a higher-order strategy is two-fold.

First, as a regional interpretation of *Change the Story*, this higher-order strategy would include all the suggested themes, settings and techniques for primary prevention expressed in ways that are meaningful to the region's organisational partners, much like the existing PVT action plan document does. The higher-order strategy would then serve as a powerful framing device for the proposed annual action planning process. Indeed, the evaluation found that PVT's partners are quite familiar with using the existing action plan document in precisely this way: as an advocacy tool to show what's possible to those they need or want to engage in primary prevention, or to demonstrate to others how work on a specific type of action or initiative – whether it's organisational change or a shared social marketing campaign – can make a positive collective difference. This occurred throughout the United project from 2012–2015. It is therefore likely that the use of a higher-order strategy to frame discussions about regional prevention opportunities at an all-day planning forum would be favourably received by partners.

PVT means organisational partners can identify actions or types of actions they can each work on, and learn from. It's a source of knowledge about how to do prevention practice, e.g. 16 Days of Activism against Gender-based Violence, organisational change. (Focus group discussant)

PVT raises the profile of prevention across the region. It has a strong presence in the region. It shows how actions can be integrated across the region, and that there are

commonalities in the work of each organisational partner even if there aren't actual collaborations. (Interviewee)

PVT creates a ripple effect across the region. I've used the document to say, 'Others are doing this work, so we should too'. Or, 'Others are ahead of us'. It's powerful for making actions happen. (Focus group discussant)

PVT shows people the value of doing things together, not always regionally, sometimes sub-regionally or in specific sectors. There's a reformulation of different ways. (Interviewee)

IC members say to others in their organisation, 'We've signed up for this, we're part of something bigger'. And they show them the document. I've seen PVT referenced in this way, as a document that has raised the profile of prevention within an organisation and as a way of getting an organisation's actions happening. (Interviewee)

The concept of an annual action planning process framed by a higher-order strategy was also explicitly tested among evaluation participants via the online survey, where respondents were asked to rate the statement, 'Other prevention partnerships have introduced an annual action planning process that sits under a higher-order strategy. I'd like to see something like this for our partnership, so we can identify tangible actions for the coming year'. Results show that:

- The majority (86 per cent) strongly agreed/agreed with the statement
- 9 per cent neither disagreed nor agreed with statement
- Importantly, no respondents disagreed with the statement

A higher-order strategy with supporting action plans (annual) would help us to collaborate more on regional initiatives and strengthen our ability to measure our collective impact. (Survey respondent)

The option to set action plans under an overarching strategy makes sense and also frees up partners to develop actions and an individual level to contribute towards region-wide changes in key areas where action is needed. Integrated effort is essential. (Survey respondent)

Second, a higher-order strategy will be the place where the partnership can express its long-term vision (or a refreshed version of it) of communities, cultures and organisations in the west that are non-violent, non-discriminatory and gender equitable, and that promote respectful relationships between women and men. It will be prudent for PVT's partners to set a ten-year horizon for a higher-order strategy and vision to align them with the timeframe of the Statewide Family Violence Action Plan and its dedicated and resourced primary prevention component, soon to be developed by the Victorian Government as a recommendation of the Royal Commission into Family Violence, as mentioned previously in this report.

Consideration 5: Priority settings and techniques

It is proposed that PVT's partners consider using the annual action planning process to identify one or two priority themes, settings and/or techniques that they, collectively, will focus upon for any given twelve-month period. This identification would not deny partners from implementing actions regarding 'non-priority' themes, settings or techniques; it would merely signal to partners that they, as a partnership, intend to apply their efforts and build evidence in a more saturated (rather than dispersed) way for any given twelve-month period.

The evaluation found that a form of saturation has, in fact, has been occurring in the region. Up to the current time, and especially through United, the western region partnership and action plan can be said to have saturated the partner organisations themselves, as a priority setting, with different types of organisational capacity building actions as the main (although not exclusive) technique. Victorian

evidence-based practice demanded this focus, as captured by the practice of 'getting our own house in order' (Wilkinson 2011; VicHealth 2016).

While United's evaluation found that transformative organisational change for gender equity needs long-term commitment and resourcing, and that the organisational change journeys of PVT's partners are far from complete, this current retrospective process evaluation and review discovered considerable momentum and readiness among partners to move 'outward' and into settings such as workplaces other than local governments, community health services or primary care partnerships, schools and (especially) the community.

> *I don't think we could have justifiably tried to make significant changes side by side with community unless we were getting our own houses in order. One of the greatest strengths of this period of time is either you're getting your own house in order or you're deliberately not doing so, it's that damning if you're not. You get exposed for not. People ask questions. (Focus group discussant)*

> *PVT has been great for giving us a sense about what each other's organisational partners are doing, using that to get our own organisations to move on a bit. But relatively speaking it would be great to figure out how to make an imprint on other settings besides our own. The things we've done have worked really well, but it's how to extend the sphere of influence. (Focus group discussant)*

> *One thing to think about more in the next iteration of PVT is the community. How to engage the community more in this conversation? We really haven't tackled this. We have local governments and partners who are close to the community and we have this untapped resource. (Focus group discussant)*

Consideration 6: An annual strategic work plan for the EGG

It is proposed that PVT's partners consider using the annual action planning process to identify key pieces of strategic work required of the EGG to oversee the partnership and its prevention actions over any given twelve-month period. Findings from the evaluation suggest there is an urgency for the EGG to re-focus its attention on advocacy activities beyond the region rather than within it (as has occurred to date), as the most important context for the western region's partnership going forward is unquestionably the Victorian Government's implementation of the recommendations arising from the Royal Commission into Family Violence, especially the primary prevention strategy of the Statewide Family Violence Action Plan (Recommendation 187).[3] Findings from the evaluation found at least two strategic opportunities exist.

The first strategic opportunity is to champion the expertise, leadership, maturity and evidence base of the west in primary prevention, and thereby secure a sustainable (funded) future for the partnership as the prevention infrastructure in Melbourne's west. Such outward-bound advocacy is not new to PVT's partners, and has been done in the past. During their interviews, regional and external informants highlighted the significance of PVT's development at the same time that the last statewide policy (A Right to Respect) was being formulated, around 2009. Back then, the working group of the western region partners – who were the furthest along of most (if not all) Victorian partners in prioritising primary prevention – worked closely with the (former) Office of Women's Policy, to gain consistency at the regional and state levels in the application of VicHealth's framework to strategy and policy. According to one informant who had been involved in the development of A Right to Respect:

> *Those conversations helped me at the time to really better understand the role of the regions: that idea that there was a need to have an infrastructure more 'towards' the local level that could coordinate and pull together evidence-based actions from the bottom up. (Interviewee)*

3 A second important context is the statewide Gender Equality Strategy, which will be finalised ahead of the primary prevention strategy. The Royal Commission into Family Violence report recommends that the primary prevention strategy guide and be guided by the Gender Equality Strategy.

Similar prospects exist at the current time to influence the forthcoming statewide primary prevention strategy as a coordinated plan for Victoria; and it would be remiss of the region's partners if they did not, via their EGG, present themselves to the new Office of Prevention and Women's Equality to articulate the readiness, capacity and evidence of the partnership as a regional primary prevention system, still the furthest along of most (if not all) regional partners but this time in its achievements and maturity as an infrastructure. Put simply, it is time to act now to squarely situate the region's primary prevention system as a critical part of state-level planning and policy to 'change the story' of violence against women in Victoria.

> *Valuing and articulating what the regional partnership is, what it looks like in prevention, and how we know that partners are ready … I think there's an opportunity here for the western region partners to articulate how they are 'in front' of that, how they are more ready than anywhere else and can spell out things like what the capacities of a prevention partnership are and how the west is high on these capacities. That would be a good piece to work to do. Not only demonstrating the existence of the partnership, but how the partnership has enough experience to articulate to government what might be standardised. The west is not the only region with a prevention partnership, of course, but I understand that there are specific achievements and reach that it has that aren't replicated elsewhere. So the opportunity to demonstrate what regional readiness looks like, for themselves and statewide prevention. (Interviewee)*

> *We don't know what the opportunities are post the Royal Commission into Family Violence. But we want to be in the zone. (Focus group discussant)*

The second strategic opportunity lies in the role the region's partners and its EGG can play in the current policy climate, to advocate more broadly for primary prevention as distinct to and separate from the response system. This distinction appears to be under threat through the governance mechanisms established for the family violence reforms that are underway.

The argument for conceptualising and establishing the prevention and response systems as differentiated yet alongside one another was initially put by PVT's partners in their written submission to the Royal Commission into Family Violence. Indeed, this submission was noted by several evaluation participants as one of the most significant achievements of PVT and United, insofar as it demonstrated to influencers beyond the region that a viable, visible and distinct primary prevention system is not only possible but a reality. The argument for the separateness of primary prevention as a system was, of course, echoed in submissions and evidence provided by many others as the work of the Royal Commission progressed in 2015. The Royal Commission findings recognised family violence prevention as a distinct and specialist area of practice, requiring different expertise and skills than the specialist work required in family violence response.

While the Royal Commission has acknowledged the importance of 'sustainable and certain' governance for both prevention and response, its 'proposed governance architecture' – and the statewide and regional structures that have since been established – utterly collapse the separateness of the two systems.[4] As things stand, Victorian primary prevention is not reflected as a discrete area of practice or infrastructure in governance arrangements for the family violence reforms underway, with regional efforts being tied to Family Violence Regional Integration Committee structures (i.e. response) through an 'information flow and cross membership' relationship only. As things stand, regional primary prevention (and statewide primary prevention for that matter) therefore remains without any appropriate mechanism for strategic oversight and accountability as distinct to and separate from response.

A bold piece of advocacy work thus presents itself to the region's partners and its EGG to push more broadly for adequate governance arrangements for Victorian primary prevention – both statewide and regional – as a system differentiated from and alongside response.

4 The proposed governance architecture can be found in Volume VI, pp. 128–129 of the report and recommendations of the Royal Commission into Family Violence (State of Victoria 2016). The related diagram, Figure 38.2, is included in Appendix 4 of this evaluation report.

We've got interesting days ahead it terms of regional prevention infrastructure and governance … Who owns and drives prevention at the regional level is an open question [and] there's absolutely a role for the western partnership to say, 'This is what quality prevention can look like. What would it take to get this in every region across the state?' (Interviewee)

In identifying pieces of strategic work such as the external advocacy suggested above, and in shaping an annual strategic work plan for the EGG, the region's partners could then nominate their executive or senior manager representatives who can best contribute to the work plan; and the EGG, once formed, could then nominate the most appropriate member from this group as chair. These nominations would occur on an annual basis (i.e. they would be very time limited) so that the EGG is evolved into a dynamic structure with targeted strategic partnership actions and the best people available and on board to execute them.

Results from the online survey give insight into which of the region's partners is considered the most appropriate to chair the partnership and its EGG. The survey asked respondents to rate the statement, 'Women's Health West is well connected to other women's health services/ regional strategies and the state's prevention infrastructure. With a statewide prevention strategy likely in the next twelve months, it makes sense that Women's Health West is chair of our partnership and its EGG'. Results show that:

- The majority of respondents (71 per cent) strongly agreed/agreed with the statement
- 19 per cent neither disagreed/agreed, while 5 per cent disagreed.

Based on these results, PVT's partners are asked to consider Women's Health West as the nominated chair for the partnership and its EGG.

I'm keen to make sure we have the strongest possible structure, processes and plan, and I think having an organisation where gender equity and prevention of violence against women is core to their work chairing and leading this work, means that we will position our partnership to achieve the best outcomes possible for women and communities. This will be all the more important when family violence prevention comes 'off the boil' and competition for funds dies down. (Survey respondent)

Consideration 7: Refreshed terms of reference

It is proposed that PVT's partners consider formally recognising the role of the IC's smaller working groups in progressing regional primary prevention activity, and the important function of the IC as a community of practice and safe space for sharing, reflection and learning, by revising the terms of reference for the IC. It is proposed that PVT's partners also consider revising the EGG's terms of reference to reflect the group's evolution into a more dynamic structure with an annual strategic work plan, in keeping with Consideration 6.

Collecting shared impacts and sharing collective impacts

As discussed in the preceding section, the existing PVT action plan document is a higher-order strategy that has functioned as a framing device for partners, especially through United, to identify and implement primary prevention actions, whether within their own organisations or as shared endeavours across the region. As originally conceptualised, PVT's seven action areas are broad enough to ensure a range of mutually reinforcing primary prevention activities occur in a comprehensive yet flexible fashion, depending on the organisational mandates, priorities, readiness and capacities of partner agencies.

This evaluation's explorations of PVT as a mechanism for coordinated, integrated planning and implementation of primary prevention actions – from the governance and implementation structures it has put in place to the format of the action plan document itself – have shown PVT to be highly effective in accommodating partner readiness and bringing them along from 'where they are at'. The multiple

achievements of both PVT and United both speak to this. The evaluation's investigations into how PVT and United have thus far been evaluated, however, reveal a downside to having a higher-order action plan without a companion operational plan.

The findings in snapshot

- While PVT as a document has been useful as a higher-order strategy for partners to advocate for primary prevention actions, there is a weakness in relying upon it as a 'stand-alone' document for implementing regional actions. It makes it difficult for partners to plan for evaluation and agree to markers of success (indicators) in an integrated and coordinated way.

- Evaluation of the region's prevention efforts could be greatly strengthened through the introduction of an annual action planning process (see preceding section), which would have evaluation planning tethered to actions identified and endorsed by each organisational partner for any given twelve-month period. As with the primary prevention actions, organisational partners would endorse activities identified through evaluation planning at the start of each twelve-month cycle, with a commitment from partners to undertake agreed evaluation activities and pool their data as part of their accountability to the partnership.

Challenges of evaluating regional prevention actions

Specific questions were put to evaluation participants about evaluating prevention actions in the context of regional partnerships. Their answers revealed three main challenges that partners have grappled with along the way.

The first evaluation challenge is not unique to the regional partnership, and it encompasses the long-term social transformation agenda that is primary prevention. Any desired changes on the root causes or structural drivers of violence against women are likely to take years of coordinated and integrated effort, which means that partners can only realistically focus on the achievements of their work that are immediate or perhaps medium term (Kwok 2013). While this is a perfectly sound use of evaluation, there can be pressure put on partners to demonstrate more.

> *Progress in this area can be ponderous and difficult to specifically identify. Often we can only evaluate what we've just done because any resulting benefit may not appear for some time. I believe that the challenge is to retain momentum, intent and focus in the face of the few signs of success. (Respondent to questions by email)*

The second challenge has arisen through the way the PVT has been designed and used as a mechanism for coordinated and integrated planning and implementation of primary prevention actions. PVT allows organisational partners to come into the region's prevention work in a flexible way, based on their readiness and level of engagement. This has seen a flourishing of discrete projects or initiatives undertaken by partners, either individually or collaboratively, especially during United. Process and impact evaluation has correspondingly been conducted via discrete activities led by Women's Health West; for example, assessing the reach of a regional forum for executive leaders, or the impacts of attending the forum on leadership commitment to progress gender equity (Women's Health West 2015b). What has not been achieved is an integrated and coordinated approach to evaluating the partnership's actions as a whole, so that the processes and impacts of discrete projects or initiatives over a defined period of time can be aggregated to tell a story of how the region is 'changing the story' of violence against women by achieving certain indicators of success.

United was required to undertake an external evaluation as part of its funding requirements from the Department of Justice and Regulation. United contracted the Australian Research Centre for Sex, Health Society (ARCSHS) at La Trobe University to design and administer a Gender Equity Staff Attitudes survey in PVT's partner organisations (local government, community health and primary care partnerships). The survey was conducted twice, in 2013 and 2015, to determine any changes in the organisational cultures of PVT's partners over the three years of United. As an activity, this major

undertaking – which recruited over 2,000 participants in total – produced findings that illustrated the region's progress towards part of PVT's vision: of organisations in the west that are non-violent, non-discriminatory and gender equitable, and that promote respectful relationships. What the study could not do (at least not well) is attribute the changes observed from 2013 to 2015 to the specific initiatives or projects implemented through United, or identify how those changes occurred.

These two ways in which PVT and United have undertaken evaluation activities reveal a third challenge experienced by the partnership, and that is in untangling the distinction between:

- Population-level monitoring of the overall progress of the region – or in the case of the ARCSHS survey the progress of a specific setting in the region – in relation to the partnership's longer-term vision, where overall progress is the result of multiple contributing factors and explanations

- Capturing changes that are directly attributable to partners' efforts in relation to the 'targets' of specific prevention actions (such as participants of the executive leaders' forum or those who participate in a 16 Days of Activism against Gender-based Violence campaign) – and understanding why the changes occurred, what could have improved things (in short, process and impact evaluation), and how the successes of discrete projects and initiatives could be rolled into a collective regional impact

Considerations moving forward

Two final considerations for the next iteration of the western region partnership and action plan are suggested to PVT's partners based on the challenges of evaluating prevention actions.

Consideration 8: Evaluation planning as part of action planning

It is proposed that PVT's partners consider including evaluation planning as part of the annual action planning process (Consideration 3), so that process and impact evaluation can be tied to the prevention actions identified and endorsed by organisational partners for any given twelve-month period. At the same time, the conduct of the partnership's evaluation activities can be planned for, coordinated and properly resourced (e.g. should any common data collection instruments need to be developed, or should partners require evaluation capacity building support).

- An output of the evaluation planning would be an evaluation plan, which would include the partnership's agreed markers of success (indicators) and be finalised within four months of its companion operational primary prevention plan. The lead on this work would be Women's Health West and a specially convened working group whose members bring capacity in evaluation planning and processes.[5]

- As with the primary prevention actions, evaluation activities for any coming year would be endorsed in principle by organisational partners attending the all-day planning forum. During this day, partners would also commit to undertaking their agreed evaluation activities and pooling their data as part of their accountability to the regional partnership.

- The task of integrating the pooled evaluation data into an account of how the region is 'changing the story' of violence against women would then fall to Women's Health West as the lead partner who would work alongside the evaluation working group. The information would be brought back to the partnership at the end of the twelve-month planning cycle, as a way of sharing the collective impact and maintaining momentum for the work, and to set the tone for

5 The Inner North West Primary Care Partnership has produced the *INCEPT Evaluation Guide*, which could be helpful for the partnership's evaluation planning, and is available at <http://inwpcp.org.au/current-activities/prevention/incept-evaluation-guide-mar-2016/>. *Together for Equality and Respect*, in Melbourne's eastern region, has developed a regional evaluation framework for their four-year primary prevention strategy; while the framework relates to a higher-order strategy, it is designed to sit alongside the action plan for implementing the strategy. This framework could also be helpful to the western region partnership as it embarks upon evaluation planning for its first twelve-month operational primary prevention plan.

the next all-day planning forum.

The concept of including evaluation planning as part of an annual action planning process was put to evaluation participants through the online survey. The online survey asked respondents to rate the statement, 'An annual action planning process could help us to evaluate better. It could help us select measurable and achievable indicators, bring together our achievements, and contribute to a collective regional picture or evidence base'. Results show that:

- A resounding majority (91 per cent) strongly agreed/agreed with the statement
- 5 per cent neither disagreed or agreed; and 5 per cent were not able to rate the statement
- Importantly, no respondents disagreed with the statement

Annual action planning and evaluation planning would allow the telling of a comprehensive narrative that is visible across the whole region. (Survey respondent)

I think the action planning and planning for evaluation would tie in together well. It would let partners see that this is what they've signed up to do in the year, and this is what they've signed up to feed into the region as data for evaluation. (Interviewee)

Consideration 9: Monitoring regional progress

It is proposed that PVT's partners consider monitoring the progress of the region as quite a distinct activity from evaluation – and requiring a separate level of resourcing and capacity – and that such monitoring occurs in relation to one or two of the shared population-level gender equality indicators contained in Our Watch's Guide to Prevention Monitoring (forthcoming). This would ensure that the region's monitoring activities are at least aligned with national-level activities. Indeed, the partnership might even consider contributing to the national data.

As the experience of ARCSHS survey showed, however, whole-of-setting monitoring activities (let alone whole-of-population ones) are complex and expensive to undertake; and they tend to demonstrate only that a change has happened, not why or how (which is of far more value to those planning and implementing actions). The partnership should therefore take its time in considering this as a next step.

Listing of key considerations

This report has just presented the main findings arising from the evaluation, under the three themes of 'The lead agency partnership model and the roles and responsibilities of partners', 'Structures and processes that govern the partnership and support its work', and 'Collecting shared impacts and sharing collective impacts'. As shown in the previous chapter, these findings lent themselves to nine considerations for PVT's partners as they embark upon the next iteration of the regional partnership and action plan. The nine considerations are brought together and listed here in summary form.

Consideration 1: A new partnership instrument

It is proposed that PVT's partners develop an appropriate partnership instrument that can:

- Enshrine the western region's lead agency partnership model as the approach for its partnership and action plan
- Explain the expectations, roles and responsibilities of all partners within the partnership model, and in particular the accountability of each and every partner to the partnership in implementing the actions to which they, as partners, whether lead or otherwise, have agreed

Consideration 2: Two different membership tiers

It is proposed that PVT's partners consider introducing an option for organisational partners to join the partnership at two different membership tiers:

- Full implementing partners committed to undertaking primary prevention actions, with voting rights at the EGG or other decision making forums
- Associate partners who are part of the primary prevention system but not in a position to be implementing primary prevention actions, and who would therefore be without voting rights to decisions affecting the partnership until such time as they can progress to becoming full implementing partners

Consideration 3: An annual action planning process

It is proposed that PVT's partners consider introducing an annual action planning process that can support partners to identify concrete primary prevention activities and have these endorsed by necessary organisational decision makers at the same time.

- This process could be a full-day planning forum that brings together relevant executive and/or senior management people and all officer- or worker-level primary prevention staff, so that an authorising environment for each and every partner's chosen actions over any given twelve-month period is generated and agreed upon from the outset.
- The output resulting from the all-day planning forum would be an operational primary prevention plan, and the participation of decision makers in this full day would reflect the necessary level of authorisation required of each organisational partner for the resourcing and implementation of their respective actions contained in the operational primary prevention plan.

Consideration 4: A higher-order strategy

It is proposed that PVT's partners consider retaining something like the existing PVT action plan document as a higher-order strategy, but revised so it is consistent with *Change the Story*, the new evidence-informed framework for a shared national approach to primary prevention. The higher-order strategy would serve as a powerful framing device for the annual action planning process (Consideration 3).

Consideration 5: Priority settings and techniques

It is proposed that PVT's partners consider using the annual action planning process to identify one or two priority themes, settings and/or techniques that they, collectively, will focus upon for any given twelve-month period. This identification would not deny partners from implementing actions related to 'non-priority' themes, settings or techniques; it would merely signal to partners that they, as a partnership, intend to apply their efforts and build evidence in a more saturated (rather than dispersed) way for any given twelve-month period.

Consideration 6: An annual strategic work plan for the EGG

It is proposed that PVT's partners consider using the annual action planning process to identify key pieces of strategic work required of the EGG to oversee the partnership and its prevention actions over any given twelve-month period (i.e. a work plan). In the context of the Victorian Government's implementation of the recommendations arising from the Royal Commission into Family Violence, there is particular urgency for the EGG to re-focus its attention on strategic advocacy activities beyond the region, rather than within it, in order to:

- Champion the expertise, leadership, maturity and evidence base of the west in primary prevention, and thereby secure a sustainable future for the partnership as the prevention infrastructure in Melbourne's west

- Push for adequate governance arrangements for Victorian primary prevention – both statewide and regional – as a system that is distinct to and separate from response

In identifying pieces of strategic work, such as the external advocacy described above, and in shaping an annual strategic work plan for the EGG, the region's partners could then nominate their executive or senior manager representatives who can best contribute to the work plan; and the EGG, once formed, could then nominate the most appropriate member from this group as chair (with Women's Health West strongly suggested as that member). Nominations would occur on an annual basis (i.e. they would be time limited) so that the EGG is evolved into a dynamic structure with targeted strategic partnership actions and the best people available and on board to execute them.

Consideration 7: Refreshed terms of reference

It is proposed that PVT's partners consider formally recognising the role of the IC's smaller working groups in progressing regional primary prevention activity, and the important function of the IC as a community of practice and safe space for sharing, reflection and learning, by revising the terms of reference for the IC. It is proposed that PVT's partners also consider revising the EGG's terms of reference to reflect the group's evolution into a more dynamic structure with an annual strategic work plan, in keeping with Consideration 6.

Consideration 8: Evaluation planning as part of action planning

It is proposed that PVT's partners consider including evaluation planning as part of the annual action planning process (Consideration 3), so that process and impact evaluation can be tied to the prevention actions identified and endorsed by organisational partners for any given twelve-month period, and the conduct of the partnership's evaluation activities can be planned for, coordinated and properly resourced.

Consideration 9: Monitoring regional progress

It is proposed that PVT's partners consider monitoring the progress of the region in relation to one or two of the shared population-level gender equality indicators, contained in Our Watch's *Guide to Prevention Monitoring* (forthcoming). This would ensure that the region's monitoring activities are aligned with national-level activities; and the partnership might even consider contributing to national data in this way.

Recommendations and conclusion

Four recommendations are now put to PVT's partners and the EGG in particular, as they embark upon developing the next iteration of the partnership and action plan for Melbourne's west. The recommendations are grounded in the main findings arising from this retrospective process evaluation and review of PVT, and the nine considerations to which they led.

Recommendation 1: Develop a partnership agreement

That the EGG immediately implement a process for developing a partnership agreement for the region's primary prevention partnership. The partnership agreement must enshrine the lead agency partnership model, and Women's Health West as the lead partner, as the approach for primary prevention in Melbourne's western region. The partnership agreement must explain the expectations, roles and responsibilities of full implementing partners within the partnership model; in particular, their accountability to the partnership and the actions to which they have agreed. The Partnership Agreement must also explain the expectations of associate partners.

That the partnership agreement is finalised in time to be signed at the inaugural full-day planning forum of the partnership (Recommendation 3). From there, the partnership agreement should be reviewed every twelve months as a living partnership document.

Recommendation 2: Develop a higher-order strategy

That the EGG immediately approve the development of a higher-order strategy that is similar to the existing PVT action plan document, but revised as the region's interpretation of *Change the Story*, the new evidence-informed framework for a shared national framework for primary prevention. The higher-order strategy should align with the framework's themes, settings and techniques for action, injected with a regional flavour. The higher-order strategy should have a ten-year horizon.

That the development of the strategy should be led by Women's Health West and involve all (or as many as possible) of the region's partners, through the EGG and IC structures. The strategy should be ideally completed within three months of the EGG receiving this report of PVT's retrospective process evaluation and review.

Recommendation 3: Hold an inaugural action planning forum

That the EGG immediately develop a process and plan for bringing together executive/senior manager-level and officer/worker-level representatives of the partnership for an inaugural full-day planning forum, including the communications and engagements needed for this, and that coordination and resources for the forum are secured so it can be held between four and six months of the EGG receiving this report.

Further, that the agenda for the full-day planning forum includes (but is not limited to):

- Selecting one or two priority settings and/or techniques for which the partnership can saturate its efforts over the next twelve months
- Identifying organisational partners' actions for the next twelve months
- Identifying the pieces of strategic work required of the EGG to oversee the partnership and its prevention actions over the next twelve months
- Nominating executive or senior manager representatives who can best contribute to the EGG's strategic work plan for the next twelve months
- Gaining partners' commitment to all the work identified, and endorsing an annual operational primary prevention plan that contains that work (to be finalised within one month of the forum by Women's Health West as the lead partner)
- Gaining partners' endorsement and commitment to an evaluation plan to be developed

within four months of finalising the operational primary prevention plan (coordinated by Women's Health West as the lead partner)
- Signing the partnership agreement

The higher-order strategy for the partnership (Recommendation 2) is a key framing device to hold conversations and support decisions at this forum.

Recommendation 4: Convene EGG and IC meetings with refreshed terms of reference

That meetings of the EGG and IC are held as soon as practicable after the inaugural full-day planning forum, and their terms of reference are refreshed to reflect their evolved functioning and operations. In addition:

- That the meeting of the EGG nominates its chair for the year
- That the nominated chair is Women's Health West
- That the meeting of the IC identifies the smaller working groups and that need to be convened for the next twelve months to progress the year's operational primary prevention plan

In conclusion

This five-year retrospective evaluation and review has shown that the western region partnership and action plan rest upon sound operational and functional features that have evolved over the past five years, and that improvements to structures and/or processes across the domains of governance, planning, implementation and evaluation – particularly in following the recommendations of this report – should see primary prevention continue to flourish and deliver strong outcomes in Melbourne's west for the years ahead.

> *I reflect back on where this all started and it's really phenomenal in terms of what's been achieved. It's a really strong partnership, coming from [a sector] where you're always trying to establish partnerships. I really appreciate how difficult that is, to have this sort of engagement, have this sort of turn out. I think this is really impressive of itself … It takes a lot of time, sometimes it's discounted the actual work that goes into building this sort of trust. So I think it's impressive what has been achieved. (Focus group discussant)*

> *The partnership and action plan are really primed now to take on some more challenging tasks. I'm really excited for where things are at. (Focus group discussant)*

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Appendices

Appendix 1: Sources of data and methods of data collection

Appendix 2: Data collection instruments

Appendix 3: Online survey statements and results

Appendix 4: Figure 38.2 Proposed governance architecture

Appendix 1 Sources of data and methods of data collection

Evaluation questions to be answered	Sources that can help answer the questions	Methods and dates of data collection
Governance How has PVT been governed over the years? • Changes? Strengths? Weaknesses? • What governance features should be taken forward? Why?	EGG members (current) IC members past and present **Key informants:** Robyn Gregory (Women's Health West), those involved in PVT prior to the formation of the EGG **PVT and United documents:** e.g. Integrated Health Promotion (IHP) reports, United project and evaluation (Australian Research Centre for Sex, Health Society or ARCSHS) reports, EGG and IC terms of reference	**Focus group** for EGG 6 June (at scheduled EGG meeting) **Focus group** for a mix of past and present IC members and those involved in PVT prior to the formation of the EGG, week of 6 June (TBC) **Focus group** for IC members 28 June (at scheduled IC meeting) **Interview** with Robyn Gregory 26 May **Online survey** for all those invited to participate in focus groups above to determine the strength of their views on PVT's governance, administered in June **Document review** May and June
Planning How was PVT developed? How has PVT worked as a planning mechanism for a) integrated/ collaborative action across the region and b) action within individual partner organisations? • What lessons have been learned about regional action planning? • What planning features should be taken forward? Why?	PVT's development as an action plan **Key informants:** Robyn Gregory (Women's Health West), those who were involved in the development of PVT **PVT documents:** e.g. the action plan itself, IHP reports PVT as a planning mechanism for action EGG members (current) IC members past and present **Other key informants:** Those who have been part of PVT's implementation over the years **PVT and United documents:** e.g. IHP reports, United project and evaluation (ARCSHS) reports	**Focus group** for EGG 6 June (at scheduled EGG meeting) **Focus group** for a mix of past and present IC members and those involved in PVT in the early days or who have been part of PVT's implementation over the years, week of 6 June (TBC) **Focus group** for IC members 28 June (at scheduled IC meeting) **Interviews** with Robyn Gregory 26 May (face-to-face) and up to two others (telephone) on PVT's development **Online survey** for all those invited to participate in focus groups above to determine the strength of their views on PVT's planning, administered in June **Document review** May and June
Implementation How did PVT's implementation model go about enabling a supportive environment for a) integrated and collaborative action across the region and b) individual partner organisation activity? • What lessons have been learned about implementing regional prevention action? • What implementation features should be taken forward? Why?	EGG members (current) IC members past and present **Key informants:** Those who have been part of PVT's implementation over the years **PVT and United documents:** e.g. IHP reports, United project and evaluation (ARCSHS) reports, EGG and IC terms of reference	**Focus group** for EGG 6 June (at scheduled EGG meeting) **Focus group** for a mix of past and present IC members and those who have been part of PVT's implementation over the years, week of 6 June (TBC) **Focus group** for IC members 28 June (at scheduled IC meeting) **Online survey** for all those invited to participate in focus groups above to determine the strength of their views on PVT's implementation, administered in June **Document review** May and June
Evaluation How have PVT and United been evaluated? • What lessons have been learned about evaluating regional prevention partnerships and actions? • What evaluation features should be taken forward? • Why?	**United evaluators:** Steph Rich, Sue Dyson **Key informants:** Those who have had a role in evaluating PVT or United along the way PVT and United documents e.g. IHP reports, United project and evaluation (ARCSHS) reports	**Conversation** with Steph Rich following her participation in the focus group, week of 6 June (TBC) **Conversation** with Sue Dyson TBC **Email** with specific questions to those who have had a role in evaluating PVT or United along the way, administered late May **Document review** May and June

Summary of main data collection methods

- 3 x focus groups (those unable to attend focus groups will be given an opportunity to participate in the evaluation with questions sent via email)
    - 1 x EGG
    - 1 x IC

- 1 x mix of past and present IC members along with others involved in PVT in the early days or throughout implementation

- 4 x face-to-face interviews
    - With Robyn Gregory, Renee Imbesi, Lara Fergus/Patty Kinnersley, Kellie Nagle

- Telephone interviews
    - With up to two regional key informants (TBC) who can speak to PVT's development process and help build a rich account of this

- 1 x online survey specifically designed for those participating in the focus groups to determine the strength of their views in relation to PVT's governance, planning and implementation … NOTE: this instrument will be developed once the focus groups get underway, as it will be based upon views generated by participants

- Emails with specific questions to those who have had a role in evaluating PVT or United (two or three questions to be developed)

- Conversations with Steph Rich, Sue Dyson (two or three questions to be developed)

Appendix 2 Data collection instruments

Schedule of questions for the EGG focus group

1. My understanding is that PVT's governance structure has evolved since the early days and through the United project.

    - What can you tell me about the journey of the EGG e.g. its membership, purpose?
    - What are some of the reasons that have prompted the changes?

2. What do you think are the current strengths of the EGG as a governance structure for PVT? Why do these strengths exist? Any challenges the group currently faces as the governance structure for PVT? Can any of these be expressed as opportunities for the governance of a regional partnership and action plan into the future?

3. Thinking a bit more broadly now, what do you think are the major statewide or national developments in primary prevention in recent times? Paint a picture for me of the evolving landscape within which our regional work is placed, and how this is vastly different to, say, 2010 (the start of PVT) or even 2012 (the start of United).

    - In what ways do you think these developments have a bearing on regional partnerships and action plans like PVT?
    - What things would we need to consider for the future governance of PVT? And for planning the next iteration of PVT's partnership and action plan?

4. PVT's vision is of communities, cultures and organisations in Melbourne's west that are non-violent, non-discriminatory and gender equitable, and that promote respectful relationships between women and men. PVT is the mechanism for realising this vision by offering signatories an enabling and coordinating context for primary prevention action in and across the region.

    - How do you think PVT has gone as a mechanism for prioritising and integrating action a) across the region and b) within individual partner organisations?
    - What, in your view, have been the implementation successes of PVT? Any standout examples? What's enabled these? And the 'not-quite-so-successful' examples? Any particular ones? What were the contributing factors there?
    - What lessons can be learned from PVT over the past five years about planning and integrating regional prevention action? Which of these can these be applied to the next iteration of PVT? How?

5. I'd like us to describe PVT's implementation model. I understand there's an IC whose members receive high-level guidance and organisational leadership support for their work through the EGG. There's also the lead partner role that Women's Health West has in the coordination and implementation of partnership actions; this was really evident throughout United, for instance, where we saw an intensive program of capacity development activities led by Women's Health West for PVT partners. Anything else that describes PVT's implementation model?

    - What do you think of the level of partner involvement or engagement in PVT enabled through the EGG/IC pairing? What are the strengths? And the challenges? How do these factors impact on partner accountability to PVT? What improvements to this aspect of PVT's implementation model could be made to the future?
    - What do you think are the strengths in having Women's Health West as the lead agency for PVT? And challenges? What could be improved about this aspect of the implementation model going forward?

6. A series of four overarching questions to finish …

- What do you think have been the biggest achievements of this group as a governance structure over the last few years? How well do you think you've tracked against the key performance indicators in the terms of reference?
- What do you think are the biggest achievements of the PVT partnership over the past few years? How well do you think the partnership has tracked against the vision, objectives and action areas set out in PVT?
- What's the legacy of PVT thus far a) for the region and b) for primary prevention?
- Finally, drawing on our discussion today, what do you think are the top considerations for a relevant, effective and sustainable regional partnership and action plan for Melbourne's west in the future?

7. Any other comments to add?

Schedule of questions for IC focus group

1. PVT's vision is of communities, cultures and organisations in Melbourne's west that are non-violent, non-discriminatory and gender equitable, and that promote respectful relationships between women and men. PVT is the mechanism for realising this vision by offering signatories an enabling and coordinating context for primary prevention action in and across the region.

    - How do you think PVT has gone as a mechanism for prioritising and integrating action a) across the region and b) within individual partner organisations?
    - What, in your view, have been the implementation successes of PVT? Any standout examples? What's enabled these? And the 'not-quite-so-successful' examples? Any particular ones? What were the contributing factors there?
    - What lessons can be learned from PVT over the past five years about planning and integrating regional prevention action? Which of these can these be applied to the next iteration of PVT? How?

2. I'd like us to describe PVT's implementation model. I understand that the IC receives high-level guidance and organisational leadership support for primary prevention action through the EGG. There's also the lead partner role that Women's Health West has in the coordination and implementation of partnership actions; this was really evident throughout United, for instance, where we saw an intensive program of capacity development activities led by Women's Health West for PVT partners. Anything else that describes PVT's implementation model?

    - What do you think of the level of partner involvement or engagement in PVT enabled through the EGG/IC pairing? What are the strengths? And the challenges? How do these factors impact on partner accountability to PVT? What improvements to this aspect of PVT's implementation model could be made to the future?
    - What do you think are the strengths in having Women's Health West as the lead agency for PVT? And challenges? What could be improved about this aspect of the implementation model going forward?

3. Now for some questions about the EGG as I'm interested in your perspectives.

    - What do you think have been the strengths of the EGG as a governance structure for PVT? Why do these strengths exist?
    - From your point of view, what challenges face the current EGG as the governance structure for PVT? Can any of these be expressed as opportunities for the governance of a regional partnership and action plan into the future?

4. Thinking a bit more broadly now, what do you think are the major statewide or national developments in primary prevention in recent times? Paint a picture for me of the evolving landscape within which our regional work is placed, and how this is vastly different to, say, 2010 (the

start of PVT) or even 2012 (the start of United).

- In what ways do you think these developments have a bearing on regional partnerships and action plans like PVT?
- What things would we need to consider for the future implementation of PVT?
- And for planning the next iteration of PVT's partnership and action plan?

5. A series of four overarching questions to finish …

    - What do you think have been the biggest achievements of the IC as an integral component of the PVT implementation model over the past few years? How well do you think the IC has met the purpose stated in its terms of reference?
    - What do you think are the biggest achievements of the PVT partnership over the last few years? How well do you think the partnership has tracked against the vision, objectives and action areas set out in PVT?
    - What's the legacy of PVT thus far a) for the region and b) for primary prevention?
    - Finally, drawing on our discussion today, what do you think are the top considerations for a relevant, effective and sustainable regional partnership and action plan for Melbourne's west in the future?

6. Any other comments to add?

Schedule of questions for regional informants (interviews)

1. I'm interested in what you can you tell me about PVT's development process.

    - What was the context for Victorian primary prevention back then?
    - What were the key considerations that went into the conversations, engagements, planning and partner sign-on/endorsement of PVT?
    - What were the biggest challenges and how were they overcome?
    - Did anything surprise you, pleasantly or otherwise?

2. My understanding is that PVT's governance structure has evolved since the early days and through the United project.

    - What can you tell me about the journey of the EGG e.g. its membership, purpose?
    - What are some of the reasons that have prompted the changes?

3. What do you think are the current strengths of the EGG as a governance structure for PVT? Why do these strengths exist? Any challenges the group currently faces as the governance structure for PVT? Can any of these be expressed as opportunities for the governance of a regional partnership and action plan into the future?

4. Thinking a bit more broadly now, what do you think are the major statewide or national developments in primary prevention in recent times? Paint a picture for me of the evolving landscape within which our regional work is placed, and how this is vastly different to, say, 2010 (the start of PVT) or even 2012 (the start of United).

    - In what ways do you think these recent developments have a bearing on regional partnerships and action plans like PVT?
    - What things would we need to consider for the future governance and implementation of PVT?
    - And for planning the next iteration of PVT's partnership and action plan?
      [Referring to Q.1] What key considerations, challenges or surprises from PVT's development last time would be relevant next time around?

5. A series of four overarching questions to finish …

    - What do you think are the biggest achievements of the PVT partnership over the past few years? How well do you think the partnership has tracked against the vision, objectives and action areas set out in PVT?
    - What's the legacy of PVT thus far a) for the region and b) for primary prevention?
    - Finally, drawing on our discussion today, what do you think are the top considerations for a relevant, effective and sustainable regional partnership and action plan for Melbourne's west in the future?

6. Any other comments to add?

Schedule of questions for external informants (interviews)

1. I'm interested in your thoughts on PVT's place in the Victorian primary prevention landscape. In your role as [FILL IN AS APPROPRIATE] …

    - Can you provide comment on PVT as the first regional partnership and action plan in Victoria, and what you saw/see as its significance for policy, programming or practice?
    - What do you think have been the biggest achievements of the PVT partnership over the past few years?
    - Up to this point in time, what do you think is PVT's (unfinished) legacy for Victorian primary prevention?

2. What do you think are the major statewide or national developments in primary prevention in recent times? Paint a picture for me of the evolving landscape within which our primary prevention work occurs, and how this is vastly different to, say, 2010 (the start of PVT) or even 2012 (the start of the DRJ-funded project United). In what ways do you think these recent developments have a bearing on regional partnerships and action plans like PVT? For example:

    - What things would we need to consider for the future governance and implementation of regional partnerships and action plans like PVT?
    - And for planning regional partnerships and action plans like PVT?

3. Thinking about your responses to my questions today, can you give me your top two or three considerations for a relevant, effective and sustainable regional partnership and action plan for Melbourne's west in the future? Why these considerations?

4. Any other comments to add?

Appendix 3 Online survey statements and results

Statement	SD (%)	D (%)	N (%)	A (%)	SA (%)	Other (%)
There is confusion among some organisations about what's required of them as partners in the regional partnership and action plan	0	17.4	21.7	60.9	0	0
A signed formal agreement between all organisations involved in the regional partnership and action plan would help clarify partner expectations, roles and responsibilities	0	0	21.7	34.8	39.1	4.4
It will be important in the coming years to bring new partners to the regional partnership and action plan to reflect the increasing breadth of primary prevention work	0	4.4	0	52.2	43.5	0
Other regional partnerships have adopted a two-tiered membership that differentiates between full implementing partners and associate partners. I'd like to see something like this for our regional partnership and action plan	4.4	8.7	39.1	13.0	34.8	0
Our partnership has too many organisations involved	8.7	65.2	26.1	0	0	0
While the current PVT action plan allows partners to use it as a tool for developing actions, some organisations struggle with being accountable for actioning anything suggested in the plan	0	9.1	18.2	31.8	31.8	9.1
Other prevention partnerships have introduced an annual action planning process that sits under a higher-order strategy. I'd like to see something like this for our partnership, so together we can identify tangible actions for the coming year	0	0	9.1	36.4	50.0	4.6
It makes sense to bring the EGG and IC together through annual action planning. Organisational actions and joint partner initiatives could be identified and endorsed at the time of planning, and implementation could then occur more efficiently	0	0	9.1	31.2	54.6	4.6
An annual action planning process could help us to evaluate better. It could help us to select measurable and achievable indicators, bring together our achievements, and contribute to a collective regional picture or evidence base	0	0	4.6	36.4	54.6	4.6
An annual action plan is great in theory, but I'm concerned about adding a layer of planning for my organisation	9.1	50.0	4.6	18.2	13.7	4.6
The implementation of joint partner initiatives in a regional action plan is best progressed through specifically convened smaller working groups rather than a whole-of-group IC	0	4.8	23.8	52.4	9.5	9.5
The IC is important for the partnership's work, but it is better suited as a community of practice with a focus on information sharing, learning and reflection, rather than a place to go through the 'nuts and bolts' of implementation	0	23.8	14.3	38.1	14.3	9.5
The lead agency partnership model, with Women's Health West as the lead partner, will remain central to the success of our region's primary prevention efforts in the coming years	0	4.8	0	52.4	38.1	4.8
Women's Health West is well connected to other women's health services/ regional strategies and the state's prevention infrastructure. With a statewide prevention strategy likely in the next 12 months, it makes sense that Women's Health West is chair of our partnership and its EGG	0	4.8	19.1	33.3	38.1	4.8

SD = Strongly Disagree
D = Disagree
N = Neither disagree/agree
A = Agree
SA = Strongly agree

Appendix 4 Figure 38.2 Proposed Governance Architecture

(Source: State of Victoria 2016)