AUSTRALIAN INSTITUTE FOR PRIMARY CARE & AGEING
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Victorian Responsible Gambling Foundation

Gambling Harm Prevention Programming Framework

SUMMARY

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List of Acronyms

CALD: Culturally and Linguistically Diverse
VRGF: Victorian Responsible Gambling Foundation

Terms

Affected Others: Affected others refers to any person with a significant relationship with a person who gambles who is affected by their behaviour (Langham, et al. 2015). This may include family members or the community.

Commercial Determinants of Health: The commercial determinants of health are the activities of the private sector or industry that have a positive or negative affect on health outcomes.

Early Intervention: Early intervention requires intervening or supporting an individual at an early point in the development of gambling related harm. It often produces better longer term outcomes and results in less harm to the individual and others.

Gambling: Williams et al. (2017) define gambling as "staking money or something of material value on an event having an uncertain outcome in the hope of winning additional money and/or material goods."

Gambling-related harm: There is currently no universal, accepted definition of gambling-related harm; however, Langham et al. (2015) have provided a definition that is easily operationalised to allow more effective measurement of gambling-related harms consistent with Public Health issues.

> *Any initial or exacerbated adverse consequences due to an engagement with gambling that leads to a decrement to the health or wellbeing of an individual, family unit, community or population.*

Harmful Gambling: Any type of repetitive gambling that a person engages in that leads to (or aggravates) recurring negative consequences, such as significant financial problems, addiction, or physical and mental health issues. Additionally, the individual's family, social network and community may also experience negative effects. The degree of harm can range from inconsequential, to transient, to significant; harm can be episodic or chronic (Abbott et al., 2018).

Harm Reduction Strategies: Strategies that target people who are engaging in harmful gambling that aim to identify problematic situations and foster the relationship between them and specific health services (Velasco et al., 2021).

Normalisation of gambling: The interplay of socio-cultural, environmental, commercial and political processes which influence how different gambling activities and products are made available and accessible, encourage recent and regular use, and become an accepted part of everyday life for individuals, their families, and communities (Thomas, 2018).

Prevention: Approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of that disorder or reducing disability.

Public Health Approach: Public health approaches aim to maximise the health of the population by combining health promoting strategies across the population. The public health approach looks beyond the clinical or pathological perspective to gain insight into factors that may influence health outcomes in a population, and how an individual might operate in their environment.

Social Determinants of Health: The social determinants of health are factors that occur on an individual, social, or economic level and contribute positively or negatively to health outcomes.

1. About the Framework

The Gambling Harm Prevention Programming Framework ('the Framework') developed by La Trobe University provides an overarching, cohesive structure to guide the Victorian Responsible Gambling Foundation's (VRGF) prevention program activity. It provides an overview of the latest conceptualisation of gambling related harm and advances in prevention approaches to enable VRGF to evolve its current prevention activities.

1.1 A PUBLIC HEALTH APPROACH

Gambling can cause harm to Victorians, resulting in significant, individual, personal, social and economic costs (Browne et al., 2017; Langham et al., 2015). With increases in the range of gambling products and gambling advertising, gambling related harm has emerged as a social problem and a public health concern. Its effects extend beyond the individual to families and friends, workplaces, and the community.

The complexity of the individual, social and ecological factors that contribute to gambling and gambling related harm requires a comprehensive conceptualisation and Framework. Causal pathways alone do not adequately describe the complex interplay of influences that prevent and reduce gambling related harm (Langham, 2015). The contemporary conceptualisation of gambling related harm reflects a move away from the responsibility of gambling behaviour solely being with the individual. It incorporates a public health approach that recognises the social and commercial determinants of health and health-related behaviour. These determinants exert a powerful influence on health outcomes.

The Framework reflects this contemporary approach and presents gambling related harm as a public health issue rather than solely within the 'control' or responsibility of the individual who gambles. VRGF's current work reflects elements of the public health approach. The Framework provides VRGF with a tool to plan and implement activities based on a clear rationale. It provides VRGF with a resource to review current activities to identify those likely to be effective and to highlight areas where future activities are required.

1.3 PURPOSE

The Framework can support VRGF to adopt a strategic approach to future gambling harm prevention activities by providing:

1. An overarching Framework to inform strategic decisions and map organisation-wide activities.
2. Five detailed Theories of Change to guide how VRGF undertake activities based on the latest developments in public health, best practice, and evidence as reported through peer-reviewed and grey published literature.
3. A tool to communicate to internal and external stakeholders on how and why decisions are made and to ensure a shared understanding of VRGF's approach to reducing gambling related harm.

1.2 DEVELOPMENT OF THE FRAMEWORK

The Framework (Figure 1) is underpinned by a Rapid Evidence Assessment (Clune et al., 2022) and Background Paper (Ratnaike et al., 2022) also undertaken by La Trobe University. These provide a rationale for current and future decision making based on theoretical conceptualisations of gambling related harm and the public health approach. Five Theories of Change (Figures 4–8) sit alongside the Framework (Figure 1)—one for each of the five recommended Action Areas.

2. The Framework

The Framework is based on the public health approach for preventing gambling related harm. It uses the prevention continuum to guide the choice and implementation of prevention efforts across population groups at different levels of risk using universal, selective and indicated approaches. As some groups are more at risk of experiencing gambling related harm due to social or commercial determinants of health, specific at-risk groups are identified as priorities. Settings are also targeted to enhance engagement with at-risk groups.

2.1 ACTION AREAS AND IMPLEMENTATION

The Framework comprises five Action Areas consistent with the public health approach and based on prevention goals:

- Action Area 1: Tackling the normalisation of gambling
- Action Area 2: Building capacity in the community
- Action Area 3: Leveraging prevention partnerships
- Action Area 4: Upskilling for early detection and treatment efficacy
- Action Area 5: Building evidence to reduce gambling related harm.

While each Action Area is underpinned by a linked Theory of Change (Figures 4–8), the interaction between areas is important in creating prevention opportunities that will lead to the longer-term outcome of reduced gambling related harm. A comprehensive approach to preventing gambling related harm requires simultaneous activity across all Action Areas underpinned by a coordinated approach to designing, sequencing and timing of activities. For example, *Tackling the normalisation of gambling* (Action Area 1) is an important precursor to enhance activities in other Action Areas such as Action Area 4 *Upskilling for early detection and treatment efficacy*.

2.2 GUIDING PRINCIPLES FOR USE

For VRGF's work to be effective in reducing gambling related harm, the resources invested in prevention efforts need to focus on coordinated strategies, approaches and programs that reach all Victorians and are likely to deliver maximum benefit to the Victorian community (Schroder-Back et al. 2014). Eight principles have been developed to guide the use of the Framework. These principles recommend that VRGF:

1. Apply a public health approach that integrates social and commercial determinants of health models to guide who and what to target, and the settings in which to intervene.
2. Use multiple interventions across different Action Areas with a coordinated message and, where possible, address the interplay between Action Areas and activities.
3. Address environmental factors and industry actions that contribute to harmful gambling behaviour.
4. Co-design local solutions.
5. Use evidence-based solutions.
6. Take a coordinated approach with partners.
7. Engage front line health and support workers (including venue support workers).
8. Evaluate initiatives to assess impact and efficacy for continuous improvement.

2.3 MEASURING OUTCOMES

Reducing the development and severity of gambling related harm takes many years and requires appropriate data and evaluation to measure impact. VRGF has taken steps to measure the impact of their existing strategies, approaches and programs and should continue to do so in a coordinated and integrated way with

future initiatives. To support this, the Framework links to VRGF's Outcomes Framework (detailed in the Background Paper, Ratnaike et al., 2022).

This Framework provides a strategy to undertake these activities based on the latest developments in public health, best practice, and evidence as reported through grey and published literature. It enables VRGF and its partners and stakeholders to have a shared understanding of VRGF's approach in reducing gambling related harm.

Figure 1: The Gambling Harm Prevention Programming Framework Overarching Framework

Purpose: To prevent and reduce gambling harm for all Victorians					
OUTCOMES	Intermediate	**VRGF OUTCOMES**			
		Normalisation of gambling is reduced and replaced with an alternative perception and discourse	**Reduced risk in target groups**	**Improved early intervention of gambling harm Increased engagement in treatment and support**	**Trends identified and addressed Strong evidence base established Improved environments [incl policy]**
	Short-term	▪ Raised awareness about commercial determinants and influences in settings ▪ Changed language and discourse that challenges normalisation and individual responsibility ▪ Improved attitudes and behaviours that counter normalisation	▪ Increased community capacity to identify and address harm ▪ Engagement of at-risk groups ▪ Local access to help seeking ▪ Protective factors strengthened ▪ Risk factors minimised	▪ Increased capacity of front-line workers, venue support workers and community members to detect and address harm ▪ Translation of evidence into practice improvements ▪ Improved quality and effectiveness of education and awareness resources	▪ Improved knowledge of program effectiveness ▪ Improved knowledge for government and awareness
PUBLIC HEALTH APPROACH					
REGULATORY ENVIRONMENT			SOCIAL DETERMINANTS OF HEALTH		COMMERCIAL DETERMINANTS OF HEALTH
GUIDING PRINCIPLES		Utilise a public health approach that integrates social and commercial determinants of health models to guide who and what to target, and the settings in which to implement.			
		Use multiple interventions across different focus areas with a coordinated message – and address the interplay between focus areas and activities.			
		Address environmental factors and industry actions	Co-design local solutions	Evidence based	Coordinated approach with partners	Engage front line health and support workers
ACTION AREAS		**1. TACKLE THE NORMALISATION OF GAMBLING** [increase awareness about risks of gambling; encourage people experiencing harm to seek support]	**2. BUILDING CAPACITY IN THE COMMUNITY** [target at-risk groups with tailored initiatives; strengthen protective factors at individual and community level]	**4. UPSKILLING FOR EARLY DETECTION & TREATMENT EFFICACY** [increase access to and uptake of support and treatment at different points of gambling related harm]	**5. BUILD EVIDENCE** [Support, conduct, monitor, measure and share research & evaluation]
		3. LEVERAGING PREVENTION PARTNERSHIPS [Partner with other organisations to strengthen key messages and strengthen engagement with hard to reach at risk groups] *Example activities: Pilots, shared funding, cross-promotion, strengthen ability to scale up, co-morbidities*			
EVIDENCE INFORMED CONSIDERATIONS		▪ Raise awareness about commercial determinants ▪ Challenge social and cultural norms using value-based messaging to counter industry messaging, change attitudes and language [and clearcall to action] ▪ Focus on products and settings of high risk	▪ Highly targeted of risk and protective factors ▪ Locally developed; tailored ▪ Diversionary and alternative activities to gambling ▪ Place-based health promotion activities	▪ Stepped care approach across prevention continuum ▪ Train frontline workers and those placed to identify harm to implement screening and assessment tools	▪ Track new & emerging products ▪ Implement robust evaluations ▪ Deepen understanding of: harm, support, treatment and impacts of emerging threats ▪ Knowledge translation [incl. inform government]
RISK FACTORS Young age I Older age I Social isolation I Culturally isolated I Mental health challenges I Parents who gamble				**PROTECTIVE FACTORS** Positive peer influence I Engagement with community I Positive social connectedness I Positive cultural connectedness I Wellbeing support I Positive role modelling	
PREVENTION GOAL REACH		**PRIMARY UNIVERSAL [GENERAL POPULATION]**	**SECONDARY SELECTIVE [AT RISK GROUPS]**	**TERTIARY INDICATED [THOSE EXPERIENCING HARM]**	
TARGET AUDIENCE AND KEY SETTINGS		**TARGET AND AT-RISK GROUPS** Young males [12–24 years]; Culturally and linguistically diverse groups; People experiencing mental health challenges (and other co-morbidities); People experiencing social disadvantage; First Nations People; Children of people who gamble; Older people		**KEY SETTINGS** Pubs; Clubs; Casinos; Online; Community based settings; Council owned spaces (e.g., community houses); Workplaces; Sport; Schools.	
ACTIVITIES		▪ Campaigns to the general public (universal approach) ▪ Support for initiatives at local level for at-risk groups	▪ General and specific community-based programs	▪ Build capacity in the service system ▪ Promote a positive help seeking pathway	▪ Product tracker ▪ Knowledge translation
CONTEXT		▪ Gambling related harm affects not only the individual, but also those around them and the broader society. ▪ The development of gambling related harm involves a complex interplay of many individual, social and ecological factors. ▪ Patterns of gambling vary and are complex as some groups may reduce their gambling frequency over the lifespan while others increase. ▪ Gambling harm is not dichotomous – levels of harm are conceptualised as existing on a continuum where support and intervention can occur at any point. ▪ There is no gold standard for approaching gambling related harm. Preventing and reducing the impact of gambling harm requires a complex, multi-pronged and coordinated approach.			

3. The Nature of Gambling Related Harm

3.1 CURRENT CONCEPTUALISATION OF GAMBLING HARM

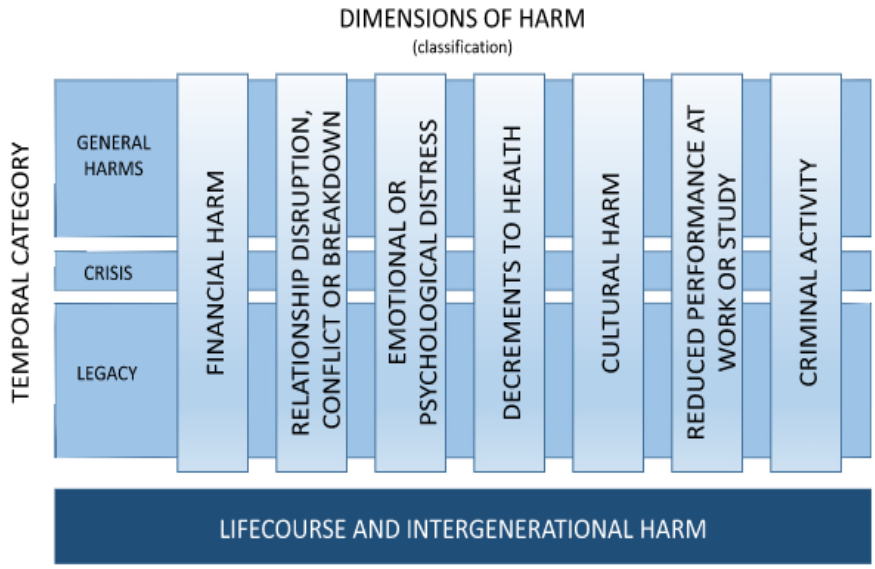
Gambling can result in harm to the individual, those around them and society. While not everyone who gambles experiences gambling related harm, the experience of gambling related harm can be significant for some individuals and those around them. Australia has the highest rate of financial loss to gambling in the world with losses attributed to a wide range of gambling products (Browne et al., 2017).

Although there is currently no universal, accepted definition of gambling related harm, Langham et al. (2015) provide a definition that VRGF have used, and that is easily operationalised to allow more effective measurement of gambling related harms consistent with other public health issues.

> *Any initial or exacerbated adverse consequences due to an engagement with gambling that leads to a decrement to the health or wellbeing of an individual, family unit, community, or population.*

Langham et al. (2015) reflect the complex, socially constructed nature of gambling related harm through a broader domain-based approach rather than limiting the range of harm to distinct categories of mild, moderate and severe. This domain-based approach enables gambling related harm to be conceptualised, and measured, within the life of the person who gambles, their family and friends, and the community. Each domain can occur sequentially or in conjunction with other domains. Figure 2 illustrates the domains and their relationship to increasingly more severe levels of harm. Langham et al. (2015) note that gambling is conceptualised as a behaviour that may produce harm as a consequence. As gambling related harm is not a disease in a clinical sense, the Dimensions of Harm model does not comprise discrete categories on a continuum using severity of harm. Unlike other behaviours, harm caused by gambling can continue once the gambling ceases or can increase or decrease when influenced by other factors. Langham et al. (2015) also explain that the domains are not causative factors for developing gambling related harm.

Figure 2: Langham et al.'s (2015) Dimensions of Harm



Source: Langham et al. (2015)

3.2 OPERATING ENVIRONMENT

Change in gambling behaviour depends on modifying ideas, values and behaviours in response to a range of individual, environmental or systemic factors. The gambling related external operating environment is challenging as the gambling industry is profit-driven and well-resourced to effectively attract, engage, retain and re-engage people in gambling. Current challenges include the normalisation of gambling, increased advertising, and the type, range and mechanisms of gambling products specifically designed to appeal to new and emerging audiences.

VRGF operates in a dynamic and changing social, political and technological landscape. Its work is affected by external factors, many of which are beyond VRGF's control. Therefore, the Action Areas should be implemented to reflect this operating environment and will require a degree of flexibility. Influences in the operating environment that may affect VRGF's program of work include:

- individual, community and social stressors, often triggered by external factors.
- government regulation of the gambling industry.
- availability of 24/7 gambling.
- emergence of new gambling products and new gambling features.
- increased frequency, targeting or mechanisms of gambling advertising.
- emerging new pathways to gambling e.g. gaming.
- emerging at-risk groups.

3.3 PREVENTION PARADOX

The prevention paradox suggests that greater societal gains are achieved through a small reduction in gambling-related harm among the large number of people who gamble at a lower frequency and experience less direct harm. This contrasts with focusing solely on the small proportion of people who gamble at high frequency, and experience greater direct harm (Browne, et al., 2020).

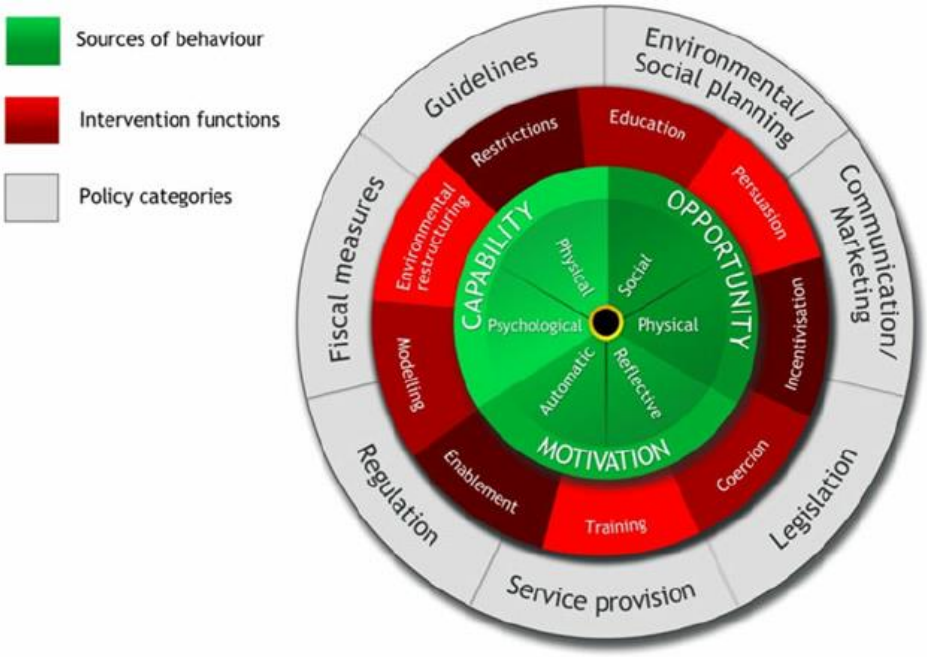
This is for two reasons. Firstly, reducing harm where lower levels of harm are experienced (early stage) can prevent the development of further harm. Secondly, addressing harm at higher levels is more costly in social and financial terms. Lifetime gains can be made through prevention at early stages. Disrupting the development of increasingly more severe levels of gambling related harm is important in reducing the overall size of the problem within a population. The public health approach aims to prevent and intervene early in the development of gambling related harm to reduce future severity. This approach maximises outcomes and benefits for all Victorians because it applies to the whole population. Nonetheless, there is also an ethical responsibility to support people who experience high levels of harm even if solely focusing on this group will not maximise community gains.

3.4 BEHAVIOUR CHANGE THEORY

The commercial determinants of health approach argues that traditional behaviour change theory—with a focus on motivating individuals to change—is not enough to challenge the heavy and pervasive influence of the gambling industry (Abbott et al., 2018). Nonetheless, the Theory of Planned Behaviour (Ajzen, 1988) and dual processing behaviour change frameworks such as the Behaviour Change Wheel (Michie et al., 2011, provide theory-based explanations of how behavioural change can occur within the five Action Areas of the Framework. As illustrated below (Figure 3), the Behaviour Change Wheel recognises that multiple factors both internal and external to the individual impact behavioural change. The central hub of this framework (the inner green circle known as the COM-B model), focuses on what needs to change within the individual for

behaviour change to occur. According to the COM-B model (Michie et al., 2011), behaviour change requires a change in an individual's capability, opportunity and/or motivation to perform the behaviour itself or the behaviours that compete with or support it. The influence of contextual factors that reside outside the individual are recognised in the middle and outer layers of the framework. The middle layer (the red middle circle) outlines a series of intervention categories, such as education and restrictions, that can be implemented to facilitate behaviour change. Factors operating in the broader social context that support or enable these interventions, such as guidelines and legislation, are represented in the outer ring (grey circle) of the Behaviour Change Wheel. The Behaviour Change Wheel has been used extensively as an overarching framework to design programs and interventions aimed at changing behaviour (Isenor, et al., 2021).

Figure 3: The Behaviour Change Wheel



Reproduced from Michie at al. 2011

The Theory of Planned Behaviour focuses on individual beliefs, attitudes, perceived and actual behavioural control and perceptions of social norms (Ajzen, 1988; Norman et al., 2018) which collectively contribute to an intention that predicts a behaviour.

4. Public Health Approach for Reducing Gambling Related Harm

4.1 GUIDING PRINCIPLES OF THE PUBLIC HEALTH APPROACH

The public health approach adopts a population focus to health issues, and it recognises that many factors contribute to adverse health outcomes such as gambling related harm. Therefore, some groups are at increased risk of experiencing gambling related harm. Approaches to reducing harmful gambling are changing from pathological, 'individual' based models to approaches that encompass multiple social and cultural factors that influence gambling related behaviour (Gordon & Reith, 2019). Table 1 provides an overview of some differences between the public health approach and the individual, treatment-based approach. These differences are important when structuring a prevention program.

Table 1: Public Health Approach vs Individual Approach

INDIVIDUAL APPROACH	PUBLIC HEALTH APPROACH
▪ Focus on individual	▪ Focus on community as a whole
▪ Responsibility of individual alone for their behaviour	▪ Encourage responsibility of government and industry
▪ Focus on individual behaviour change	▪ Focus on awareness and policy change
▪ Focus on 'pathological gambling' treatment	▪ Focus on prevention and harm continuum
▪ Stigmatising	▪ Non-stigmatising

4.2 THE PREVENTION CONTINUUM

Prevention involves reducing the potential for gambling related harm as well as reducing the impact or worsening of gambling related harm (McMahon et al., 2019). Prevention activities should cover the full range of prevention opportunities—from awareness to help seeking and early intervention, through to specific approaches and programs (McMahon et al., 2019). The prevention continuum represents three levels of activity, with clear prevention goals, that target people at different levels of risk (Table 2). Each successive level is increasingly more targeted from the population focus of universal approaches, to the at-risk groups targeted by selected approaches, and then the high risk groups and those exhibiting gambling related harm targeted by indicated approaches.

Table 2: The Prevention Continuum

PRIMARY WHOLE POPULATION	SECONDARY AT RISK GROUPS	TERTIARY HIGH RISK GROUPS
Universal approaches	Selective approaches	Indicated approaches
Target: Whole Population	Target: At-Risk Groups	Target: Those exhibiting gambling related harm
Goal: Health Promotion and Prevention	Goal: Screening/Focus on Early Intervention	Goal: Reducing Impact and Further Harm

Access for individual support can occur at any stage

PRIMARY WHOLE POPULATION	SECONDARY AT RISK GROUPS	TERTIARY HIGH RISK GROUPS

4.3 DETERMINANTS OF HEALTH

The public health approach aims to maximise the health of the population by combining health promoting strategies across the population. It looks beyond the clinical or pathological perspective to gain insight into factors that influence health outcomes in a population, and how an individual might operate in their environment. The interplay of individual characteristics and environmental conditions determine health outcomes. These characteristics and conditions are considered to be the determinants of health. These social and commercial determinants of health are not always within the control of the individual (World Health Organisation, 2021) and are detailed in Table 3.

Table 3: Determinants of Health

DETERMINANTS OF HEALTH	
Social Determinants of Health	Commercial Determinants of Health
▪ The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems in place to deal with illness. ▪ These circumstances are shaped by a wider set of forces including economics, social policies, politics and commercial determinants of health. ▪ Social determinants of health are important because addressing them helps prevent illness and promotes healthy lives and societal equity.	▪ Commercial determinants of health are the conditions, actions and omissions by corporate actors that affect health. ▪ Commercial determinants arise in the context of providing goods or services for payment. They include commercial activities and the environment in which commerce takes place. They can have beneficial or detrimental impacts on health. ▪ Commercial activities positively and negatively shape the physical and social environments in which people live, work, play, learn and love.

Source: World Health Organisation, 2021

4.4 RISK AND PROTECTIVE FACTORS FOR GAMBLING RELATED HARM

Risk factors are characteristics of the individual or in the situational environment that may predispose an individual to develop gambling related harm. Protective factors are characteristics that buffer the individual against the effects of risk factors and therefore reduce the potential for gambling related harm. The public health approach seeks to create supportive environments and strengthen protective factors to reduce the impact of risk factors. The risk and protective factors identified most relevant for the Australian context are detailed in the Table 4 below. The Rapid Evidence Assessment (Clune et al., 2022) and Background Paper (Ratnaike et al., 2022) provide justification for why these were selected.

Table 4: Risk and Protective Factors

RISK FACTORS	PROTECTIVE FACTORS
Young age	Positive peer influence
Older age	Engagement with community
Social isolation	Positive social connectedness

RISK FACTORS	PROTECTIVE FACTORS
Cultural isolation	Positive cultural connectedness
Mental health challenges	Wellbeing support
Parents who gamble	Positive role modelling

4.5 AT-RISK GROUPS

At-risk groups are people who may be at increased risk of developing gambling related harm (Langham et al., 2015). In the public health approach, at-risk groups are targeted with selective approaches to prevent harm from developing. This requires a different approach to the universal approach that applies to the population, regardless of individual risk factors. The evidence outlined in the Rapid Evidence Assessment (Clune et al., 2022) and Background Paper (Ratnaike et al., 2022) suggests that the following groups are at greater risk of developing gambling related harm:

- young males (12–24 year olds).
- people who are culturally and linguistically diverse.
- people who are experiencing mental health challenges and other comorbidities.
- people experiencing social disadvantage.
- First Nations People.
- children of people who gamble.
- older people.

As gambling products become more sophisticated, emerging groups that may be targeted by industry initiatives in the future, and hence be at elevated risk, include:

- women
- young people involved in gaming.

4.6 SETTINGS

Engaging in gambling harm prevention initiatives may occur through intermediaries (e.g. community leaders, educators, health professionals, sport coaches etc) rather than directly by the individual. Therefore, selecting appropriate settings for initiatives is important. The public health approach targets specific settings to enhance opportunities for prevention, particularly with groups at greater risk of gambling related harm. The local context for gambling is very important. Place-based initiatives implemented in familiar settings, can influence the social worlds that people interact in. These initiatives can be effective in engaging individuals, increasing access to and enhancing the penetration of health promotion messages, and shaping and guiding behaviour (Savic et. al., 2016).

Key features appear in some settings that may encourage gambling and or contribute to the normalisation of gambling. These include:

- availability (including online and physical availability).
- features that promote normalisation such as providing gambling in sports clubs and social clubs.
- promoting or encouraging gambling in the workplace (such as sweep stakes or social groups of employees gambling together).
- information in other languages to attract people who may be culturally isolated.
- free food and drink, and temperature control in gambling venues that creates a safe environment.

- advertising.
- role modelling by using celebrities to promote gambling.

As settings often promote social norms, there is potential to challenge the 'normalisation' of gambling in these environments, to influence the discourse around gambling and to promote behaviour change.

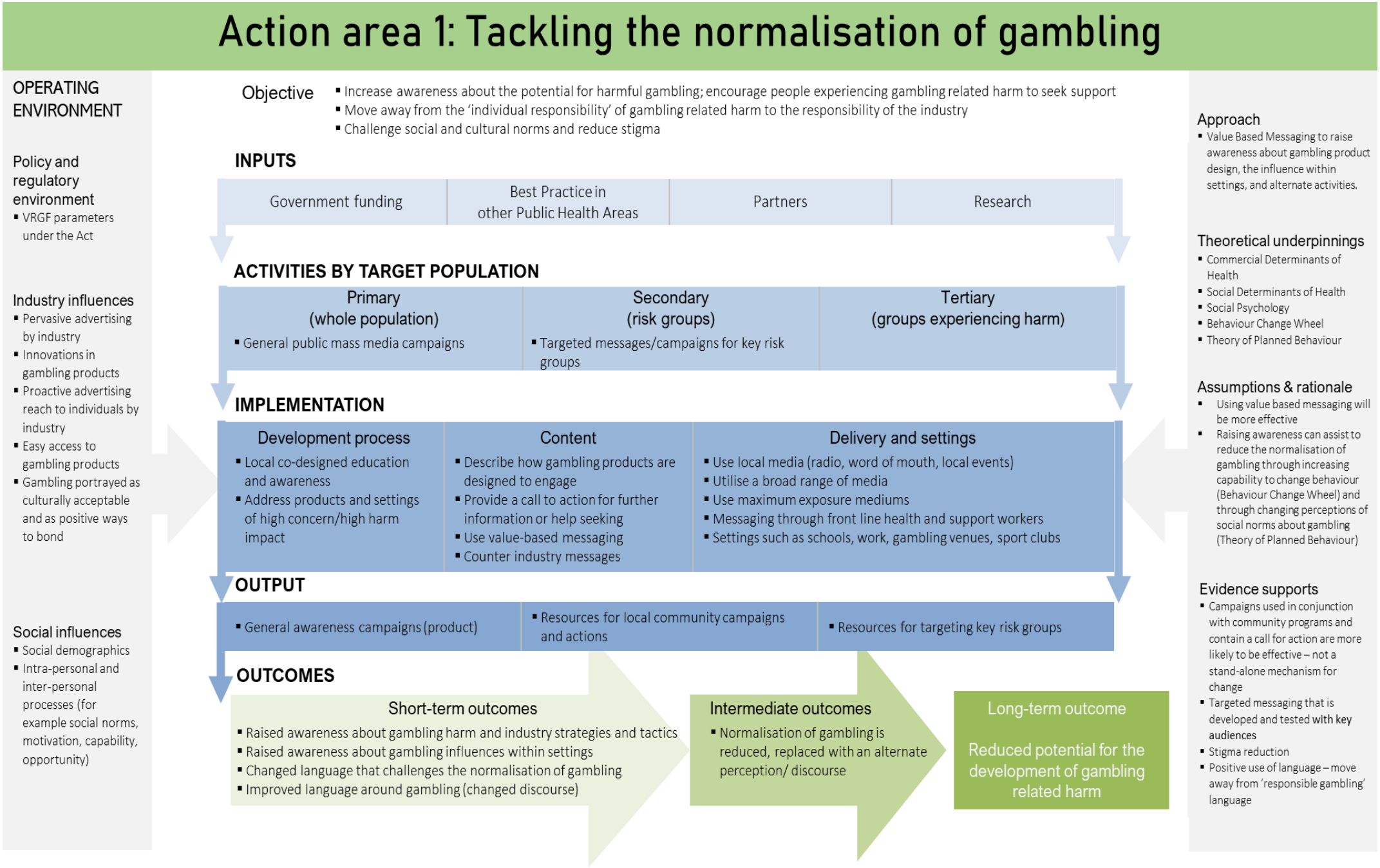


Figure 4: Theory of Change Action Area 1: Tackling the normalisation of gambling

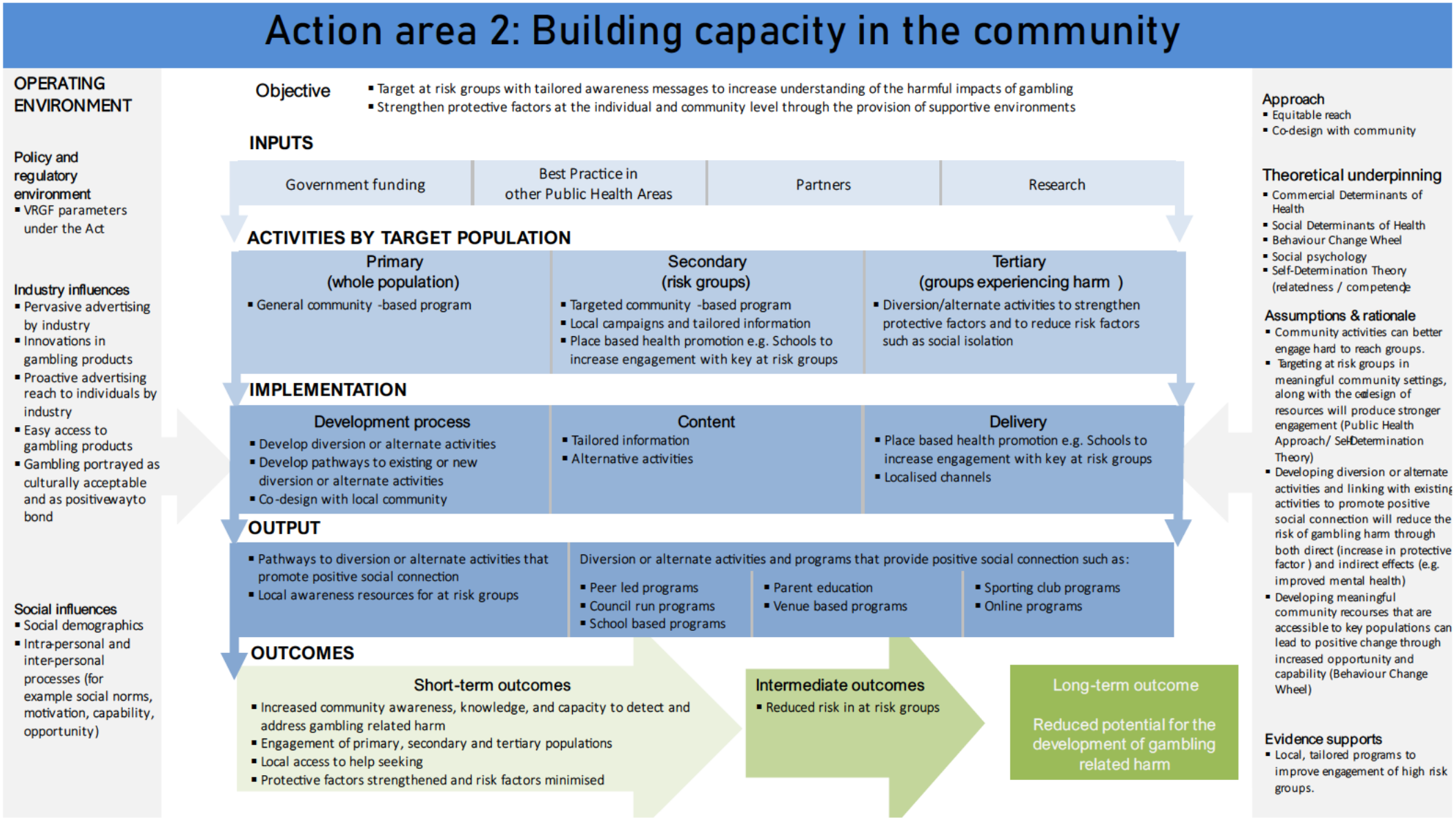


Figure 5: Theory of Change Action Area 2: Building capacity in the community

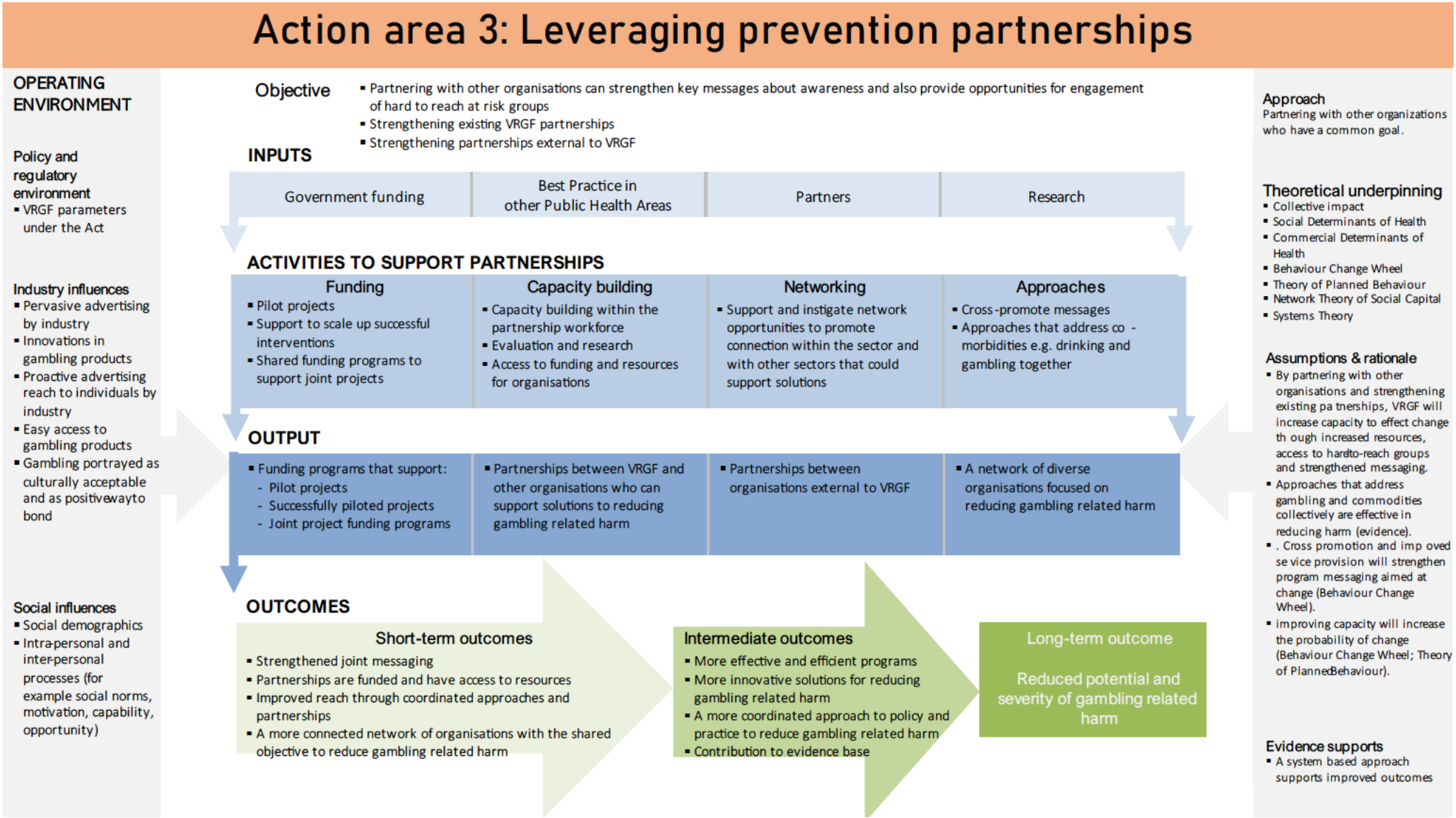


Figure 6: Theory of Change Action Area 3: Leveraging prevention partnerships

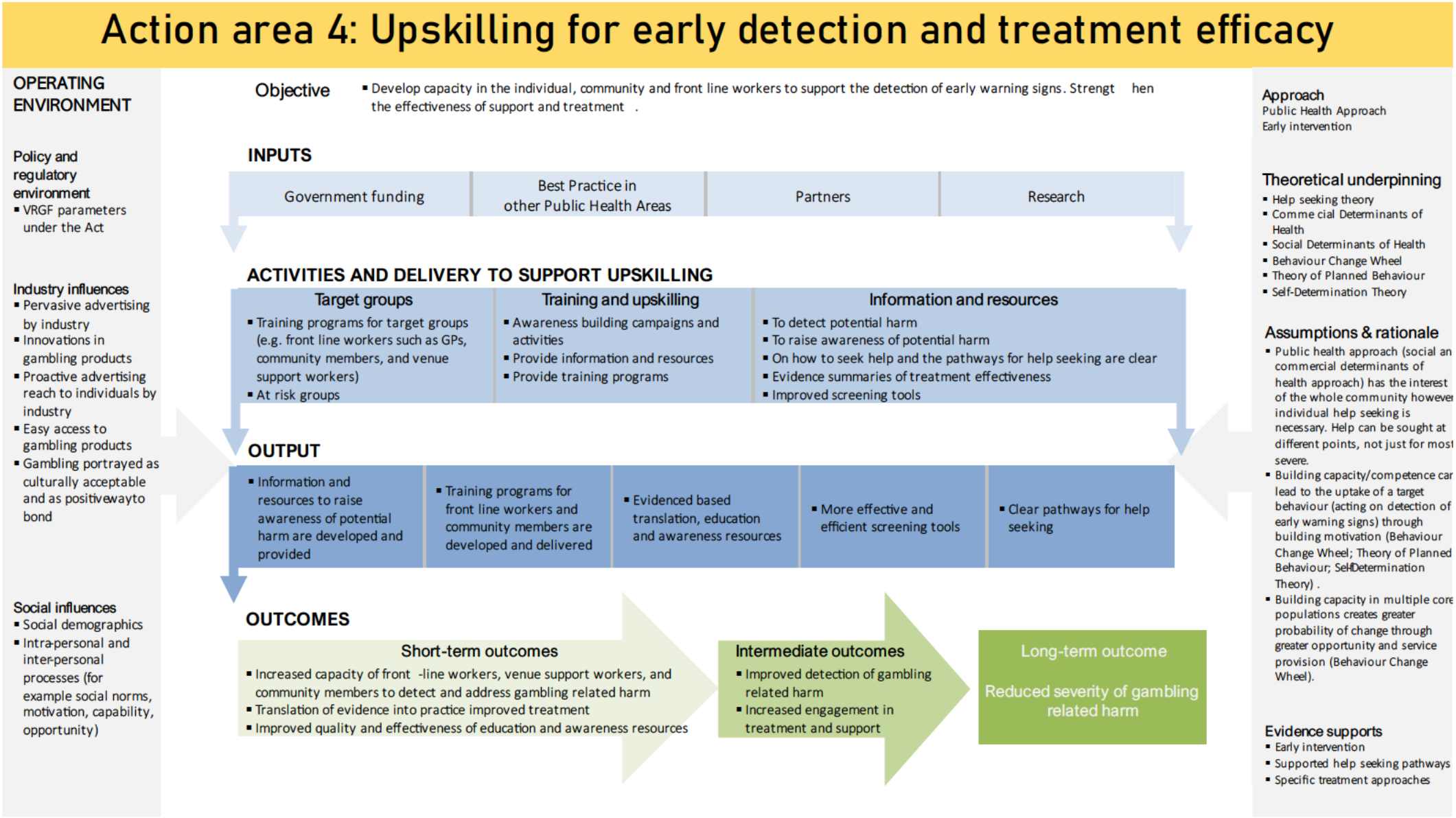


Figure 7: Theory of Change Action Area 4: Upskilling for early detection and treatment efficacy

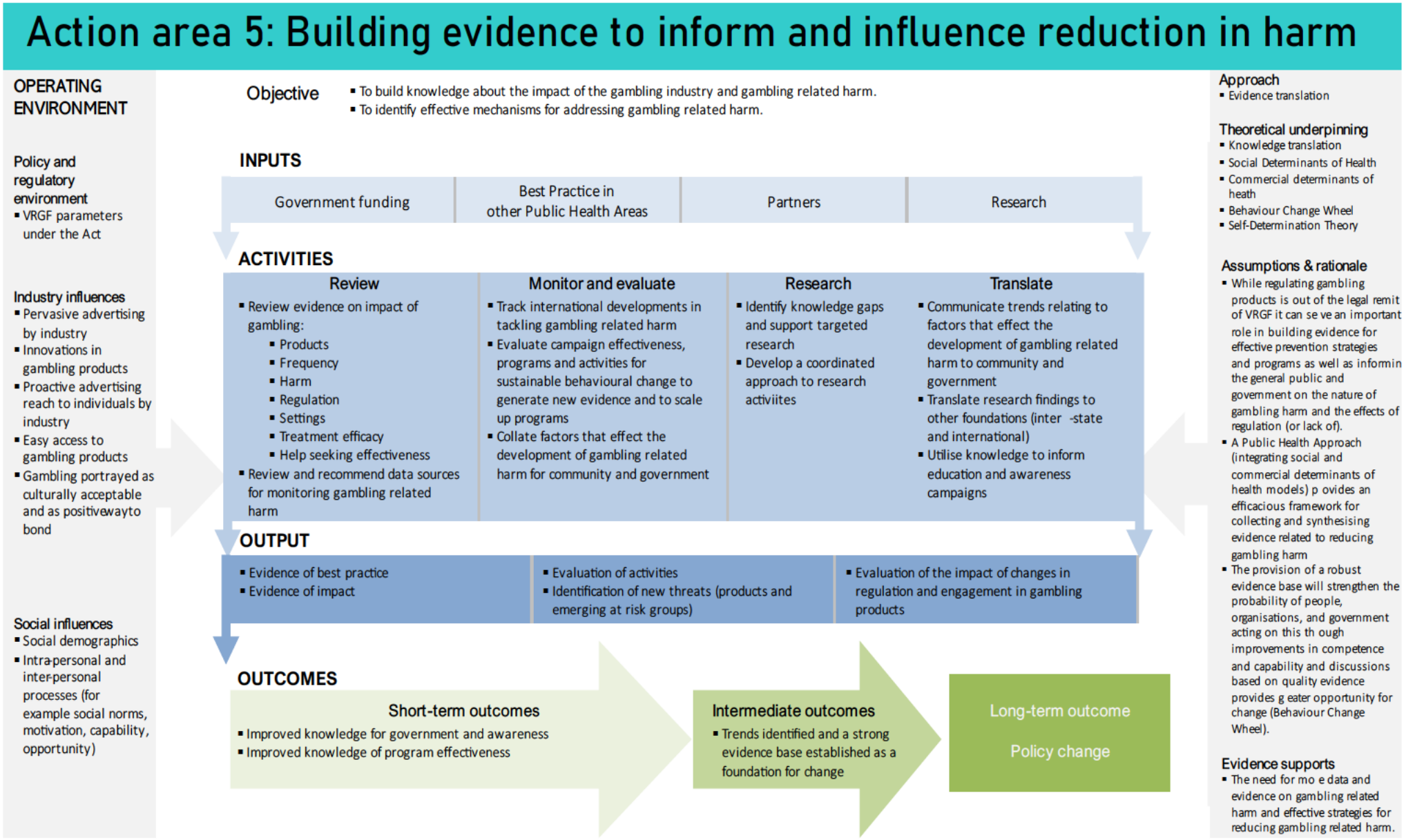


Figure 8: Theory of Change Action Area 5: Building evidence to inform and influence reduction in harm

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