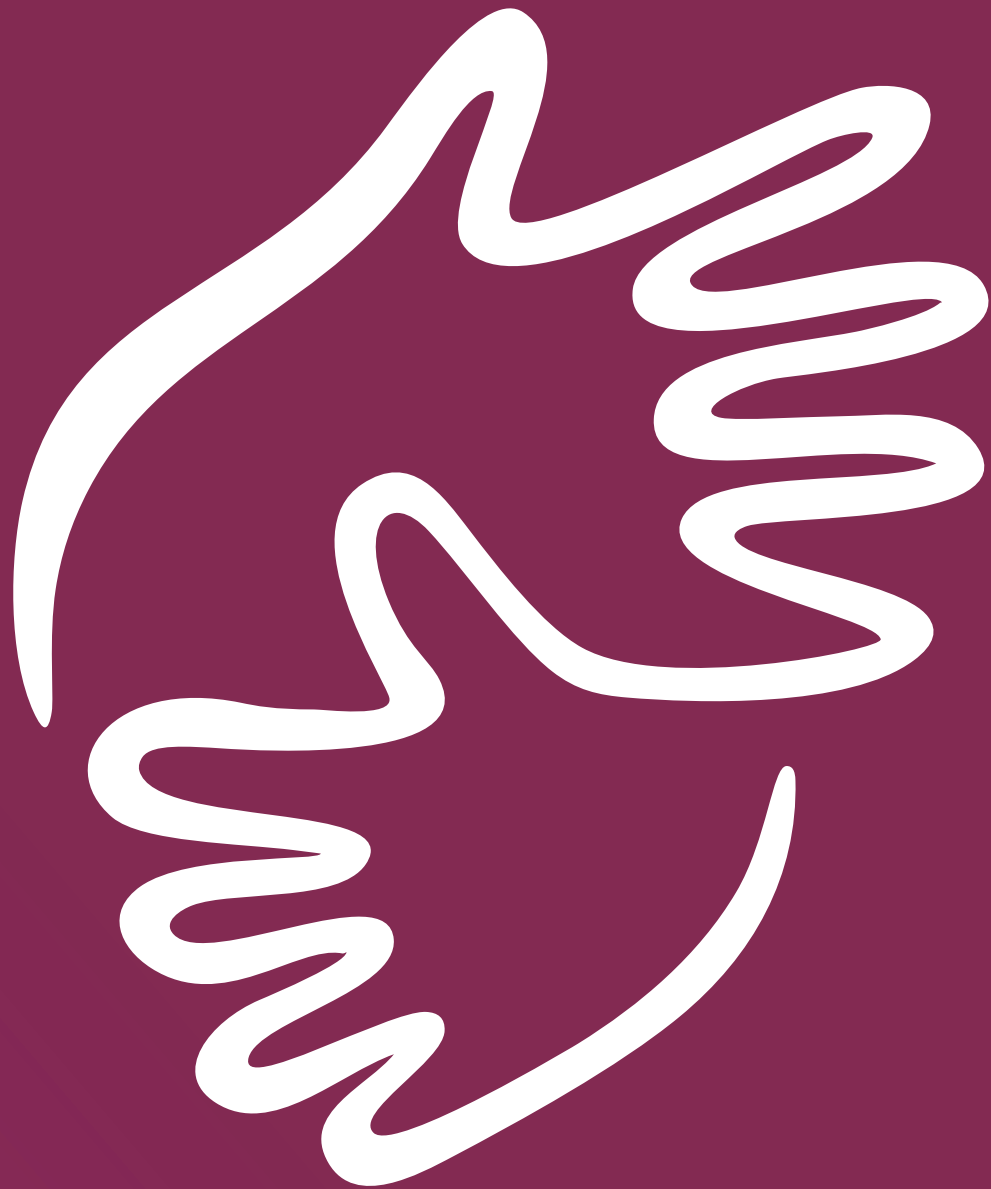


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What works to prevent violence against women and girls - Evidence Reviews

Paper 3:

Response mechanisms to prevent violence against women and girls

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WhatWorks
TO PREVENT VIOLENCE

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1. Introduction

Violence against women and girls (VAWG) is one of the most widespread violations of human rights worldwide, affecting one-third of all women during their lifetime. It is the leading cause of death and disability of women of all ages and has many other health consequences. VAWG is a fundamental barrier to eradicating poverty and building peace.

Over recent decades, the issue of VAWG has received increasing global attention which has led to the establishment of systems and programmes that respond to women and girls who have experienced violence. Such response mechanisms include a variety of interventions implemented by formal institutions, as well as by informal institutions, across the security and justice, health and social sectors. Their primary purpose is to ensure that women and girls who experience violence receive support, affirmation and advice about their options, as well as medical attention, counselling, shelter and access to justice.

The global women's movement has been at the forefront of advocating for the expansion and strengthening of comprehensive response mechanisms, so as to ensure that all survivors of VAWG receive the multiple forms of support they need to recover from abuse. Women's organisations have also advocated for new legislation to criminalise various forms of VAWG – including domestic violence and marital rape - and have engaged in extensive awareness raising work at community level, in order to break the silence surrounding VAWG and encourage women to seek support from these response mechanisms. The results of this advocacy have varied between countries: some countries now have a fairly comprehensive legislative framework to criminalise VAWG (although in most cases, there is a significant implementation gap); some have policies in the police and justice systems, and paralegal sectors, to assist with apprehension and prosecution; some have medical and nursing

staff with better awareness of VAWG; some have a wider range of counselling and support interventions to assist abused women. In other countries, response mechanisms are in a rudimentary state and an effective legal framework does not exist.

VAWG response mechanisms have, for the most part, been developed and deployed with the primary goal of providing improved support services to women and girl survivors, through strengthening the response of the police and criminal justice system, and the health system and social sector. In and of itself, this goal is vitally important. However, an assumption is often made that strengthened response mechanisms will also lead to a decrease in rates of violence. For example, it is assumed that health sector responses could lead to reduced rates of reoccurrence, or that strengthened police and criminal justice systems may prevent violence through deterrence. Whether or not response mechanisms also have the potential to prevent violence is a key question for the field of violence prevention. However, these assumptions have not yet been proven, and, as this paper will show, research in this area is still limited.

1.1 What Works global programme and evidence review

This Paper is the third in a series of four evidence reviews that were produced by the programme 'What Works to Prevent Violence against Women and Girls' (What Works). What Works is a DFID-funded global programme investing £25 million over five years to improve the evidence base on the prevention of VAWG. It supports both innovative primary prevention programmes and rigorous research into and evaluation of prevention programmes - across Africa, Asia, and the Middle East, that seek to understand and address the underlying causes of violence in order to stop it before it starts.

The papers were produced to assess the current state of research and the evidence base, in order to inform the research agenda of the

global What Works programme. The focus of What Works is to advance the field of primary prevention in particular, although this is understood to be closely aligned with response efforts. The outline of the individual papers is as follows:

Paper 1: State of the field of research on violence against women and girls.

Paper 2: Interventions to prevent violence against women and girls.

Paper 3: *Response mechanisms to prevent violence against women and girls.*

Paper 4: Approaches to scale-up and assessing cost-effectiveness of programmes to prevent violence against women and girls.

1.2 Scope and goals of the review

This paper examines the evidence base on the effectiveness of response mechanisms for VAWG in preventing the occurrence or reoccurrence of violence. In this paper, we review interventions that are designed primarily to respond to VAWG, but which have a secondary or parallel aim of preventing VAWG or targeting key risk factors that contribute to the perpetration (by men) or the experience (by women) of VAWG. It is important to make

it clear that assessment of the interventions in this paper focuses only on their effectiveness in preventing VAWG or addressing related risk factors. Along with the other papers in this series, this paper aims to:

- Inform the violence prevention research agenda and priorities for innovation; and
- Establish a baseline of the state of knowledge and evidence against which to assess the achievements of the What Works programme over the next five years.

1.3 Types of violence covered by this review

VAWG takes many different forms globally, and is most likely to be perpetrated by someone known to the victim, such as a family member or intimate partner. Clarifying the different forms of VAWG is important to: identify the specific risk factors that make each form of violence more likely; address the social norms, attitudes and practices surrounding violence; ensure the tailored design of preventative interventions and policies.

The What Works programme focuses on intimate partner violence (IPV), non-partner sexual violence, and child abuse. This review,

Table 1. Definitions of forms of VAWG addressed by this paper

Child abuse or maltreatment	Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (WHO, 1999).
Child sexual abuse	Contacts or interactions between a child and an older or more knowledgeable child or adult ... when the child is being used as an object of gratification for an older child's or adult's sexual needs. These contacts or interactions are carried out against the child using force, trickery, bribes, threats or pressure" (UNICEF, 2001).
Intimate partner violence (IPV)	IPV refers to any behaviour in an intimate relationship that causes physical, sexual, or psychological harm including aggression, sexual coercion, psychological abuse and controlling behaviour (WHO, 2005). An intimate partner or relationship is defined as a person with whom an individual has a close, personal relationship that may be characterized by emotional connectedness, regular contact or sexual behaviour, identification as a couple, and cohabitation. Intimate partners may include current or former spouses, boyfriends or girlfriends, dating partners, and ongoing sexual partners (Breiding et al., 2015).
Sexual violence, partner or non-partner	Any act in which one person uses force, coercion or psychological intimidation to force another to carry out a sexual act against his or her will or participate in unwanted sexual relations (WHO, 2004).

Source: *Table of forms of VAWG adapted from Solotaroff and Pande (2014: 7-8).*

likewise, focuses on these types of violence, as defined in Table 1.

1.4 The social ecological model: Risk and protective factors

The dominant paradigm for understanding VAWG is the socio-ecological model, which posits that violence emerges from the interplay of multiple interacting factors at different levels of the social 'ecology' (Heise, 1998; 2012; Solotaroff and Pande, 2014; WHO, 2002). The ecological model has been used to help illustrate the multiple risk and protective factors across individual, relationship, family, community and societal levels. The model highlights the complex interplay of factors across and between these levels, and can therefore provide key points for prevention interventions (Heise, 1998). Significantly, this

conceptualization of violence means that different combinations of factors interact to increase the likelihood of either perpetrating violence or being a victim. The social ecological model provides the framework for the examination of risk and protective factors contained in the What Works review papers. In the case of this paper, we consider response interventions that target these risk factors. For the diagram and a full discussion of the model, please see Paper 1.

1.5 Content and structure of report

In this paper, we review interventions that are designed primarily to respond to VAWG, but which have a secondary or parallel aim of preventing VAWG or targeting key risk factors that contribute to the perpetration (by men) or the experience (by women) of VAWG. The

interventions reviewed are within the following four areas:

Police and Justice sector:

Police and security personnel training and capacity building

- Police response and advocacy
- Community policing
- Women's police stations or specialised units
- Specialised courts
- Legal interventions
- Paralegal training interventions
- Protection orders
- Alternative or restorative justice

Crisis intervention:

- Hotlines
- Immediate response and care for survivors
- One-stop centres, sexual assault centres and other women's support centres
- Shelters

Health sector:

- Screening interventions
- Health care professionals' training
- Referral and case management

Social sector:

- Counselling, therapy and psychosocial support
- Advocacy and support to access services
- Perpetrators' (batterers') programmes

The list of interventions is not exhaustive, but the paper focuses on the most common intervention areas.

The first half of the paper presents a summary of the evidence by sector. For each, we present:

- a topline summary of: (i) types of evidence;

(ii) evidence of effectiveness of intervention in reducing rates of violence and known risk factors;

- a description of the intervention type;
- a summary of the types of interventions and the extent of evidence found;
- an assessment of what the evidence suggests in terms of the effectiveness of the intervention in: (i) reducing rates of violence; (ii) reducing known risk factors for violence.

The second half of the paper discusses the findings, and presents: an overall summary of the strengths, gaps and limitations in the body of evidence; a synthesis of the overall findings; and a discussion of what this means for the prevention agenda. Finally, we present recommendations in terms of priorities for supporting innovation and conducting research in the area of response mechanisms.

An overall summary of this paper can be found at: www.whatworks.co.za.

2. Methodology

2.1 Search process and inclusion criteria

This paper is based on a rapid review of the existing evidence on the impact of interventions designed to strengthen response mechanisms in preventing VAWG. We included interventions that are designed primarily to respond to VAWG, but which have a secondary or parallel aim of preventing VAWG. The broad sectors included are: security and justice interventions; crisis intervention, health and social sector response mechanisms. The focus of the review was on the prevention of intimate partner violence, non-partner sexual violence and child abuse.

Given the limited time-frame for this work, and the large field of interventions that provide response mechanisms to VAWG, this synthesis paper largely relies on existing systematic and comprehensive reviews. The starting point

for the paper was a database developed for a 'review of reviews' of interventions to prevent VAWG, which was conducted by the Global Women's Institute (GWI) of George Washington University, and from which we identified relevant reviews and studies dating from 1998. This 'review of reviews' drew extensively from existing systematic and comprehensive reviews as well as a number of relevant individual studies and impact evaluations that were identified through academic databases and Google Scholar. Individual studies with a title that appeared to suggest the study included relevant information on response mechanisms, were identified and checked. Through this process, we selected 58 potentially relevant studies, including systematic and comprehensive reviews, and impact evaluations and program evaluations dating from 1998.

Furthermore, we searched independently for academic literature on response mechanisms, using keyword searches in Google, Google Scholar and Pubmed. We also browsed a small number of specific journal editions, dating from 2010. These were: Gender and Development, the Journal of Development Effectiveness, Journal of Development Studies, World Development, Development in Practice. The broad areas included: security and justice; social service; health sector response mechanisms; and community-level response mechanisms. These were later broken down into more specific intervention areas, as the search progressed. Through this process, a further 60 documents were identified.

We also searched for grey literature dating from 2005 (such as individual programme evaluations) by visiting the websites of bilateral and multilateral donors, the UN and other international agencies, international NGOs, and research institutes. Our search strategy was reliant on published sources, but we also sent out emails to VAWG networks, requesting sight of any unpublished materials. However, this yielded only a few additional studies and we

are aware that there are a number of program evaluations, especially qualitative evaluations that we have not been able to access for this review. A full list of search terms is available in Annexure 1; a full bibliography is attached as Annexure 2; and the tables, with summary information on studies and reviews analysed, are available on request and online.

Our inclusion criteria consisted of the following:

- **Completed** reviews or individual studies (including randomized control trials (RCTs), quasi-experimental studies, cohort evaluations, qualitative studies, pre-test and post-test designs, case studies, and expert opinions).
- Studies focusing on interventions intended to prevent violence (primary prevention) or further violence (secondary prevention).
- Studies focusing on the effectiveness of interventions in either preventing/reducing further VAWG or reducing risk factors for violence in responding to survivors' needs.
- Studies from: high-income, medium-income and low-income countries; and from development, humanitarian and conflict-affected contexts.

2.2 Assessment criteria

In order to provide a consistent rating of the evidence across the reviews, we adapted the evidence criteria from the Canadian Task Force on Preventative Health Care. We ensured that the evidence rating was broad enough to cover different sectors and intervention types (i.e. not just health) and would capture: (i) types of evidence; (ii) evidence of effectiveness of intervention. These ratings are presented at the beginning of each section for that intervention type, and are defined as indicated in Table 2 below. Further, a detailed narrative interpretation of the specific rating is provided for each intervention type.

Table 2. Quality and classifications of evidence reviewed

QUALITY OF EVIDENCE ASSESSED
I: Evidence obtained from at least one properly randomized controlled trial (RCT).
II-1: Evidence from well-designed controlled trials without randomization.
II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control.
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments could also be included in this category.
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

CLASSIFICATION OF RECOMMENDATIONS
A. There is good evidence to recommend the intervention for preventing VAWG.
B. There is fair evidence to recommend the intervention for preventing VAWG.
C. The existing evidence is conflicting and does not allow to make a recommendation for or against the intervention; however, other factors may influence decision-making.
D. There is fair evidence to conclude that the intervention is not effective in preventing VAWG.
E. There is good evidence to conclude that the intervention is not effective in preventing VAWG.
F. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

2.3 Limitations of the review

This rapid assessment of evidence is not designed to be a systematic review and is by no means exhaustive. There are a number of limitations to the review and the research evidence reviewed, i.e.:

- This paper represents a summary and analysis of the evidence from, primarily, quantitative research published in peer-reviewed journals and organizational reports, which evaluate diverse VAWG interventions from around the world. The evidence assessed here comes solely from interventions and studies that
- were found in the process of the review; it is therefore reliant upon the existence of published reviews and evaluations. We recognise that there may be many other promising interventions that are not included here, as they have not yet been evaluated or had evaluations published.
- Most interventions were developed to provide response mechanisms and services to VAWG survivors; very few have been designed with a view to preventing VAWG. Hence many evaluations have not measured overall and sustained impact on the occurrence of VAWG.

- Where impact on the occurrence of VAWG is measured, it is important to note that measurement of short-term outcomes may over-estimate effect, as many interventions require the effective operation of systems beyond the control of the intervention, in order to sustain impact over the long-term.
- Many of the evaluations and studies reviewed have methodological weaknesses, which are discussed in detail in Section 4. Where possible, we have included footnotes with brief commentary about any key methodological limitations with the studies reviewed. Many of the weaknesses apply to understanding the impacts of VAWG interventions in general, for example: small sample size; a high rate of drop out and loss to follow-up; and difficulty in developing outcome measures, particularly given the short time-frames of most studies.
- This review considers individual interventions, given that many of the studies focus on the impact of single interventions. However, many interventions are designed to be used in combination with other interventions or as part of a system. In evaluating combinations of interventions, or interventions in complex systems, it is difficult to distinguish the impact

of different components with confidence (although a multi-arm study can do this to some extent). Therefore, in some cases, an evaluation of an individual intervention really reflects a package of interventions or an intervention within a system.

- This review includes only a limited number of qualitative evaluations of interventions from NGOs and donor agencies, primarily because they are unpublished and difficult to access.
- The review is limited by the fact that we only drew upon literature published in English.
- For an in-depth discussion of methodological challenges in researching VAWG, please see Paper 1.

3. Assessment of the evidence base

3.1 Police and justice sector responses

Police and justice sector responses to VAWG training for police, specialised police units or courts, legislated tools such as protection orders or pro-active arrest policies and interventions to assist access to justice, such as paralegal services or second responder interventions.

3.1.1. Police and security personnel training and capacity building

Types of evidence	Evidence of effectiveness of intervention
II-3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline – end-line comparisons).	F. There is insufficient evidence to make a recommendation.

Description of intervention:

Training and capacity building initiatives for police and security personnel mainly aim to build knowledge, skills and capacity to respond to violence against women and girls. The objectives of the training programmes include:

- Providing information on: how and why VAWG occurs; survivors’ needs and the services available to them; and how to ensure

that survivors are not further victimised as a result of the police investigation.

- Promoting attitudinal change by building self-awareness, gender awareness, and the interpersonal skills, communication skills and life skills (e.g. stress and anger management) of police personnel.
- Developing skills to manage investigations and conduct risk reduction and prevention activities, including implementing

response protocols, investigating incidents, collecting evidence, conducting interviews, undertaking risk assessments, managing cases, etc.¹

Summary of evidence available:

Despite the widespread implementation of police training and capacity building programs (often including the objective to improve prevention of and response to VAW), there have been a limited number of studies on their impact. We identified two comprehensive reviews (Heise, 2011; Morrison et al., 2007) that looked at a wider range of interventions, but included reference to findings of evaluations on police and security personnel training and capacity building. Neither review included RCTs. Three mixed methods evaluations of police training programs in Pakistan, the Pacific Islands (Cook Islands, Kiribati, Samoa, Tonga, Vanuatu) and Honduras (Khalique et al., 2011; Turnbull, 2010; UNFPA, 2009) were also identified. It is likely that there are further evaluations of NGO-funded and perhaps even UN-funded training programmes, however these were not found online.

None of the studies identified assess the impact of training and capacity building activities on reducing violence. The Morrison et al. (2007) review cites several evaluations of training programs that aim to measure change in knowledge, attitudes and practices (KAP), through surveys administered before, immediately after, and as a six-month (or more) follow-up to training. The Heise (2011) review relies on a 2005 evaluation of training programmes on child rights for police in developing countries, which involved a desk review, an international questionnaire circulated to 67 countries and participatory evaluations of police training programmes in Ethiopia and Bangladesh (Wernham, 2005). The individual studies are also focussed on assessing the effects of interventions on the attitudes of police personnel and the development of

Training and capacity building initiatives

Pakistani NGO **Rozan's 'Rabta'** program (which began in 1999) involves providing training workshops to police personnel, in order to: raise their awareness about how gender norms affect their personal and professional levels; and build their capacity to deal more sensitively and effectively with cases of violence against women and girls.

UNICEF's Gender Sensitization and Police-friendly Project developed a training module that focused on violence against women and children involving over 500 police personnel, from the Director-General and Inspector-General to police constables in remote stations in Karnataka, India. By December 2006, over 2,800 police personnel had been trained in workshops, including 327 probationary sub-inspectors, and 754 probationary constables.

organisational capacity to respond to cases of violence against women and girls.

Effectiveness of the intervention:

Impact on VAWG reduction: None of the studies identified assess the impact of training and capacity building activities on reducing VAWG - usually because impact on occurrence of VAWG was not a defined objective of the intervention.

Impact on risk factors: There is some evidence that training programmes may be able to bring about positive changes in the attitude and behaviour of police and security personnel towards women and girl survivors of violence, and that as a result, they may have increased credibility among survivors (Khalique et al., 2010; UNFPA, 2009).

¹Security Knowledge Module-Endvawnoworg: <http://www.endvawnoworg/en/articles/1078?set=clearobjectivesfordifferenttypesoftraininghtml?next>

Issues emerging from the evidence base:

Implementation weaknesses are the key factors affecting outcomes of training programmes and, as a result, many training programmes do not achieve even narrow training objectives. Heise (2011) argues that police training initiatives are often undertaken as ‘one-off’ events, rather than being institutionalised in police training colleges and on national police training curricula, and that there are usually no refresher training sessions or follow-up (Heise, 2011; Khalique et al., 2010). This is particularly problematic, as police personnel change postings frequently. This finding is echoed by an evaluation of a police training program in Pakistan (Khalique et al., 2010). Programs are often delivered by people who lack first-hand knowledge of police culture and who are thus “more likely to be temporarily tolerated and indulged rather than treated as legitimate agents of long-term change” (Heise, 2011). Lessons learned are that:

- i. Training initiatives must have strong ownership from senior police officials –

personnel at all levels (including senior police officials as well as decision-makers) should receive training.

- ii. Training must be linked to institutional change to be sustainable, for example through: embedding the issues in policies, procedures and manuals, as well as a standard curriculum that is provided to new recruits; and as part of in-service training at a police training college or equivalent.
- iii. Training should aim to build trust between participants and trainers, by starting with less sensitive issues, and gradually introducing topics on gender inequality and violence perpetrated by personnel.
- iv. Police personnel should be involved as trainers – because they understand the practical realities of police work and are likely to have greater credibility. An ideal team would include individuals with complementary knowledge and skills, for example combining police personnel with NGO, social welfare and child rights trainers.

3.1.2. Pro-active arrest policies

Types of evidence	Evidence of effectiveness of intervention
I: Evidence obtained from at least one properly randomized controlled trial.	C. The existing evidence is conflicting and does not allow for a recommendation to be made for or against the intervention.

Description of intervention:

Proactive arrest policies are based on laws that empower the police to make arrests in cases of previously-reported domestic violence, either: without a warrant; or with a pre-issued, but not served, warrant. These laws could include mandatory arrest policies which require police to make an arrest if they believe domestic violence has occurred, or preferred arrest laws which instruct them that arrest is the preferred response (Hirschel et al., 2007). These policies emerged in high-income countries in the 1980s in response to the recognition

legislative change to criminalise violence was not sufficient to address domestic violence (Heise, 2011).

Summary of evidence available:

Three comprehensive reviews (Chesney-Lind, 2002; Goodmark, 2004; and Heise, 2011) on a range of police response and advocacy interventions including pro-active arrest policies were identified. The Heise review cites four studies, the last of which re-pooled and analysed the data from the earlier three. The Chesney-Lind study looks at the impact

of mandatory arrest policies on the arrests of women and girls. Heise (2011) points out that assessing interventions that are part of complex justice systems presents various methodological challenges, which could affect whether studies are able to register an impact on individual procedures or policies.

Effectiveness of the intervention:

Impact on VAWG reduction: There is some evidence that pro-active arrest policies may have a modest effect on preventing violence perpetration amongst some men - especially those who are first-time domestic violence offenders with no other criminal history. However, it is unclear if proactive arrest policies are more effective in preventing violence than other police responses, such as issuing warnings, providing counselling, or separating couples (Garner et al., 1995; Fagan and Brown, 1984, cited in Heise, 2011).

Heise (2011) cites the 1984 Sherman and Berk experiment that took place in Minneapolis in the US: it found that arresting perpetrators of domestic violence cut the risk of future violence assaults by half over a six month follow-on period, compared with the strategies of separating couples or advising them to seek help. Subsequent studies aiming to replicate that study found that, on average, arrest was no more effective than other police responses, such as issuing warnings, providing counselling, or separating couples (Garner et al., 1995; Fagan and Brown, 1984, cited in Heise, 2011). However, analysis of Garner et al study showed that arrest reduced repeated violence amongst men who were married, employed and living in communities with low unemployment. Equally, it found that, in some cities, arrest actually increased violence among men who were unmarried, unemployed and living in areas of high employment. This led some researchers to argue that arrest might only be effective with men with “a high stake in conformity” (Sherman et al, 1992; Pate and Hamilton, 1992, cited in Heise, 2011).

Heise (2011) cites a 2001 analysis of the data from these studies on pro-active arrests, which found that arrest policies reduced violence by: 30 percent, according to victim reports; but by a much smaller percentage, for the same individual, when measured by police reports. Critically, the study noted that regardless of whether or not they were arrested, more than half the men did not assault their partner again during the follow-up period. Most cases of domestic violence reported to the police are perpetrated by a very small group of men who are repeat offenders – most likely men with a history of arrest for other crimes – and these interventions do not appear to have much, if any, impact on them. One study from the United States found that “8% of women accounted for more than 82% of the 9,000 separate incidents of domestic violence that were recorded over 6 months.” (Maxwell et al. 2001, cited in Heise, 2011: 78). However, even if potentially not very effective, none of the research suggests that proactive arrest policies are harmful or increase women’s exposure to violence.

Impact on risk/protective factors: The Goodmark (2004) review found evidence that arrest rates in the District of Columbia in the US increased from 5 percent in 1990 to 41 percent in 1996 once the mandatory arrest law was introduced (Epstein, 2003, cited in Goodmark, 2004). Mandatory arrest laws also led to a greater number of cases being brought before prosecutors. However, prosecutors often found that women were reluctant to testify, because they did not want to see legal sanctions brought against their partner, they did not trust the justice system, or they feared reprisal. It was feared that this would affect the motivation of police personnel to observe the mandatory arrest law. In the 1980s, this led to the adoption of ‘no drop’ policies in San Diego and Duluth in the US.

3.1.3. Mandatory reporting

Types of evidence	Evidence of effectiveness of intervention
II-3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline – end-line comparisons).	D. There is fair evidence to recommend against this type of intervention: the intervention may increase arrests, however, this is outweighed by the unintended negative consequences, including increased risk to survivors.

Description of intervention:

Mandatory reporting is a legal provision requiring healthcare workers, or other professionals (e.g. social workers), who learn that a person is experiencing domestic violence, to report it to the police.

Summary of evidence available:

None of the studies assess the impact of mandatory reporting on rates of violence. Instead, they focus on the extent to which reporting leads to police dispatches, referral to support services and/ or understanding the perspective of women and healthcare providers. We found one comprehensive review (WHO, 2013) that includes 23 studies on mandatory reporting policies. One study aimed to assess changes in police dispatches, six focussed on the perspectives of healthcare providers, and 17 focussed on the views of women (one through a survey). Three individual studies were also identified: Gielen et al., (2000); Rodriguez et al., 2001; Malecha et al. (2004). The Gielen et al. (2000) study is a RCT; the Rodriguez et al. (2001) study adopted a non-randomised controlled trial approach.

Effectiveness of the intervention:

Impact on VAWG reduction: Mandatory arrest policies have been shown to increase the likelihood of arrest in the US, as well as cases brought into the criminal justice system and to the attention of prosecutors, but there is no evidence that it has an impact on rates of violence. Prosecutors have often found that survivors who are coerced into bringing a case to the police are reluctant to testify (Epstein

2003, cited in Goodmark, 2004), due to: not wanting to use the legal system against their partners, mistrust of the judicial system, or fear that perpetrators may become more violent as a consequence of the reporting.

There is also evidence that some perpetrators may become more violent after arrest or prosecution, especially those who are unmarried and unemployed (Sherman et al., 1992; Pate and Hamilton, 1992). Two reviews of mandatory arrest policies in the US found that they can have unintended negative consequences for women and girls, particularly if a woman is also arrested for committing a violent act in self-defence (Chesney-Lind, 2002; Goodmark, 2004).

Some studies have found that fear of negative consequences may discourage women from disclosing domestic violence to healthcare providers that have a mandatory reporting policy (Gielen, 2000; Rodriguez et al., 2001; WHO, 2013). Research findings are conflicting as to whether a majority of abused women support mandatory reporting. For example, Rodriguez et al., 2001 finds a majority of women in favour of mandatory reporting, but in several studies, abused women have indicated a fear of being at greater risk of abuse following a mandatory report (Malecha et al., 2000). The Rodriguez et al. (2001) study also found that 44.3 percent of abused women opposed mandatory reporting, with those who were currently seeing or living with their partners, non-English speakers, and those who had experienced physical or sexual abuse within the last year being more likely to oppose mandatory reporting. The WHO review (2013) concluded that mandatory reporting

should not be undertaken, as it undermines women’s autonomy and decision-making and may place them at risk. This review also highlights that further research is needed on how health services that are aimed at women suffering partner violence can be effectively linked with child protection services and the police.

Impact on risk/protective factors: The focus of this type of intervention is on arrest and therefore there is little reported on the impact of risk factors for violence

3.1.4. Protection orders

Types of evidence	Evidence of effectiveness of intervention
II–3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline – end-line comparisons).	B. There is fair evidence to recommend the intervention, although violence does not always stop after a protection order is issued. There are also risks to women’s autonomy and choice that should be considered.

Description of intervention:

Protection orders (also known as restraining orders) against domestic violence perpetrators are injunctions designed to protect women in the aftermath of a domestic violence incident. They can be initiated by women themselves (rather than the police or justice system), and can be granted on limited evidence, as an emergency measure and made permanent after a hearing. In the Philippines, barangay (community) officials in Panang can grant ‘barangay protection orders’ that are valid for 15 days. In the UK and Indonesia, police can issue temporary protection orders or notices directly, until a court issues a permanent one (Heise, 2011; Kelly et al., 2013). Protection orders can include specific conditions, such as: barring or removing perpetrators from the home, preventing the perpetrator from coming within a certain distance of the survivor, establishing temporary custody arrangements for children, and confiscating weapons. If a man violates a protection order, he can be arrested or held in contempt of court (Heise, 2011; Kelly et al., 2013). According to data from the National Institute of Justice (2000), 20 percent of the two million US women who experience physical abuse, rape or being stalked by their partners every year, obtained a protection order (Holt et al., 2003).

Summary of evidence available:

Most of the research on protection orders focusses on high-income countries. Heise (2011) identifies the dearth of evaluations from non-Western/ low-income countries about the effectiveness of protection orders on reducing VAWG as a critical gap. The evidence on protection orders comes mainly from two comprehensive reviews covering civil law remedies (Goodmark, 2004; Heise, 2011). The Heise review includes four studies from the US, and one review of 32 studies. Three individual studies from the US, UK and South Africa were also identified. Two of these (Kelly et al., 2013; Mathews & Abrahams, 2001) used police records and court records (one with a pre/ post design, the other using a case matching comparison approach), supplemented with qualitative approaches, in order to assess changes in levels and types of violence once a protection order intervention had been introduced. The third study (Cesario et al., 2014) focusses on the experiences of immigrant women in the US, using a cohort study approach to assess the impact of shelter and protection order interventions on their mental health, and that of their children.

Effectiveness of the intervention

Impact on VAWG reduction: There is some evidence that protection orders reduce violence for some survivors some of the time (i.e. a lower number of incidents), but that levels of violence post-protection order still remain relatively high. Heise (2011) cited four studies from the United States, which report rates of re-abuse of 23 percent to 70 percent (McFarlane et al., 2004; Holt et al., 2003; Carlson et al., 1999; and Logan and Walker, 2010, cited in Heise, 2011). Heise (2011) cites a further review study done on 32 studies, which found that, on average, 40 percent of protection orders are violated (Spitzberg, 2002, cited in Heise, 2011).

A 2013 study of a pilot of Domestic Violence Protection Orders (DVPO) in the UK used a case matching approach to assess the effect of DVPOs in 289 cases on the recurrence of violence (Kelly et al., 2013). It found that, on average, there were 2.6 fewer repeat incidents of domestic violence in cases where the DVPO was applied, compared to 1.6 fewer incidents where no further action was taken after arrest, i.e. an additional reduction of one incident of domestic violence per survivor. The follow-up period ranged from nine to 19 months. Protection orders appeared to be most effective in reducing re-offending in more chronic cases (where there had been three or more previous domestic violence incidents involving police attendance).

A study from South Africa found that protection orders were only finalised/taken into effect in about half of cases where temporary protection orders had been granted (Mathews

and Abrahams, 2001). Whilst men could be arrested for violations of protection orders, they were rapidly released and many women feared for their safety. Some reported that the impact of protection orders was short-term and others mentioned a shift to emotional abuse. Protection orders are hard to implement in low-income and middle-income settings, where options for independent residence are limited due to economic and socio-cultural constraints.

Impact on risk/protective factors: Some studies have found evidence of improved psychological outcomes for women who have been granted protection orders. For example, one US study (Logan and Walker, 2009 in Heise (2011)) found that the majority of women – even those who experienced violations of their protection orders – reported feeling “safer” with the order, with 75 percent saying that the order was either “extremely” (51 percent) or “fairly” (27 percent) effective at addressing the abuse. Most of the women beneficiaries of the Domestic Violence Protection Orders (DVPO) pilot in the UK said they felt safer, and reported that DVPOs provided them with time and space to consider their options. Another 2013 cohort study of 106 abused immigrant mothers in the US who accessed shelter or justice services found large improvements in the women’s mental health, resiliency, and safety, regardless of whether or not a protection order was issued. A similar finding was made for child functioning (Cesario et al., 2014). Ko (2002), cited in Goodmark (2004) argues that protection orders “interrupt the pattern of domination and control by directly restructuring the relationship level between the victim and abuser” (p.11).

²This involved matching DVPO cases to other domestic violence cases in the pilot areas where DVPOs could have been used but were not (i.e. no further action was taken) controlling for variations between cases

3.1.5. Second responder programmes

Types of evidence	Evidence of effectiveness of intervention
I: Evidence obtained from at least one properly randomized controlled trial.	C. The existing evidence is conflicting and does not allow for a recommendation to be made for or against the intervention; however, there is some indication that this type of intervention can lead to an increase in violence in some circumstances.

Description of the intervention:

Second responder programmes entail a follow-up visit (after the initial police response to domestic violence) - usually by a specially trained domestic violence police officer and a civilian domestic violence advocate. "The purpose of the intervention is to reduce the likelihood of a new offense by helping victims to understand the cyclical nature of family violence, develop a safety plan, obtain a restraining order, increase their knowledge about legal rights and options, and provide shelter placement or other relocation assistance" (Davis et al., 2008). If he is present, the responders may also warn the perpetrator of the consequences of further violence. A secondary aim is to support survivors to become more independent by providing them with counselling, skills training, public assistance and referral to other social services. These programmes have been used in the US and New Zealand.

Summary of evidence available:

The authors of a systematic review focussing on second responder programmes argue that there has been a significant increase in research on second responder programmes, and generally that this has been of high quality (Davis et al., 2008). There are also three comprehensive reviews (WHO review, 2013; Heise, 2011; Fisher, 2004) on a range of police response and advocacy interventions, including second responder programmes. Half of the ten studies included in the Davis et al. (2008) review were RCTs and most had a large

sample size. One individual quasi-experimental cohort study (non-randomised controlled) (Hovell et al., 2006) was also found.

Effectiveness of the intervention:

Impact on VAWG reduction: There is conflicting evidence about whether second responder programs lead to increased violence. Davis et al. (2008) found that programmes slightly increase the willingness of survivors to report incidents to the police, possibly as a result of greater confidence in the police. However, a study from one second responder programme implemented in New York (which included a public education component as well as a home visit) finds that this resulted in greater violence – as reported to the police, as well as in victim surveys (Davis et al., 2006). The Hovell et al. (2006) study – a quasi-experimental comparison study from the US - found that the treatment group was 1.7 more likely to experience violence than the control group. However, the authors acknowledge that they were unable to control for the variance in the social services provided, and also hypothesise that the intervention may have increased reporting of violence amongst the intervention group.

Impact on risk/ protective factors: A comparison study of women receiving second responder services in New Zealand finds that these women had more positive views about their interaction with police officials than control subjects did (Fisher, 2004); however, the impact on increased reporting or rates of violence was not measured.

3.1.6. Sex offender policies and disruption plans

Types of evidence	Evidence of effectiveness of intervention
II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies.	F: There is insufficient evidence (in quantity or quality) to make a recommendation.

Description of intervention:

Sex offender policies stipulate that sexual offenders should be recorded on a register and barred from having contact with children. This is done by vetting people who work with children across a range of settings from schools and playgroups to foster parents. Additional strategies used against known sexual offenders include home confinement, electronic monitoring and residence restrictions (Levenson and D’Amora, 2007).

Disruption plans use information about suspected perpetrators to ‘disrupt’ abuse attempts without involving the child through a range of activities. Specific strategies are dependent on the type of behaviour and the evidence available, but could include: observation of risky adults’ activities; formal warnings within legislative frameworks; application of protection orders; and investigation of other offences relating, for example to immigration and money laundering offences (Radford et al., 2014).

Risk assessment strategies estimate the likelihood that a convicted sexual offender will re-offend on the basis of identified risk factors associated with recidivism – have also been developed by researchers (Radford et al., 2014). These can enable police to identify those at highest risk of offending, and on whom the more intensive measures and supervision should be focussed. However these strategies have yet to be integrated into policy and programming initiatives.

Summary of evidence available:

We identified two comprehensive reviews of sex offender policies and disruption plans (Levenson and D’Amora, 2007; Radford et al., 2014); Levenson and D’Amora, (2007) argue there is limited research on sex offender management policies, and a need for large-scale, systematic investigations (Levenson and D’Amora, 2007). Most of the studies in the reviews are cohort studies aiming to understand the impact of sex offender policies on recidivism by comparing outcomes for cohorts of sex offenders released before notifications schemes were put in place, and those released afterwards.

Radford et al. (2014) highlights the lack of evidence on child sexual abuse response interventions in low- and middle-income countries. Given that the effectiveness of specific response interventions depends on a great extent on the wider child protection system, more contextualised evidence is needed before interventions that have been proven in HICs can be implemented in LICs.

Effectiveness of the intervention:

Impact on VAWG reduction: There is little evidence that registration as a sex offender or community notification reduces recidivism by sexual offenders (Zevitz, 2006, Walker et al., 2005, Adkins et al., 2000, and Schram and Milloy, 1995, all cited in Levenson and D’Amora, 2007). A recent comparison group study from the US found that registration as a sex offender does not predict whether or not a sex offender re-offends (Tewkesbury et al. 2012, cited in Radford, 2014). Several studies have also looked

at the impact of electronic monitoring on recidivism, finding no difference from offenders under close supervision (Bonta et al., 2000, cited in Levenson and D’Amora, 2007).

Key informant interview³ research from the UK found that informants strongly supported disruption plans when there was a coordinated and proactive multi-agency approach (Jago and Pearce, 2008). However, there is no other evidence of their effectiveness. Radford et al. (2014) also highlight that they may be difficult to implement in low resource settings, particularly as they depend on the availability of special sex offender orders, which may be difficult to support. Police personnel have noted a concern that their staff and financial resources may not be sufficient for notification activities (Caputo, 2001; Caputo & Brodsky, 2004; Malesky & Keim, 2001; Matson & Lieb, 1996; Zevitz, Crim & Farkas, 2000a, 2000b, cited in Levenson and d’Amora, 2007).

There is evidence that registration and notification can have adverse consequences

for sex offenders and impact their rehabilitation (Levenson and Cotter, 2005, Tewksbury, 2005, Tewkesbury et al., 2012, Zevitz et al., 2000 - all cited in Radford, 2014). Evidence from the US shows that significant numbers of sex offenders have been subject to the loss of homes and jobs, harassment, property damage, and to a lesser extent, physical assault, and harm to family members. Some researchers have thus argued that targeted sex offender registration and notification on a case by case basis may be a better policy option (Tewkesbury et al., 2012, cited in Radford, 2014).

Impact on risk/ protective factors: Levenson and D’Amora (2007) cite various studies that focus on the impact of notification a wider set of stakeholders. Some studies have found that notification leads to greater anxiety amongst community members because they don’t know how to protect themselves. Conversely, mental health professionals have also warned that registration could create a false sense of security for parents.

3.1.7. Community policing

Types of evidence	Evidence of effectiveness of intervention
II-3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline – end-line comparisons).	F. There is insufficient evidence to make a recommendation.

Description of the intervention:

There is no clear definition of the term ‘community policing’, but it usually involves police departments organising their management, structure, personnel, and information systems in a way that supports community-level partnerships with women’s advocates, healthcare providers, community groups and members, traditional and community leaders, NGOs and CBOs, private businesses, and the local media and enables

joint and proactive problem-solving focused on survivor safety.⁴

Summary of evidence available:

Two studies on community policing (Giacomazzi et al., 2001; Robinson & Chandek, 2000), both from the US were identified. Neither of these studies assessed the impact of interventions on preventing violence – the Giacomazzi study assesses the organisational effectiveness of an interagency

³The methodology included a small-scale literature review and interviews with key personnel in twenty Local Safeguarding Children Boards (LSCB) areas to explore models and approaches to the prosecution of offenders.

⁴(Robinson and Chandek, 2000); Security Knowledge Module, Endvawnow.org: <http://www.endvawnow.org/en/articles/1095-community-based-policing.html>

The Parivartan Community Policing Programme, India

The Parivartan Programme involves women police officers in community sensitization in poor areas of Delhi. The activities included pantomimes, door-to-door campaigns, and distribution of literature on rape and domestic violence, as well as self-defence programmes, the formation of women's safety committees, and sensitization of male police officers. For the impacts of the programme, see below.

Source: *Parivartan case study, Security Knowledge Module, Endvawnnow.org*:

http://www.endvawnnow.org/uploads/browser/files/security_parivartan_case_study.pdf

co-ordination initiative in an unnamed city in the south-western US, in developing and implementing responses to violence against women. The Robinson & Chandek (2000) study assesses whether community policing officers are more effective in securing survivor participation in the investigation of cases. Both studies used comparison methodologies.

Robinson & Chandek (2000) argue that the lack of clarity regarding the definition of community policing – “a conveniently elastic term which is often loosely used to accommodate virtually any policing activity” (Weatheritt, 1987, cited in Robinson et al., 2000) – means that it can be difficult to differentiate community and traditional policing practices.

Effectiveness of the intervention:

Impact on VAWG reduction: The impact of community policing on reducing VAW has not been studied. There is no evidence that community policing encourages greater engagement by survivors in the criminal justice process, or greater collaboration between police and community actors. A 2000 study that looked at whether police personnel operating under a community policing mandate were able to secure higher victim participation in the criminal justice process, found that there was no effect, and that situational factors were most strongly influential on victim participation

(Robinson and Chandek, 2000).

Impact on risk/ protective factors: There is anecdotal evidence that community policing improves police-community engagement. A qualitative study of New Delhi Police's Parivartan programme concluded that it led to greater engagement of community women and information exchange with police officers. The programme included women police officers forming women safety committees, conducting door-to-door awareness campaigns and distributing safety literature on rape and domestic violence in low-income areas of the city. This also improved the intelligence available to women police officers to inform their crime prevention efforts, which was important as female officers often respond to sexual assaults cases.⁵

⁵Parivartan case study- Security Knowledge Module- Endvawnnow.org: http://www.endvawnnow.org/uploads/browser/files/security_parivartan_case_study.pdf

3.1.8. Women’s police stations or specialised response units

Types of evidence	Evidence of effectiveness of intervention
III: Qualitative studies, ethnographies	F. There is insufficient evidence to make a recommendation

Description of the intervention:

Women’s police stations (WPS) are somewhat of a misnomer. They are generally police units that serve (predominantly) women, are usually staffed by female police personnel (but not exclusively), and they provide specialised services to women survivors of domestic or sexual violence. They usually raise awareness and receive complaints; provide support in accessing healthcare, counselling and financial assistance; and help in initiating legal action, for example getting protection orders.

Summary of evidence available:

No studies were found that measured the impact of women’s police stations on the occurrence of violence. Most of the studies found focused on understanding women’s experience of accessing women’s police stations. Two comprehensive reviews were identified that refer to WPS briefly (Heise, 2011; Morrison et al., 2007). The Heise 2011 review relies predominantly on a mixed methods evaluation of WPS in Brazil, Ecuador, Nicaragua and Peru which aims to understand the ‘lived experiences’ of women accessing WPS. The Jubb et al. (2010) study argues that more research on the impact of WPS on preventing violence is needed. One qualitative study on the effectiveness of all-women police units in Tamil Nadu, India on dowry-related issues (Natarajan, 2005) was also identified.

Effectiveness of the intervention:

Impact on VAWG reduction: No studies found directly measured the impact of women’s police stations on the occurrence of violence. There is

The evolution of Women’s Police Stations

First established in Brazil in 1985, Women’s Police Stations spread to Ecuador, Nicaragua and Peru as the first state responses to the passing of legislation on violence against women in those countries. They have since been widely replicated across Latin America, and in other countries, including Ghana, India, Kosovo, Liberia, the Philippines, Sierra Leone, South Africa (where they are not women-only) and Uganda. In Brazil alone, there are 475 stations. The models of WPS vary between countries and have In Ecuador, Sierra Leone, and Peru, they are authorised to respond to domestic violence only. In Argentina, Brazil, South Africa and Nicaragua, the stations also handle complaints of non-spousal violence. In most countries they are part of the police, but in Ecuador they are justice administration units, and in addition to receiving and investigating cases, can also give verdicts and order protection measures.

Source: *Security Knowledge Module, Endvawnow.org: <http://www.endvawnow.org/en/articles/1093-womens-police-stations-units.html>*

also no evidence that they guarantee timely and effective access to justice for women, and punishment for perpetrators.

A 2005 study on WPS in Tamil Nadu, which included interviews with 60 dowry victims⁶, found that half of the women interviewed indicated that partner violence had decreased, with most believing that this was due to the

⁶The sample was randomly selected from a pool of 474 survivors whose case records were also analysed for the study.

intervention by the women police. However, 5 percent reported that the intervention aggravated the situation. The study argued: "In many ways, the all-women police units (AWPUs) act as a surrogate village "Panchayat" with the important difference that women police are in charge of resolving the dispute and they often serve as advocates for the women" (Natarajan, 2005: 102).

Impact on risk/ protective factors: There is some evidence that WPS increase reporting of abuse,

as well as women's access to care services (Morrison et al., 2007). Heise (2011) and Jubb et al. (2010) argue that their effectiveness lies in the provision of an entry point to the justice system. WPS in some settings successfully raised awareness of VAW, portraying it as 'a public, collective, and punishable matter' (Jubb et al., 2010), as well as increasing women's access to security and justice measures and referral services, and improving their knowledge and exercise of their rights.

3.1.9. Specialised courts

Types of evidence	Evidence of effectiveness of intervention
II-3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline – end-line comparisons).	F. There is insufficient evidence to make a recommendation.

Description of the intervention:

Specialist courts, for example sexual offences courts, seek to either 'cluster' or 'fast track' cases of violence against women. They aim to improve the conviction rate, as well as the experience of survivors and their families, the effectiveness of the court system in protecting women, increased co-ordination with other justice sector actors, and a reduction in delays and rates of victimisation (Cook et al., 2004). Sexual offences courts have operated in South Africa and Liberia. (South Africa Department of Justice and Constitutional Development, 2013) Specialist domestic violence courts have operated in parts of the United States, Canada and the UK for over ten years. In conflict and humanitarian crises specialised legal courts, prosecution units/tribunals; indictments via the International Criminal Court may also be established (Spangaro, 2013; IDLO, 2013).

Summary of evidence available:

Overall, there is limited evidence (in quantity or quality) of the impact of specialist courts on reducing violence against women. There

are only a few published process or outcome evaluation studies on specialist courts. We identified one systematic review (Spangaro et al., 2013), and three individual studies (Cook et al., 2004; Gover et al., 2003; and Sadan et al., 2001). Of these, one of these (Gover et al., 2003) used a quantitative (non-randomised) methodology. Most of the studies in the Spangaro review focus on Rwanda and countries from the former Yugoslavia as the sites of specialist tribunals on sexual violence in conflict. Otherwise, most studies focus on specialised courts in urban areas in high-income countries. Three studies (IRC, 2012; Sotirovic, 2012; Wells, 2005) covering interventions implemented in Tanzania, and the International Criminal Tribunals of Rwanda and the former Yugoslavia were also identified.

Some of the studies highlight various methodological challenges, including: a wide variation in court size and the volume of cases handled; where evaluations seek to compare results 'before' and 'after', a lack of equally comparable baseline data from all courts; and where evaluations have used 'control court(s)', a lack of appropriate and comparable data (Cook et al., 2004; Sadan et al., 2001).

Effectiveness of the intervention:

Impact on VAWG reduction: Specialised courts have not generally been evaluated for their impact in reducing violence against women and evidence is very limited. For example, Spangaro et al. (2013) found no evidence that specialist courts were associated with reduced risk or incidence as most studies did not set out to specifically measure this. Some of the studies reviewed indicated increased risk of violence to survivor witnesses. While one study found that women felt that their risk of further violence was reduced by participating in a process in which sexual violence was highlighted as being wrong, and perpetrators were held accountable (Mischowski and Mlinarevic, 2009, cited in Spangaro et al., 2013), other studies found that women were subject to retaliation, lack of protection, ostracism and stigma (Brouneus, 2008; Nowrojee, 2005, both cited in Spangaro et al., 2013). There was further evidence that survivors can find the process of testifying traumatic (Denov, 2006, cited in Spangaro et al., 2013).

Impact on risk/ protective factors: There are some indications of positive impact on access to justice for survivors. An evaluation of a specialised domestic violence court in South Carolina, US, using interrupted time series analysis, found significantly lower rates of re-arrest among defendants processed through the specialised court (Gover et al., 2003). Similarly a pilot assessment of the Sexual Offences Court in South Africa found conviction rates of 65 percent in 1999 in the specialised courts, which was nearly twice that of other courts (Sadan et al., 2001). Evidence from a mixed-method evaluation of five models of specialist domestic violence courts or fast track systems in England and Wales identified three key positive effects: (1) enhanced effectiveness of court and support services for victims; (2) improved advocacy and information-sharing; and (3) increased levels of victim participation and satisfaction, and thus increased public confidence in the criminal justice system (Cook et al., 2004).

3.1.10. Paralegal programmes

Types of evidence	Evidence of effectiveness of intervention
I: Evidence obtained from at least one properly randomized controlled trial.	C. There is insufficient evidence (in quantity or quality) to make a recommendation (but some promising indications of positive impacts).

Description of the intervention:

Paralegal programmes usually focus on developing, training and institutionalising the work of community-based paralegals, whether in post-conflict, transitional or developing countries. Paralegals usually live and work in the communities they serve and use their knowledge of the formal justice system (and sometimes alternative mechanisms - see next section) to assist women in pursuing legal cases after experiencing abuse. In addition, other community-based legal interventions (which

may or may not be implemented alongside or by paralegals) offer legal education and legal aid services to women (IDLO, 2013).

Summary of evidence available:

Five individual studies (Bell and Goodman, 2001; Campbell, 2006; Chibuta, 2011; Hester and Westmarland, 2005; and Weisz, 1999) were identified. Only the Bell and Goodman (2001) study – a RCT study – was aimed at understanding the effectiveness of paralegal interventions in reducing abuse (amongst

other outcomes). The other studies, which include quasi-experimental studies and mixed methods evaluations, were focussed on understanding the impact on women's awareness of legal processes, and their access to justice services.

Effectiveness of the intervention:

Impact on VAWG reduction: There is some evidence that training advocates/paralegals to support women in accessing the legal system can reduce short term re-abuse. A RCT of a legal advocacy programme in the US, which trained law school students to work intensively with women seeking protection orders, found that women in the treatment group reported significantly less physical and psychological re-abuse and marginally better emotional support in comparison to women in the control group - at six week follow-up (Bell and Goodman, 2001).

Impact on risk/ protective factors: There is also some evidence that training advocates/paralegals to support women in accessing the legal system can increase women's access to justice. Testimonies from women and girls gathered for an evaluation⁷ of an Access to Justice programme for refugee communities in Tanzania indicated that the training of paralegals and establishing paralegals units had made it easier for them to access legal services than before (Chibuta, 2011). An evaluation⁸ of 27 domestic violence projects implemented across the UK in 2000 onwards found that an increased number of women reported domestic violence to the police when they were supported through legal advocacy, with women finding it particularly useful when they were accompanied to court. Providing targeted legal support to black and ethnic minority women increased their engagement with the criminal justice system; however, one study also found a 'patchy' police response (Hester and

Women's paralegal committees in Nepal

From 2010-12, DFID, through UNICEF Nepal, funded the Women's Paralegal Committees programme, which supported the formation of women's paralegal committees within Village Development Committees (VDCs). The programme's four main components included: promoting legal awareness; providing alternative dispute resolution for simple cases; providing referral to formal and informal justice and social service providers; and early detection of cases and protection of individuals at risk.

Source: *DFID Nepal cited in DFID (2013) Addressing Violence Against Women and Girls through Security and Justice Programming*

Westmarland, 2005). A 1999 qualitative study⁹ of a mandatory arrest/ no drop prosecution/ treatment programme/ and outreach package found that advocates were more effective at providing information to survivors than the police due to their empathic and empowering approach (Weisz, 1999).

Morrison et al. (2007), however, highlight evidence that indicates that survivors' access to justice cannot be achieved without broad reform of the judicial system, in order to address issues of corruption, procedural delays, lack of transparency and the lack of a formal judicial presence in poor and rural settings. In other words, community-based legal programmes need to connect women to a justice system that actually functions to investigate and prosecute their cases.

⁷The evaluation collected qualitative and quantitative data through key informant interviews, focus group discussions, field observation, and collecting case studies and testimonials.

⁸A RCT was considered unethical and so other forms of comparison were used as appropriate including using baselines to measure change over time from and/or by comparing one intervention or one context with another.

⁹Based on open-ended interview and focus group discussions with survivors and advocates.

3.1.11. Alternative and restorative justice mechanisms

Types of evidence	Evidence of effectiveness of intervention
II-3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline – end-line comparisons).	F. There is insufficient evidence to support these types of interventions. The evidence comes mostly from very small studies and high-income countries. Most studies indicate that, in order for them to be effective, individual-level and system-level conditions need to be in place. The literature also highlights important risks to women.

Description of the intervention:

‘Alternative’ justice and dispute resolution mechanisms are terms used to refer to a wide range of activities and systems. Essentially, these are legal, mediation or arbitration processes that occur parallel to or instead of a mainstream legal system (particularly when the latter is weak and ineffective). They are often considered to be alternatives to the failures of the formal justice system where victims can be excluded from proceedings and where the court is more focussed on the potential harm to society rather than compensating the individual for the particular harm suffered. There is evidence from countries such as Afghanistan, for example, that women prefer informal justice systems, because they believe them to be more effective and efficient.

The relationship between formal and alternative mechanisms varies in practice. A country like South Africa¹⁰ has a parallel system of informal traditional courts that have limited jurisdiction, both geographically and in terms of the types of cases that may be heard in them (which may include domestic violence cases, but not sexual offence cases). Other countries may have a second system that is based on religious law. In some settings, restorative justice is an adjunct to the legal system. Alternative justice systems are generally not appropriate for very severe offences. In countries where alternative systems have been most evaluated, they are used in a manner that is akin to a diversion

program for offences that would be unlikely to gain a conviction or a custodial sentence in a normal court.

While the literature is often unclear on the different types of alternative or restorative justice, it is important to distinguish between the following broad categories of alternative mechanisms:

Informal justice mechanisms are centred on the role of particular community leaders or decision-makers, who are chosen by the community within which the mechanism is located. These leaders may preside in a court-like setting, or other venue – such as a community gathering place or a private home. The wider community may also play a role in making and enforcing the decision.¹¹

Restorative justice is receiving increasing attention in cases of domestic violence (in part as a response to women’s preferences). Although there is no agreed definition of restorative justice, the aims tend to include bringing together key stakeholders, in a face-to-face meeting, to collectively decide on its resolution, with a view to parties voicing their experiences and feelings. Restorative justice has taken various forms in different countries, e.g.: the conferencing model in New Zealand and Australia; dispute resolution models in the US; sentencing circles in Canada; citizen panels in the US and Canada; and victim-offender mediation in the US, UK and Germany (Hudson, 2002).

¹⁰A constitutional democracy with a conventional legal system based on Roman Dutch law.

¹¹Security Knowledge Module, Endvawnnow.org: <http://www.endvawnnow.org/en/articles/881-informal-justice-mechanisms.html>

Hybrid mechanisms have both formal and informal attributes. They may have started off as community-based mechanisms, but have gradually become integrated into the formal justice system, for example: the local 'resistance' courts in Uganda, which are now Local Council Courts; courts that integrate indigenous case resolution mechanisms, such as in the US and Canada; and the gacaca courts in Rwanda.

There is fierce and ongoing debate about whether or not restorative justice is appropriate for cases of violence against women, and the UN and Council of Europe prohibit member states from using mediation in VAW cases. However, restorative justice approaches have been tried in Canada, Europe, New Zealand and Australia, as well as in India and Africa. It is important to note that restorative justice can also be implemented in the formal justice sector.

Summary of evidence available:

We identified 12 comprehensive reviews that cover informal and restorative justice (IDLO, 2013; Gavrielides and Artinopoulou, 2013; Burgess, 2012; Heise, 2011; Stubbs, 2007; Cameron, 2006; Curtis-Fawley and Daly, 2005; Goel, 2005; Hopkins, 2004; Grauwiler, 2004; Hudson, 2002; Krieger, 2002; Koss, 2000). In addition, we reviewed four individual studies on restorative justice (Coker, 2006; Daly, 2006; Hopkins and Koss, 2005; and Koss et al., 2003).

Most of the studies focus on restorative justice approaches in high-income countries, rather than informal/ traditional/ customary justice mechanisms in low-income countries. There are also methodological challenges with some studies. The few studies on restorative justice that do exist are based on small samples, and do not take a long-term approach, which could provide solid conclusions (Gavrielides and Artinopoulou, 2013). The body of evidence is also compromised by vague and ill-defined concepts (Stubbs, 2007). For example: while various studies look at women's satisfaction

with restorative justice approaches, it is not always clear what this means; most studies do not go beyond assessing women's satisfaction with the process to looking at longer-term outcomes, and do not examine specific aspects of women's victimisation and the characteristics of victims and offenders. Research into alternative justice for rape survivors in Arizona, USA floundered when an insufficiently large number of perpetrators agreed to participate because participation was voluntary and only offered to men who would probably have received non-custodial sentences, or may not have been convicted in criminal courts (MP Koss, personal communication). Overall, these interventions are under-researched, due to the heated debate regarding the suitability of restorative and alternative justice mechanisms for dealing with VAWG cases (Gavrielides and Artinopoulou, 2013).

Informal justice institutions in Bangladesh

The *shalish* in Bangladesh is a community based justice system in which local leaders resolve disputes and impose penalties. In the traditional *shalish* system, the leaders are mostly men who uphold traditional cultural norms and practices, which often results in discriminatory rulings against women. Nagorik Uddyog, a local NGO, has been working to transform the *shalish* system so that works better for women. This includes: supporting the formation of more representative *shalish* committees; providing training to *shalish* members on existing laws; forming Legal Aid Committees to regularly review the outcomes of *shalish* hearings; and promote better record-keeping.

Source: *DFID (2013) Addressing Violence Against Women and Girls through Security and Justice Programming.*

Effectiveness of the intervention:

Impact on VAWG reduction: Overall, the evidence is limited and conflicting. A review of 400 cases of youth sexual offences that were finalised through court proceedings or conference proceedings, over a six-and-a-half-year period in South Australia, found that the prevalence of reoffending was higher for court-case youth (66 percent) than conference-case (48 percent) youth (Daly, 2006) - although it was notable that it was high in both groups and there was no control group.

There is some evidence that perpetrators change their behaviour following participation in mediation processes, but this may be because these processes are voluntary and thus include men who want to change. For example, 40 percent of Austrian women in Pelikan's (2000) study stated that their partner's behaviour had changed as a result of mediation (for example: trying to find new ways to communicate with his partner; finding a job; tackling alcoholism; spending more time with the family). A small South African qualitative study found that: women who were still in the relationship said that it improved following mediation; and those who decided to separate said that mediation helped them to do so amicably (Dissel & Ngubeni, 2003).

Critics of restorative justice argue that unequal power relations undermine the process by limiting survivors' voices, and can allow perpetrators to 're-victimise' survivors. Cameron (2006) reviewed restorative justice practices in Canada and found that this can be through victim blaming, threats of physical violence, and actual physical violence and coercion. Bringing survivors and perpetrators together for negotiation can create further risks for women (Koss, 2000).

Impact on risk/ protective factors: There is some evidence that women derive psychological

benefits from restorative justice approaches, e.g. some women found getting an apology was restorative. However, other research found that men who apologised easily were much more likely to reoffend (Daly, 2006).

Studies also highlight some important challenges and lessons:

- Mediation may only be effective under the same conditions that many response interventions for VAWG are effective, namely when the victim has resolved to have a life without physical violence, and has the resources to live independently (Pelikan, 2000).
- The role, skills and training of mediators is important: Krieger (2002) found that mediators often lacked adequate training, and found the psychological effects of dealing with domestic violence difficult to deal with. A case study of the Bougainville Centre for Peace and Reconciliation (PFM) showed that women mediators dealt with Gender-based Violence (GBV) cases differently to male mediators.¹² Women were more likely to recognise women's substantive legal rights, and to refer cases to the formal justice system if they believed that they could not guarantee an equitable outcome for the victim. They would, almost without exception, prohibit a solution that involved a victim marrying her rapist. In cases of domestic violence, women mediators were more likely to threaten the perpetrator with action at the state court if the violence did not stop and simultaneously inform the victim of her right to refer the case to court and explain how to do so. They also counselled women survivors of domestic violence on their options, should they decide to change their situation, including: providing referrals to NGOs that offered support; and arranging for trauma counselling.

¹²The case study involved a survey administered to 394 people but it does not clarify how the sample was selected.

3.2 Crisis intervention

3.2.1. Hotlines

Types of evidence	Evidence of effectiveness of intervention
III: Qualitative studies, ethnographies.	F. There is insufficient evidence to allow for a recommendation to be made.

Description of the intervention:

Telephone hotlines enable survivors and their family or friends, to speak about the violence they are experiencing, and to obtain information about how to address specific issues (such as housing or childcare) or how to access support services. Hotlines are usually staffed by volunteers and professionals who have received training in crisis intervention, and they may operate 24 hours a day, seven days a week (Bennet et al., 2004).

Summary of evidence available:

There is very little evidence about the effectiveness of hotlines in preventing violence. One evaluation was identified of a programme that offered a hotline combined with multiple services (counselling, advocacy and shelter) across 54 domestic violence programmes, which operates in the state of Illinois in the United States. Because of the lack of an

appropriate comparison group, the evaluation is based on user responses to a set of outcome statements that are posed at the end of a call (Bennet et al., 2004). Some of the studies on One Stop Centres (see below) briefly mention hotlines as components of the Centres, but provide no information on impact. Bennet et al. (2004) also highlight the paucity of evaluation studies of social service programs as being a gap in the evidence, arguing that most existing evaluations are limited to assessing process outcomes, such as the number of people reached, services provided, etc.

Effectiveness of the intervention:

Impact on VAWG reduction: The impact of hotlines on violence occurrence rates has not been measured.

Impact on risk/ protective factors: The Bennet et al. (2004) evaluation found that survivors calling hotlines gained information about violence, and felt they had more support. In South Africa, hotlines for violence against children (Childline) and women receive a high number of calls; however, there can be frustration when callers are not able to get a response to a call from the supposedly 24-hour service.

The SAWA Women's Protection Helpline, Palestinian Territories

Palestinian NGO SAWA has run a Women's Protection Helpline since 1994, and a Child Protection Helpline since 2004. Both helplines are provided free of charge, and provide information and support to women, men and children who have experienced violence or abuse. The program provides referral to other support services and accompaniment of individuals to hospitals or the police.

Source: *Hayes (2014)*

3.2.2. One stop centres (and sexual assault centres and other women’s support centres)

Types of evidence	Evidence of effectiveness of intervention
II-2: Evidence obtained from comparisons between times or places, with or without the intervention (e.g. baseline – end-line comparisons).	F. There is insufficient evidence (in quantity or quality) to allow for a recommendation to be made.

Description of the intervention:

One Stop Centres (OSCs) aim to provide health, police and social services in one location, allowing survivors to access the necessary services easily and speedily, and so avoid further trauma. In some contexts, OSCs also provide training and support to help women (re)enter the workplace (UN Women, 2013). OSCs can be stand-alone structures, or located in hospitals, or even in courts.

Summary of evidence available:

We found 11 studies of OSCs and other women support centres, mostly project evaluations (Bernath and Gahongayire, 2013; Chepuka et al., 2011; Colombini et al., 2012; Ellsberg et al., 2012; Grisurapong, 2002; Karki et al., 2012; Madi and Sarsour, 2012; Morel-Seytoux, 2010; Lovett et al., 2004; UNFPA, 2009; UN Women, 2013). Two studies were based on a non-randomised control design (Grisurapong, 2002; Lovett et al., 2004). The project evaluations are from a range of countries and regions (Indonesia, Malaysia,

Nepal, Occupied Palestinian Territories, Thailand, Zambia and Melanesia). However, not one of the studies measured the impact of the intervention on rates of VAWG.

Effectiveness of the intervention:

Impact on VAWG reduction: None of the studies assess the impact of OSCs on reducing violence.

Impact on risk/ protective factors: There is some (limited) evidence that OSCs increase women’s access to justice and support services. A 2004 study of quasi-experimental study of Sexual Assault Referral Centres (SARCS) in the UK found that women in comparison areas accessed fewer services, and demonstrated greater unmet need. However, the study was compromised by the small number of research participants in the comparison areas (Lovett et al., 2004).

There is good qualitative evidence that users of OSCs are often highly satisfied with the services they receive and feel more empowered. A 2010

Isange One Stop Centre, Kigali, Rwanda

An example of a well-resourced and functioning OSC is the Isange One Stop Centre (IOSC) in Kigali, which was set up jointly by the UN and Government of Rwanda. Located at the Kacyiru Police Hospital (KPH), the OSC is staffed by: one coordinator, nine psychologists, one gynaecologist, six social workers, three medical doctors (who have medical forensic expertise), four general practitioners, one psychiatric nurse, and one police officer. They provide a free 24-hour service, seven days a week, with provisions for emergency contraception, HIV prophylaxis, STI prevention, and other medication. Every survivor who arrives at the IOSC is initially seen by a social worker who provides information and access to medical, psychosocial and police services. Once the survivor is assessed and examined, the case is processed according to her/his needs. There is a safe house available with three beds and basic provisions.

Source: *Bernath and Gahongayire (2013)*.

evaluation of one-stop Child Sexual Abuse Centres in Zambia found that there were high levels of satisfaction regarding the quality of services amongst survivors, with many noting that the inclusive and consultative way in which staff behaved and the services that were provided made them feel empowered (Morel-Seytoux, 2010). A 2009 UNFPA case study¹³ of the PUSPITA program in Indonesia (which located women’s crisis centres in pesantren (Islamic boarding schools)), indicates that survivors feel supported by the highly influential pesantren leaders, and, as a result, feel more able to disclose the violence (UNFPA, 2009).

There is evidence that awareness raising activities by OSCs can be effective in changing attitudes about violence against women. The Morel-Seytoux (2010) evaluation of a USAID

funded program providing Coordinated Response Centres and Child Sexual Abuse Centres in Zambia found that the program’s strategy of providing direct services, as well as undertaking outreach and sensitisation activities at the national and community levels, had “broken the silence” regarding GBV.

Some of the studies provide information about lessons learned: specifically that the implementation of OSCs is influenced by organisational constraints, for example: lack of specialised staff, lack of training, time constraints, limited budgets, lack of clarity about roles and responsibilities, and the lack of a system of referral to external support services (Colombini et al., 2012; Ellsberg et al., 2012; Chepuka et al., 2011).

3.2.3. Shelters

Types of evidence	Evidence of effectiveness of intervention
II-2: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline – end-line comparisons).	B. There is fair evidence to recommend the intervention. However, studies have also shown that accessing shelters can increase violence for some women. There is a substantial problem of return to the abusive partner after a period of time spent in shelters.

Description of the intervention:

Shelters provide alternative housing for women experiencing violence; they are designed to accommodate women and children for emergency stays, and to allow women time to consider their options and make alternative arrangements. Shelters: provide food and clothing to women; coordinate the delivery of services to them; provide women with therapy and counselling; help women find employment and access healthcare; and even campaign to stop violence against women. Some shelters limit the amount of time a woman can stay, while others do not. Some aim to keep their location secret.

Summary of evidence available:

Our search revealed three comprehensive reviews (Morrison et al., 2007; Straka, 2006; Sullivan, 2012); and two individual studies (Bennet et al., 2004, Cesario et al., 2014). One of these (Cesario et al.) was a cohort study. However, there is limited evidence on the effectiveness of shelters. Sullivan (2012) argues that this is due to the ethical challenges of conducting randomized controlled trials among women needing to access shelters. Studies that compare women who use shelters with those who do not are compromised by other variables that affect shelter use, for example: income level, education level, access

¹³This is one of a series of qualitative case studies documenting UNFPA’s experience in VAWG programming. Each case study is based on contributions by UNFPA staff and country offices; however the exact methodology is not explained.

to other options, and the severity of abuse. It is also difficult to isolate the effect of shelters alone, as women are able to access a range of other services and interventions at the shelters. The 17 studies included in the Sullivan (2012) review are mainly short-term cohort evaluations, some of which include qualitative components. A further challenge for these studies is that they rely on self-reported data from the shelter residents themselves.

Thus there is no way of knowing what would have happened in their lives if they had not used the shelter. A significant problem with research conducted among women in shelters is that it does not measure return to the abusive partner after a period of time spent in the shelter.

Effectiveness of the intervention:

Impact on VAWG reduction: There is some evidence that the use of shelters can reduce violence, especially when measured in the longer term. The Sullivan (2012) review cites two studies undertaken in the US (in 1984 and 2004), in which the majority of women (72 percent and 79 percent women respectively) reported that use of the shelter had been effective in reducing violence being perpetrated against them. However, a small proportion of women (6 percent and 10 percent respectively) stated that violence against them had increased. Morrison et al. (2007) cite a 1999 study of women who received advocacy services while in a shelter, which found that women in the treatment group experienced more violence than those in the control group in the short-term, but less violence after two years (Sullivan and Bybee, 1999, cited in Morrison et al., 2007).¹⁴ Bennet et al. (2004) cite a 1988 study from the US, which found that shelters can have beneficial effects for women who have already started to make changes in their lives before they enter a shelter.

Sullivan (2012) highlights three studies that asked women what they would have done if

shelter had not been available to them. Their responses ranged from being homeless to experiencing continued abuse, and turning to prostitution to support themselves and their children. Some women stated that they would have either killed themselves or the perpetrator (Lyon et al., 2008; Sullivan et al., 2008; Tutty et al., 1999 – all cited in Sullivan, 2012).

Impact on risk and protective factors: The use of shelters is also associated with women deciding to leave abusive relationships. A 2007 study found that, for women experiencing moderate to severe violence, use of a shelter was significantly related to ending the relationship (Panchanadeswaran and McCloskey, 2007, cited in Sullivan, 2012). A 1992 study also found that the more types of services women used while in a shelter, the more likely they were to live independently post-shelter (Gondolf et al., 1992, cited in Sullivan, 2012). A number of studies have shown that using a shelter can help women to feel safer, more hopeful, and more knowledgeable about safety strategies to be used once they leave.

However, there are some limitations to the research into the impact of shelters, e.g. studies that compare women who use shelters with those who do not are sometimes compromised by the other variables that affect shelter use, for example: income level, education level, access to other options, and the severity of abuse. It is also difficult to isolate the effect of shelters alone, as women are able to access a range of other services and interventions at the shelters. A further challenge with these studies is that they rely on self-reported data from the shelter residents themselves. Thus there is no way of knowing what would have happened in these women's lives if they had not used the shelter. Another significant problem with research conducted among women in shelters is that it does not measure return to the abusive partner after a period in the shelter.

¹⁴Morrison uses this example to illustrate the point that many research studies on prevention initiatives do not run over a long enough period to capture long-term impact, arguing that had the researchers in this study followed the subjects for a shorter time they might have concluded that the programme had failed.

3.3 Health sector responses

Health sector interventions to prevent VAWG consist of three main approaches: training of health care providers to ask about IPV and being sensitive about IPV; screening to identify women who have been exposed to IPV but are

not presenting at the facility because of it, with or without referral or intervention in the facility; and identification of women who have VAWG exposure, when this is necessary for optimising their clinical care.

3.3.1. Healthcare professionals' training

Types of evidence	Evidence of effectiveness of intervention
II-1: Evidence from well-designed controlled trials without randomization.	F. There is insufficient evidence (in quantity or quality) in order to allow for a recommendation to be made.

Description of the intervention:

Training interventions aim to build the knowledge and skills of healthcare providers to respond to the needs of women experiencing violence. Training interventions target the knowledge, attitudes and practices of healthcare providers, and cover various matters, including: awareness about domestic violence, how to ask women about abuse, handling disclosure, documenting abuse, safety planning, developing specific guidelines and protocols for practice, and understanding locally available services for survivors (Taket et al., 2003). Training programs are often provided in-service, with sessions lasting from a few hours to a number of days, and there have been efforts to integrate VAWG training into

undergraduate or basic training curricula for healthcare providers.

Summary of evidence available:

Few studies have looked at the impact of training interventions on prevalence of violence against women. Our search found five comprehensive reviews (WHO, 2013; Taket et al., 2003; Plichta, 2007; Garcia-Moreno, 2002; Contreras et al., 2010) and two individual studies (Jackson, 2012 and Jacobs, 2002).

Most of the evidence comes from high-income countries, but there are a small number of lower quality studies from low-income and middle-income countries. The WHO review (2013) found the studies it covered as being subject to important methodological limitations,

Gender based violence protocols for healthcare workers in Afghanistan

In 2014, the Afghan government, together with WHO and UN Women, launched the first ever gender-based violence treatment protocol for healthcare providers. The protocol is based on WHO guidelines issued in 2013, and includes detailed guidance for healthcare workers on providing quality care to survivors. Specific areas include: survivor-centred care; managing rape cases, wounds and burns; and collecting medico-legal evidence. It is expected that 6,000 doctors, nurses and midwives will be trained on dealing with GBV cases over the next five years.

Source: *WHO press release: <http://www.emro.who.int/afg/afghanistan-news/gbv-treatment-protocol-afghanistan.html>*

including: lack of a comparison group; lack of assessment, either before or after the training; lack of psychometrically sound assessment tools; and extremely small sample sizes.

Effectiveness of the intervention:

Impact on reduction of VAWG: There is no evidence of the impact of training interventions alone on IPV occurrence for women, and this is rarely measured in evaluations of training.

Impact on risk and protective factors: There is no evidence of the effect of training interventions on referral to services, or attitudes and beliefs. Most studies showed some improvement in knowledge, and, to some extent, in the behaviour of providers following a training intervention. The Taket (2003) review of evaluations of programs, including training

interventions in the UK, found – at 3 month follow-up – that trainees reported: an increased awareness about abuse; more confidence in handling domestic abuse; increased commitment to raising the profile of domestic violence in the workplace; and improved procedures for handling cases. An evaluation of a training program on sexual violence in Guinea found improvement in trainee knowledge, as well as in facility procedures and policies (Jackson, 2012). The O’Campo systematic review finds that implementing multi-component approaches - which include institutional support, effective screening protocols, sound initial and ongoing training, and immediate access or referrals to support services -resulted in increased screening for IPV and in rates of disclosure.

3.3.2. Screening interventions

Types of evidence	Evidence of effectiveness of intervention
I: Evidence obtained from at least one properly randomized controlled trial.	D: There is fair evidence to suggest that universal screening is not effective in preventing VAWG. The evidence questions the appropriateness of universal screening in contexts with high prevalence, limited referral options, and overstretched healthcare providers and services.

Description of the intervention:

Screening refers to the process of identifying women who are experiencing, or have recently experienced IPV when they obtain health services. Screening can be done through a range of validated tools and protocols,¹⁵ which can be administered either through a face-to-face interview or as a self-completed questionnaire. It can also be done through one, or a series, of questions that healthcare providers ask patients once or at various points in the consultation relationship. ‘Routine’ or ‘universal’ screening occurs when all women consulting a healthcare provider are asked

about partner violence. This is distinct from ‘case-finding’ or ‘clinical enquiry’, which occurs when a woman is asked about violence based on her presenting condition. Screening is usually accompanied by referral or other intervention.

Summary of evidence available:

A large number of studies have looked at the impact of screening initiatives on reducing violence against women. These include:

- Nine systematic reviews (Coulthard et al., 2010; Feder et al., 2009; Kataoka et al., 2004; Nelson et al., 2012; O’Campo et al., 2011);

¹⁵ Nelson et al (2012) outline the following tools: Abuse Assessment Screen; Partner Violence Screen; Hurt, Insult, Threaten, and Scream tool; Woman Abuse Screening Tool; Humiliation, Afraid, Rape, Kick tool; Ongoing Abuse Screen and Ongoing Violence Assessment Tool; Slapped, Threatened, and Throw tool; Childhood Trauma Questionnaire – Short Form; Secure, Accepted, Family, Even, Talk survey; Parent Screening Questionnaire; the use of a single question.

O'Reilly et al., 2010; Ramsay et al., 2002; Taft et al., 2013; Wathen and Macmillan, 2003); of these, five (Kataoka et al., 2004; Nelson et al., 2012; Ramsay et al., 2002; Taft et al., 2013; Wathen and Macmillan, 2003) included RCT studies.

- Six comprehensive reviews (Chepuka, 2013; Evanson, 2006; Garcia-Moreno, 2002; Guedes, 2004; Plichta, 2007; and WHO, 2013). The Garcia-Moreno review included RCTs.
- Eight individual studies not included in the systematic reviews or the comprehensive reviews (Wiistand McFarlane, 1999; Hester and Westmarland, 2005; McFarlane et al., 2006; Koziol-McLain et al., 2010; Laisser, 2012; Spangaro et al., 2011; Turan et al., 2013; Matseke et al., 2013). One (McFarlane et al., 2006) is an RCT.

The majority of the evidence focuses on programs from the US, UK, Canada, Australia and New Zealand, and the WHO comprehensive review states that the quality of the available evidence on screening is 'low to moderate'. There are a number of qualitative studies from Australia and New Zealand that focus on women's views of screening (Koziol-McLain et al., 2010; Spangaro et al., 2011). Few studies distinguish between the screening approaches (routine or case-finding) being evaluated, and there are no studies comparing outcomes for women from universal screening and case-finding approaches (WHO, 2013; Taft et al., 2013).

There have been three very large and well conducted RCTs (Ahmad et al., 2009; Koziol-McLain et al., 2010; MacMillan et al., 2009).

Effectiveness of the intervention:

Impact on reduction of VAWG: There is no evidence that screening leads to a reduction in violence, or that it improves health outcomes or the quality of life for women. Several reviews conclude that the evidence does not justify

universal screening (Taft et al., 2013; Macmillan et al., 2009; Feder et al., 2009; WHO 2013).

The WHO (2013) and Taft et al. (2013) reviews question the appropriateness of universal screening in contexts with high prevalence, limited referral options, and overstretched healthcare providers and services. The Turan et al. (2013) study - a small scale mixed methods evaluation of an integrated GBV programme at an antenatal clinic in rural Kenya - found that screening in antenatal consultations declined over time, indicating that clinicians ultimately may have used more of a "case finding" approach, assessing some clients and not others. The evaluators argue that the case finding approach may be preferable for resourced-constrained settings. The WHO review argues that instead of training providers screening all women, it would be preferable to train providers to respond adequately to those women who do disclose, or show signs of, violence.¹⁶ There is no direct evidence of the value of case finding approaches, but evaluating these in a RCT would be unethical, as health care providers have an obligation to ask about violence exposure if they perceive it to be relevant for management of the presenting complaint.

Impact on risk and protective factors: The key finding emerging from almost all the reviews is that screening interventions clearly improves identification of women experiencing IPV (Nelson et al., 2012; Taft et al., 2013; O'Reilly et al., 2010; Plichta, 2007; Guedes, 2004). The Plichta review (2007) cites studies that found that 80 percent of survivors will disclose abuse if asked, but are unlikely to disclose abuse if they are not asked (Hathaway et al., 2002; Kramer et al., 2004; Krasnoff & Moscati, 2002; McCauley et al., 1998, all cited in Plichta, 2007). Taft et al. (2013) found that screening is particularly effective in improving the identification of women experiencing IPV in antenatal settings, but this is only of value if it is combined with

¹⁶There are three possible exceptions to this: i) women with mental health symptoms or disorders could be routinely screened, as this may affect their treatment and care; ii) asking women about intimate partner violence could be considered in the context of HIV testing and counselling; iii) routine enquiry could be considered in the context of antenatal care, because of the dual vulnerability of pregnancy.

an intervention that is useful to women, for example counselling interventions (for which some studies have found positive effects).

However, Taft et al.'s (2013) systematic review of 11 randomised or quasi-randomised trials found: no evidence of increased referrals as a result of screening; and insufficient evidence that screening increases the uptake of specialist services.

Two systematic reviews (Ramsay et al., 2002; Feder et al., 2009) and the Plichta comprehensive review (2007) showed that women are broadly supportive of screening interventions. The Turan et al. (2013) evaluation of a programme in Kenya found that women felt that screening increased their awareness of GBV, as well as of other GBV services available to them. The Feder et al. review (2009) found that women who did feel ready to disclose abuse felt that screening helped to reduce the stigma attached to partner violence, and helped them to understand where they might

get support once they were ready to disclose. Koziol-McLain et al.'s (2010) qualitative study of women who had received a screening intervention showed that women considered it 'therapeutic' and 'educational', and women who had experienced abuse welcomed the opportunity to speak about their experience in a safe and non-threatening environment. Spangaro et al.'s (2010) study of 122 women who disclosed abuse, in Australia, found that abused women who had been screened were more likely – six months on – to agree that being hurt by a partner affected a woman's health, and that health services should ask about abuse. The proportion of women reporting abuse six months later was substantially lower.

In addition, a number of studies suggest that many health professionals are not in favour of screening, due to a variety of challenges, including a lack of confidence and a lack of training on how to deal with responses (e.g. see Ramsay et al. (2002) on the US and New Zealand and Chepuka (2013) on Malawi).

3.3.3 Referral and case management

Types of evidence	Evidence of effectiveness of intervention
I: Evidence obtained from at least one properly randomized controlled trial.	C: There is conflicting evidence; however, most studies indicate that the intervention is ineffective in reducing violence.

Description of the intervention:

Screening interventions by healthcare professionals can be linked to referrals to care, follow-up and support services. These could include the provision of safety information, counselling and referral to shelters, and further healthcare. There is evidence, however, that screening and disclosure does not always lead to survivors being able to access the support they need. The Plichta review (2007), for example, cites various studies from the US that show that many women (up to 60 percent) who disclosed violence did not receive any

additional services (McCloskey et al., 2005; Gerber et al., 2005; Davis et al., 2003).

Summary of evidence available:

- Two comprehensive reviews covering programs that link screening to some sort of follow-up intervention: WHO, 2013; Nelson et al., 2012.
- Four individual studies: Jackson, 2012; McFarlane et al., 2006; Tumbewaze et al., 2009; Hegarty et al., 2013; Krasnoff and Moscati, 2000. The McFarlane et al. and Hegarty et al. studies were RCTs.

Nelson et al. (2012) - the more comprehensive of the two reviews - found six RCTs that met its inclusion criteria, three of which targeted pregnant women and post-partum women. One trial was rated good, four were rated fair, and one was rated poor. The review highlighted various methodological limitations, including the enrolment of dissimilar groups at baseline, high loss to follow-up or inadequately described follow-up, lack of intention-to-treat or unclear analyses, and inadequately described randomisation methods. The review argues that the trials were also subject to the challenges inherent to research on domestic violence, such as the use of self-reported measures, lack of blinding, and the lack of true control groups. The study also notes that the trials include narrowly-defined patient populations, which may not be applicable to broader populations.

The RCTs were undertaken predominantly in the US, with a smaller number done in the UK, Canada and Australia. One cohort evaluation and one qualitative study, from South Africa and Uganda, respectively, are also included.

Effectiveness of the intervention:

Impact on reduction of VAWG: There is strong evidence from five well conducted and large RCTs, in high-income settings, that large scale interventions to screen and offer case management/referral are ineffective in reducing violence. The WHO review (2013), which looked at the findings of four large and well conducted RCTs on post-screening action in healthcare settings – most commonly a prompt in the medical record of the screening test result provided to healthcare providers before patient visits, or automatic referral to a social worker or professional advocates – found that none of these studies demonstrated a reduction in recurrence of intimate partner violence.

However, the 2006 McFarlane et al. RCT, which compared the impact of a screening

intervention to a 20-minute nurse case management protocol, found that both treatment groups reported significantly less violence in the two years following. However, there was very little difference between the two groups, leading the researchers to argue that attention should be given to promoting simple screening methods and offering referral.

There is a possibility that offering interventions for pregnant women may be of more value, but there is insufficient evidence on this. Nelson et al. (2012) argued that screening followed by counselling may: reduce IPV and improve birth outcomes for pregnant women; reduce IPV for new mothers; and reduce pregnancy coercion and unsafe relationships for women in family-planning clinics.

Impact on risk/ protective factors: Two studies have looked at health outcomes and found no important differences (Hegarty et al., 2013; Macmillan et al., 2009, cited WHO, 2013). However, the Hegarty et al. (2013) study - a cluster randomised trial in Australia – found some reduction in depressive symptoms as a result of counselling.

In terms of factors that affect the effectiveness of interventions, effective management of cases requires that adequate referral systems are in place, which can be a challenge in resource-constrained contexts. A 2009 study, which aimed to assess the management of GBV survivors in health facilities of Kabarole District in western Uganda, found that respondents experienced long waiting times at the health facilities to which they were referred. A shortage of staff, a lack of privacy and a lack of medicines were also cited as common problems. Only a limited range of healthcare services were available to GBV survivors, and these were mostly at the request of the police (Tumbewaze et al., 2009). Even in high-income settings, there is evidence that most women who are, or should be, referred to services do not obtain these services.

3.4 Social sector interventions

3.4.1. Counselling, therapy and psychosocial support

Types of evidence	Evidence of effectiveness of intervention
I: Evidence obtained from at least one properly randomized controlled trial.	F: There is insufficient evidence (in quantity or quality) for us to make a recommendation, although some studies have found positive effects.

Description of the intervention:

Counselling, therapy and psychosocial support are similar types of mental health interventions, and the terms are often used interchangeably, but there are subtle differences:

1. Counselling tends to refer to a relatively brief intervention that is focused on a particular symptom or problematic situation and offers assistance in dealing with it, typically through brief educational, cognitive-behavioural, and motivational interviewing approaches.
2. Therapeutic interventions are more intensive treatments than counselling and focus on the patient's thought processes and way of being in the world, rather than on specific problems.
3. Psychosocial support includes providing practice assistance in the form of care and support to victims of violence; it may include counselling and therapeutic intervention as well.

Treatment can last anywhere between one session to several years, and can be delivered to individuals, couples or groups. Interventions typically aim to promote improvement in mental health or wellbeing.

Summary of evidence available:

Several studies have looked at the impact of counselling, therapy and psychosocial support on violence against women. These include two systematic reviews (Wathen and MacMillan, 2003; Tol et al., 2013) and four comprehensive

reviews (McCollum and Stith, 2008; Keesbury and Askew, 2010; World Health Organisation, 2013; Spangaro et al., 2013). The Wathen and MacMillan systematic review, and the McCollum and Stith, and Spangaro et al. reviews, include RCTs. Four further studies (Hester and Westmarland, 2005; Crespo, 2010; Taft et al., 2011; and Spratt, 2012) were also identified, of which: the Crespo (2010) study is a RCT; the Taft (2011) study is a cluster randomised trial.

Most studies are from the US and Western Europe, with just a few from developing countries. Several studies evaluated combined interventions, making it difficult to disentangle the effectiveness of one intervention in comparison to another, for example: a stay in a shelter, followed by advocacy and counselling; prenatal counselling; interventions for batterers and couples, including counselling (see: Tol et al., 2013; Wathen and MacMillan, 2003). Most of the comprehensive and systematic reviews conclude that there is an urgent need for a more robust evidence base (Keesbury and Askew, 2010; Tol et al., 2013; World Health Organisation, 2013).

Effectiveness of the intervention:

Impact on reduction of VAWG reduction: There is insufficient evidence to make a conclusive recommendation, but some studies have found positive effects of counselling in reducing violence. An RCT study of women receiving counselling services following a stay in a shelter in the United States (in the 'Midwest') found that the intervention group reported significantly less violence than the

control group two years after the intervention (89 percent of controls reported re-abuse vs 75 percent of women in the intervention group) (Sullivan and Bybee, 1999, cited in Wathen and MacMillan, 2003). An RCT on the effect of a cognitive behavioural intervention on IPV occurrence during pregnancy and post-partum found that the women in the intervention group were less likely to experience recurring abuse (Kiely et al., 2010).

No high quality evidence exists to compare the effectiveness of different approaches to treatment, individuals' attendance levels, duration of treatment, contextual factors, or how treatment outcomes vary by type of violence. There was also a general lack of high-quality studies looking at the impact of the counsellor/therapists' training, including the use of volunteers or lay counsellors. However, the Taft et al. (2011) cluster randomised trial did find reduced partner violence amongst pregnant women and mothers with small children receiving non-professional mentoring support through home visits, compared to women in the control group. A study of domestic violence counselling in Rwanda (Omollo-Odhiambo

and Odhiambo, 2011) found that a couples approach was effective in preventing domestic violence, as men felt part of the change process and played a key role in reaching out to other men – see the evidence review on prevention approaches in this series).

Although several studies mention the possible effect of individual, couples or group treatment, no study was found comparing outcomes between the different treatments. Couples treatment is widely used in substance abuse programs, but is considered by some to be controversial (IPV). However, McCollum and Stith's (2008) comprehensive review of the literature on 'conjoint couples treatment' found that it can be used safely to treat IPV and there has been a recent increase in the use of couples interventions to prevent VAWG. Best practice includes: careful assessment and screening of couples for inclusion in couples' treatment; modification of typical couples approaches to promoting safety and on-going assessment of safety, with contingency plans for increased risk; and couples treatment, as part of a larger community response to IPV.

Impact on risk/ protective factors: There is some evidence of positive impact on communication in relationships, as well as on the psychological health of women and children. For example, a mid-term evaluation of the Ending Domestic Violence project in Rwanda found that 44 percent of participants felt that counselling services helped them improve dialogue in addressing issues that may lead to violence (Omollo-Odhiambo and Odhiambo, 2011).¹⁷ Several studies looking at the long-term impact of counselling or psycho-therapeutic treatment for women victims of violence measure the impact on post-traumatic, depressive and anxiety symptoms, which is the immediate treatment goal (Crespo and Arinero, 2010; Bass et al., 2013; WHO, 2013).

Listening houses in DRC

In DRC, the ICRC is supporting 40 'maisons d'écoute', or listening houses, which are locally run structures at which survivors of sexual violence can receive counselling, and, where needed, referral to health services. In 2012, over 5,000 survivors received counselling, and 2,250 were referred for medical treatment. The listening houses also use workshops and radio programs to raise awareness about sexual violence.

Source: *Cotton and Nicol (2014)*

¹⁷ The evaluation applied a cross-sectional design with quantitative and qualitative approaches with 636 project beneficiaries (men and women aged 18-70) as well as implementers and key stakeholders.

3.4.2. Advocacy and support to access services

Types of evidence	Evidence of effectiveness of intervention
I: Evidence obtained from at least one properly randomized controlled trial (RCT).	C: The existing evidence is conflicting and does not allow a recommendation to be made for or against the intervention.

Description of the intervention:

Advocacy interventions aim to help abused women directly, by providing them with information and support to help access legal redress and resources in the community and have provided the backbone of many interventions on VAWG at community level. This is a very broad category of interventions, which could include advice provision and counselling of different durations, delivered by differently skilled individuals and enables access to different types of services and resources. Many interventions also provide safety-planning advice and aim to empower women to achieve their goals (Ramsay et al., 2009). Some advocacy programs work on a wide range of areas, while others focus specifically on helping women access community resources and services (e.g. housing, employment, legal or social support) (Sullivan, 2012). Engagement can last anywhere from 30 minutes to 80 hours. There is sometimes considerable overlap between advocacy interventions and counselling. Advocacy, psychosocial support and counselling interventions are delivered by a range of individuals and organisations (including social service professionals, students and trained lay-mentors), and in a range of settings (at home, by telephone, in community spaces, in health care settings).

Summary of evidence available:

Several studies have looked at the impact of advocacy interventions on violence against women. These include: two systematic reviews (Ramsay et al., 2009; Wathen and MacMillan, 2003), both of which include RCTs; two comprehensive reviews (Sullivan, 2012; World

Health Organisation, 2013); and five individual studies (Tan et al., 1995; Sullivan et al., 1999; McFarlane et al., 2000; Hester and Westmarland, 2005; and Chang, 2005). The Sullivan (1999) and McFarlane et al. (2000) studies were RCTs.

Most studies have been conducted in the United States, with one done in Hong Kong. The systematic and comprehensive reviews highlight the following methodological challenges:

- Few studies evaluate interventions of comparable intensity and duration, measure the same outcomes, or have comparable follow-up periods (Ramsay et al., 2009).
- Measurement of reabuse often focuses on the frequency of physical violence – other important aspects of abuse, such as fear, intimidation and control, are not assessed, nor is the context in which violence occurs (Bybee and Sullivan, 2002).
- Overlap between psychological and advocacy interventions (with the former having components of non-psychological support, and the latter sometimes including psychological support such as counselling) (World Health Organisation, 2013).

Effectiveness of the intervention(s):

Impact on VAWG reduction: The evidence is conflicting. The evidence suggests that these types of interventions may: lead to some reduction in physical IPV, but not sexual and emotional IPV; lead to an increase in violence in the short term. While studies have found that women who received advocacy intervention are significantly less likely to be

abused up to two years after the intervention, the effect is relatively small. The most recent and comprehensive systematic review is Ramsay et al.'s review (2009) of randomised controlled trials, in which a comparison was done of advocacy interventions for women who experience intimate partner abuse, and usual care. Ten studies involving a total of 1,527 participants were found to meet the inclusion criteria. The authors concluded that there was "no compelling evidence that advocacy generally reduces or leads to a cessation of abuse" (p.46). There is evidence that intensive advocacy (12 hours+ duration) may help reduce physical abuse in women leaving domestic violence shelters or refuges in the short-medium term (1-2 year follow-up), but there is inconsistent evidence on other forms of abuse, including emotional and sexual abuse.

The WHO review observed that the strongest evidence on advocacy interventions comes from three advocacy trials conducted in Hong Kong (Tiwari et al., 2010). The trials implemented advocacy/ empowerment interventions of brief duration to women in three settings: antenatal, shelter based, and community health centre based. Of the three settings, the studies reported benefits in abuse outcomes in the two health-care settings, but there remains uncertainty about the intensity required in order for advocacy to have an effect (WHO, 2013).

Impact on risk/ protective factors: There is some evidence that brief advocacy increases the application of safety behaviours by abused women. There was insufficient evidence on the impact on women's quality of life and mental health.

3.4.3. Perpetrators' (Batterers') programmes

Types of evidence	Evidence of effectiveness of intervention
I: Evidence obtained from at least one properly randomized controlled trial (RCT).	C: The evidence is conflicting and weaknesses in study design hampers our ability to make a recommendation.

Description of the intervention:

Batterers' (or perpetrators') programmes are aimed at preventing violence and characteristically target the most violent men, who have been identified by courts or through restorative justice models. Perpetrators' programs (also known as batterers' programs) consist of treatment or rehabilitation interventions for perpetrators of domestic violence, which can be mandated by court order, or perpetrators can voluntarily choose to attend a programme. Typically, these interventions involve the use of psycho-educational methods, which aim to: (i) help men understand how their behaviour stems from patriarchal gender norms and beliefs about men's power and control over women; (ii) help men to develop skills to deal with their anger without resorting to violence (Feder et al.,

2008; Babcock et al., 2004). Treatment can last anything between eight to 26 weeks, and can be delivered to individuals, couples or groups.

Summary of evidence available:

A large number of studies – primarily focussed on programs implemented in the US - have looked at the impact of perpetrators' programmes, i.e. whether or not individuals return to domestic violence - above and beyond what would have been expected to occur as a result of arrest and associated legal procedures. These include three systematic reviews (Smedslund et al., 2011; Feder et al., 2008; Wathen and Macmillan, 2003). The most recent and comprehensive systematic review is the Smedslund et al. (2011) study, which located six RCTs - all from the US - that included a total of 2,434 participants. The largest study had 861 participants. Four of the

trials compared men who received CBT with those receiving no treatment. The two other studies compared men receiving CBT treatment to those receiving another treatment.

- Four comprehensive reviews (Davis and Taylor, 2008; Sartin et al., 2006; Babcock et al., 2004; Feder, 2005); and
- Three further individual studies that were not included in the reviews (which included one quasi-experimental study (Bowen et al., 2005) and one cohort evaluation (Gondolf, 2003). (Babcock et al., 2011; Bowen et al., 2005; Gondolf, 2003).

In their reviews (systematic, comprehensive), Smedslund et al. (2011), Feder et al. (2008), Babcock et al. (2004) and Sartin et al. (2006) argue that most quasi-experimental studies have had significant methodological challenges, thus compromising their results. Some of the key challenges they highlight are:

- Most studies rely on criminal justice records to assess recidivism, whereas much violence is not reported.¹⁸
- Perpetrators' programmes often experience high attrition rates. As many as 40 percent of participants who attend the initial sessions do not complete the programme (Rosenfeld, 1992, cited in Sartin, 2006). While many programmes include some form of monitoring of attendance, very few include sanctions for non-attendance.
- Several studies use treatment dropouts as a comparison group, but pre-treatment differences between treatment completers and dropouts can compromise results (Sartin et al., 2006).
- Given that participants are identified through the legal system, truly random assignment is difficult to achieve. More severe offenders are probably more likely to be ordered to attend treatment (Sartin et al., 2006).

- A non-treatment group could be considered unethical, given the negative consequences for the victim (Sartin et al., 2006).

Effectiveness of the intervention(s):

Impact on VAWG reduction: Overall, there is a suggestion of a modest effect on reducing recidivism among those who attend and are retained in programmes of longer duration, but the findings are inconclusive. As noted above, a weakness of the evidence is that most studies rely on criminal justice records to assess recidivism, whereas much violence is not reported. Sartin et al. (2006) point out that: all of the studies in their review use treatment dropouts as a comparison, instead of a true control group; and pre-treatment differences make it difficult to know to what extent the recidivism is due to the perpetrators' programme.

There is some evidence that men who complete treatment in these programmes are less likely to repeat violence, but there is a high dropout rate (most studies show at least 40 percent).¹⁹ Two studies from the late 1980s, of programmes ranging from eight to 15 weeks, found that treatment completers were less likely to recidivate than those who did not complete a programme (Chen et al., 1989; Hamberger and Hastings, 1988). A 1997 follow-up evaluation (mean follow-up time of 5.2 years) of court-ordered treatment found that treatment completers had significantly fewer re-assault incidents (both all assaults and assaults against women) than treatment dropouts, rejects, and no shows (Dutton et al., 1997). Evidence on the value of being court controlled is conflicting. Similarly, there is conflicting evidence on the impact of the duration of programmes. A 2003 case series of four programmes run over four years found that: some programmes had achieved a clear reduction in physical and psychological abuse; and that the vast majority of men were able to

¹⁸ Smedslund et al (2011). Also, the Feder et al. (2008) systematic review of court-mandated batterer programmes found that official reports of domestic violence showed modest benefit, whereas victim-reported outcomes showed zero effect.

¹⁹ This is distinct from partner violence, which was the focus of the Smedslund et al. (2011) review.

sustain non-violent behaviour (Gondolf, 2003). However, in their comprehensive review, Davis and Taylor (2008) find no evidence that longer programmes have a greater impact on violence.

Some studies have generated interesting lessons about interventions:

- Some studies have demonstrated that various treatment factors can affect the effectiveness of programmes in terms of impact on recidivism e.g. length of the programme, individuals' attendance levels (Smedslund et al., 2011), whether they are court-controlled or not (Davis et al., 2000; Gondolf 2003), levels of risk monitoring, and inclusion of other community members in the treatment groups (Brown and O'Leary, 2000).
- Some studies have sought to compare the effectiveness of different approaches to treatment, but with no conclusive findings.
- Some studies find indications of improved effect when both partners undertake prior gender-specific group treatment for domestic violence (e.g. Johansson and Tutty,

1998) – especially in terms of addressing psychological as well as physical violence over the long-term.

- Studies comparing men who have completed all or most of their treatment programmes, with those who have dropped out, have found that the former are often older, more educated and more likely to be employed (Dutton et al., 1997; Saunders, 1996). Being younger, and having a history of alcohol and substance abuse are associated with increased likelihood of post-treatment recidivism (Murphy et al., 1998; Shepard, 1992).
- A number of individual studies have found that psychological/ personality traits - such as psychopathic tendencies, borderline personalities, antisocial personality (e.g. Gondolf and White, 2001; Dutton et al., 1997) and interpersonal dependency (Bowen et al., 2005) are linked to recidivism.

Impact on risk/ protective factors: The focus of this type of intervention is on recidivism and so risk factors for violence are not evaluated.

4. Discussion and recommendations

4.1 Overall strengths, gaps and limitations in the body of evidence

The interventions reviewed here were all developed and deployed with the primary goal of strengthening the response of the police and criminal justice system, and the health system or social sector to violence against women and girls. In this paper, we have not assessed evidence on their effectiveness in achieving this primary goal; we purely considered whether or not evaluations indicate that they are able to achieve a secondary goal of prevention of violence against women and girls.

Some interventions have been well-evaluated in this respect – including through well-conducted RCTs. Some show promise, but, overall, there are still many gaps and limitations in the evidence base. In a few cases, the existing body of evidence recommends against the intervention. Key findings include:

Few studies measure impact on VAWG:

The review found that the majority of interventions targeted at responding to VAWG have not been evaluated in terms of their impact on the prevalence, frequency or severity of VAWG. This is often because such outcomes are far removed from the primary goal of an intervention. However, this means that, in general, there is insufficient evidence to draw a conclusion regarding the effectiveness of different response mechanisms to prevent violence.

Limited rigorous evidence from LMICs and comparison across studies is difficult:

Most rigorously evaluated studies and evidence included in this review are from the US - a very different geographical and social context from most lower-income or middle-income countries. It is therefore unclear to what

extent these findings are generalisable to other settings, especially in the police and justice sectors, as the engagement of the sector in terms of VAWG is much higher in the US (e.g. arrest rates for domestic violence are higher).

We also found that: many of the evaluations were not rigorously designed; many were lacking a specific and limited number of primary outcomes, baselines, or rigorous data analysis. Many of the studies had small sample sizes, which may result in null findings reported due to underpowered studies, rather than a definite absence of intervention effect. Further, across the studies identified there is a wide range of methods and outcome measures used, as well as different timeframes, which means it is difficult to make an accurate comparison. The use of various and often inconsistent outcome measures (e.g. police records of repeat offence, victim reports) complicates the interpretation of study findings.

Use of police records may result in underestimating the impact of interventions:

Many studies of police and justice interventions have used police records of recidivism as the outcome. Given that much VAWG is not reported to the police, this is a crude outcome measure. For example, where women's reports are also available, it is sometimes found that these differ substantially from police reports. The effect of using a crude, lower frequency measure of violence, such as police reports, is to bias findings towards showing no effect, which may result in an under-estimate of the impact of interventions.

Few evaluations with a proper control arm:

There have been few RCTs and few evaluations of any type with a proper control arm. The disadvantage of research that does not include a comparison group (that is not receiving the intervention) is that findings may be biased if there are underlying changes in the level or intensity of violence in the society, such as has been seen in the US over time.

Key evidence gaps

- Most rigorous evaluations of response mechanisms are from high-income countries (HICs); there has been little testing of how these programmes may impact differently in low-income and middle-income countries (LMICs).
- Most interventions have not been evaluated for their impact on VAWG occurrence, often because this is quite removed from their primary goal.
- The use of various and often inconsistent outcome measures (e.g. police records of repeat offence, victim reports) complicates the interpretation of study findings.
- Studies of response mechanisms that may be effective in reducing violence occurrence have not studied or modelled population-level impact.
- Evaluations are often conducted after short follow-up periods, meaning that we understand little about how change is sustained.
- There is limited evidence on the effectiveness of response mechanisms in reducing the occurrence of violence in vulnerable groups.
- Evaluations often do not acknowledge the extent to which the overall impact on women's lives is dependent on elements beyond the control of the intervention.

Short follow-up and limited measure of community or population level impact:

Even when evaluations have measured a direct impact on violence, it has been almost exclusively among direct intervention recipients or their partners. Very few evaluations have measured an impact on VAWG at the community level or population level. The field of violence prevention needs to identify approaches to preventing violence at a community level, not just at the individual level. Furthermore, evaluations are often conducted after a short follow-up period, which means that we understand little about how change is sustained.

Limited evidence from vulnerable groups:

There is limited evidence on the effectiveness of response mechanisms in reducing the occurrence of violence in vulnerable groups, and acknowledgement that this may be different from what is seen in other groups.

4.2 Summary of the evidence

While some intervention evaluations show some impact on reducing repeat violence among those attending (or completing) the intervention, almost all the response interventions are used by only a small proportion of all women and girls who experience violence. This is because most women do not report the violence they experience to the police nor do they seek external care or formal services. Research on the prevalence of physical and sexual IPV globally suggests that about one-third of women have been exposed to violence in their lifetime and global estimates suggest 7 percent of women have experienced non-partner rape (Devries et al., 2013; Abrahams et al., 2014). Population-based research shows that only a small proportion of women who have been raped report it to the police, and an even smaller proportion of women who experience IPV, although these figures may be considerably higher in some high income settings. South Africa is a fairly typical middle

income setting, and research shows that about one in 13 women who have experienced non-partner rape have reported it to the police (1 in 25 of those who have experienced any rape). Domestic violence is reported even less often, with only 0.3 percent of women who experience it reporting it (Machisa et al., 2012). In most cases, women do not speak out about the violence they experience or they tell family members or friends, or report the incident to elders or traditional justice mechanisms. Thus, **at a population level, interventions through response mechanisms are unlikely to ever result in prevention of many incidents of violence.**

Of concern is the fact that some studies have documented adverse consequences for women from a number of response interventions. These include mandatory reporting and arrest, proactive arrest without a protection order, second responder programmes and universal screening. It is essential that evaluations look for potential adverse impacts. **The evidence suggests that these reduce when survivors of violence are able to control access to services, rather than having these imposed or mandated.**

There are also some areas of intervention that are receiving substantial investment, but where there is limited or no evidence of positive impact on the occurrence of VAWG and/or the prerequisites for impact are not in place. For example, police training and other police or legal interventions can only be effective if there is a legislative framework that criminalizes partner violence, including marital rape. Systemic strengthening of the police and justice system is much more likely to be effective than an isolated, once-off training intervention, and it may contribute to shifting social norms on the acceptability of violence. There is also a need to look at the interface between informal / traditional justice

mechanisms (where many more women report violence) and formal justice mechanisms.

Overall, the evidence available suggests that **multi-component interventions are likely to be more effective than single-component interventions in preventing VAWG, especially when applied systemically across a sector.** More research is needed on multi-component interventions. In addition, although it has not been formally evaluated, overall the evidence suggests that a comprehensive legal framework that criminalises domestic violence, including marital rape and other rape, with protection for victims, would provide an essential and enabling environment for any prevention interventions. However, there are often significant challenges to implementing such laws, especially in low-income settings.

Overall, there is potential for some interventions that are rooted in response mechanisms to prevent the occurrence of violence, but **prevention interventions have not yet been fully optimized** and further work is required to improve our approaches and better understand how to combine interventions to maximize effect.

Table 2 presents a summary of the evidence for different types of response mechanisms designed to prevent VAWG. Darker colours represent stronger evidence, ranging from no evidence to fair evidence. Green suggests that the interventions have been shown to be effective in preventing VAWG; blue suggests that they are promising; orange means the evidence is conflicting, that is, some evaluations show that they are effective and others show that they are not. Red illustrates that the interventions have been found to be ineffective; and purple is used for interventions where the impact on VAWG has not been measured.

Table 23. Summary of evidence for different types of response interventions to prevent VAWG

Impact of intervention on reducing VAWG	Effective	
	Promising	<ul style="list-style-type: none"> • Protection orders (with proactive arrest) • Shelters
	Conflicting	<ul style="list-style-type: none"> • Perpetrators' (batterers') programmes • Advocacy interventions / support to access services • Proactive arrest policies (without a protection order) • Second responder programmes
	Ineffective in preventing VAWG (or not recommended due to risks)	<ul style="list-style-type: none"> • Routine screening for VAWG in health services • Mandatory reporting and arrest for domestic violence
	Insufficient evidence	<ul style="list-style-type: none"> • Specialised courts* • Alternative and restorative justice mechanisms* • Referral and case management²⁰ • Sexual offender policies and disruption plans* • Paralegal and community-based legal programmes* • Police and security personnel training (without systemic intervention)* • Community policing* • Hotlines* • One stop centres* • Women's police stations/units* • Counselling, therapy and psychological support ²¹

*The impact on rates of VAWG has not been measured directly or is very limited.

Fair evidence for

Despite the limitations in the evidence base, this rapid review concludes that **there is fair evidence for the effectiveness of protection orders and shelters in preventing VAWG.**

Research on **protection orders** is mainly from **high** income countries, but they are used widely in middle-income countries. The research generally shows high levels of protection order violation; however, there is evidence from a number of studies that

partner violence exposure of women with protection orders is lower than that of similar women without these orders. There is limited evidence on the use of protection orders in low-income and middle-income settings. A concern is that they may be much less effective where it is hard for women to either live separately from their partner or return to their family, which is particular problem for women without independent access to resources or where there are strong cultural obstacles to separation or divorce and women living independently. In any setting where protection

²⁰ Limited evidence, but most studies indicate that this is ineffective in reducing violence.

²¹ Insufficient evidence to make a conclusive recommendation, but some promising results.

orders are available, only a minority of women who experience violence seek a protection order. Therefore, at a population level, having a legal provision for protection orders is useful for a few, and may be of particular benefit to women who experience more severe violence, but there is probably little impact on less severe violence. There has been no research on the population level impact of new introduction of strengthened legislation against VAWG and protection orders.

This review has considered evidence for protection orders and proactive arrest policies as separate interventions, because they can be used separately, but proactive arrest policies are often linked to protection orders. Protection orders require a legislative framework that allows for arrest without seeking a new warrant when they are violated. The evidence for protection order effectiveness has been in conjunction with this provision, i.e. protection order with proactive arrest if violated. In the absence of a protection order, findings conflict as to whether proactive arrest policies result in lower levels of repeat use of violence when compared to other policing interventions (such as issuing warnings or citations, providing counselling, or separating couples). However, there is no evidence that they increased violence exposure.

Shelters are used by women who have experienced severe, usually chronic, and sometimes life-threatening, abuse. They enable them to leave an abusive relationship, at least temporarily, and so prevent violence during this period, and many women benefit from the shelter assistance package. The long term impact of shelters depends on women's ability to live independently after leaving the shelter, and on their readiness to make changes in their lives and leave their partner. Shelters are rarely provided as isolated interventions. Women who enter shelters receive shelter packages that vary, but usually include counselling, information and practical assistance with accessing legal protection and independent living. At a

population level, shelters only accommodate a very small proportion of abused women, and most women who experience violence do not want or need shelter. Shelter provision is therefore unable to impact on levels of VAWG at a population level, even if individual women may benefit from them.

Conflicting evidence

In terms of their ability to prevent violence, **there is conflicting evidence on proactive arrest policies (except where they are linked to protection orders, as discussed above), second responder interventions,** and advocacy interventions that provide information and support to help access legal redress and resources in the community. **There is conflicting evidence about whether second responder programmes are helpful for survivors, or lead to increased violence. Paralegal programmes improve access to justice for women in the short term, but the long term benefit has not been assessed.**

The longer term benefit of both of these interventions is dependent on the quality of the justice system they enable access to. Further evaluation is needed of the inclusion of these programmes in a package of interventions used to strengthen the police and justice system, or in a country where the system was already relatively strong and incremental improvement was sought. However, they are unlikely to be effective in preventing many cases of violence in the absence of interventions to strengthen the system more broadly. We would caution against second responder interventions in the absence of this, because there is some evidence that they can lead to an increase in violence.

Research on **legal interventions after sexual violence in conflict and humanitarian settings** shows that they are supported by survivors and provide a perception that there is an opportunity for justice and removing impunity; however, there is no evidence that this intervention reduces sexual or other violence. Some research has suggested that

women have been subjected to retaliation, lack of protection, ostracism and stigma after testifying. There is yet no evidence that these interventions are effective as a prevention strategy, but the circumstances in which women can participate safely needs to be researched further, as women favour them as part of a response strategy.

There is also conflicting evidence on perpetrator programmes. Three systematic reviews have concluded that there is no evidence that perpetrators' programmes have any notable effect on reducing rates of recidivism; but there are weaknesses in the evidence base and there may be scope for further testing of such interventions, using diverse strategies in different settings. One of the critical problems with these programmes is a high dropout rate.

Couples treatment may be regarded as a variation of the batterers' programmes, in that men who use violence are included in a therapeutic programme. However, this is voluntary and framed in a manner that is not stigmatising. Several studies mention the possible beneficial effect of couples treatment, compared to individual treatment (with women); however no study was found that compares the outcomes of the different treatments. There is emerging evidence that men benefit from being part of the counselling process and being engaged in seeking solutions for reducing violence. This requires further research.

Fair evidence against

There is **fair evidence to suggest that routine universal screening of women for an experience of violence in health facilities is not effective in preventing violence.** Screening interventions have been evaluated using multiple methods in some very large well conducted studies and in many other studies in many countries. There is now sufficient evidence to conclude that routine

identification of women who have experienced abuse or who are in abusive relationships - unless this is relevant to clinical care - does not provide health benefits for women or reduce their exposure to violence.

The impact of interventions to identify women who experience violence may be greater when there is an intervention component. Although some interventions offering this have been shown to be ineffective, these studies have been limited by the type of intervention offered. There is emerging evidence that a more extensive cognitive behavioural therapy (CBT) intervention may be of more value. The one area where this has been explored is in antenatal services. The WHO is currently conducting a multi-centre trial of a CBT intervention in antenatal services, which will assist in providing evidence.

Health providers are encouraged to ask about experience of VAWG when it is clinically necessary for good care. This includes when treating women in mental health service facilities and with disclosure of results to women who have been tested for HIV. This activity is not considered as screening and may be better conducted by health workers who have been trained to do the make the enquiry.

There is also fair evidence to suggest that mandatory reporting and arrest in cases of domestic violence is not effective in preventing violence. Mandatory reporting and arrest is experienced by women as the State undermining their autonomy and ability to control their lives, which is particularly unhelpful for women who have been disempowered by the experience of violence at home.

In both cases, these mandatory interventions show some benefit to a group of domestic violence survivors, but others experience adverse effects with escalating violence. All interventions evaluated seem to work better at the stage when both partners, or either the

woman or man is ready for change. Research repeatedly reminds us that this readiness needs to be achieved through a process and that it cannot be forced on individuals.

Insufficient evidence

Currently there is **insufficient evidence (either because there is not enough evidence or because the impact on VAWG occurrence has not been measured) that the following interventions are effective in preventing violence:** most other police and legal interventions, including police training, sexual offender policies, disruption plans, community policing, women's police stations, specialised courts and paralegal interventions and community-based legal interventions (although these show promise); crisis interventions, including hot lines and One Stop Centres; alternative or restorative justice mechanisms; and counselling, therapy and psychological support (although these show promise).

Police training on violence against women and girls has never been evaluated for its effectiveness in preventing violence against women and girls. This omission suggests that police training is not conducted with the intention of reducing violence against women and girls overall, but in strengthening responses to individual cases. Research suggests that many police training interventions are limited in their own right, because they are delivered outside the context of systemic intervention within the police services and are not taken to scale. Research is needed on how to optimise systemic intervention models within the police service, which includes training as a component. For purposes of prevention, the evidence suggests that police training alone is not an appropriate avenue for investment of resources intended for prevention.

Women's police stations (or units) and specialised courts have not been evaluated for their impact on reducing the occurrence

of violence, although convicting and jailing perpetrators removes a small group from society - at least for the period of their incarceration - and insiders perceive them to be of value. The population level impact of this type of approach is uncertain. Research has shown that creating women's police stations (or units) does not necessarily solve the problems that are systemic in many police services. For example: female officers do not automatically demonstrate better attitudes towards survivors simply because of their gender; staff of these units have been shown to sometimes prevent women from filing a complaint, encourage them to negotiate with the perpetrator instead of upholding their rights, or blame them for the violence that they have experienced. In addition, these units can be severely underfunded, and lack equipment, transport and other key resources (Morrison et al., 2007; Jubb et al., 2010). A further problem is that even when women's police stations work well, their work can be undermined by other parts of the justice system (Morrison et al., 2007). One of the major gaps with specialised units has been failure to evaluate interventions to change social norms within the police force, as an institution, and as they relate to gender and gender-based violence. It is likely that change here will be essential for sustained effect of training and special units in the police force.

There have been some evaluated examples of **specialised courts** for domestic violence and rape, which show that they can have a much higher conviction rate than other courts. Further research is needed to understand how these courts can be optimised, and on the needs and modalities of support to staff to mitigate the effects of secondary trauma. Available evidence suggests that including specialised courts in a package of interventions to be evaluated for their ability to strengthen the police and justice responses to VAWG would be recommended.

Two interventions for child abuse prevention have been used in some settings: **placing**

known sex offenders on registers; and interventions to disrupt potential sex offenders being able to access victims.

Sex offender registers provide some potential for excluding known offenders from certain categories of contact with children. Their main weakness is that the great majority of sexual offences are never reported to the police and, across all countries, only a small minority of cases that are opened result in a conviction. Since only convicted offenders are included in registers, they include the names of a very small proportion of those who are a risk to children. Thus the potential for impact on violence prevention, at a population-level, is very small.

Most sex offender initiatives seek to limit the contact children have with strangers, but most child sexual abuse is carried out by people known to, and trusted by, the victim. All sex offenders are not the same, and so the risk of recidivism is wide-ranging, with the most dangerous and habitual sex offenders likely to be less amenable to treatment. Therefore, programmes should develop and conduct appropriate risk assessment and target strategies accordingly. There is no evidence that these interventions have the potential to make a population-level impact on reducing violence against children.

Hotlines provide advice and support to survivors of VAWG and their contribution to an overall set of survivor support services is evident. Whether hotlines can prevent further abuse from occurring is unknown and this is not their primary objective. Prevention of violence is generally not an objective of One Stop Crisis Centres, or it is very much a secondary objective for those service providers that do see domestic violence survivors. Their impact on violence prevention, over and above that of other service delivery models, is likely to be small, because so few women who have experienced violence report to such centres.

Research has been conducted into the use of **alternative or restorative justice approaches**

for domestic violence and sexual offences. Most of the studies have been small and the findings have been mixed. Larger studies from Australia have not been randomised, therefore the difference between groups in terms of re-offence rates - about 50 percent in all study arms - may have been due to selection bias. There are considerable ethical concerns and other difficulties in these approaches and the overall conclusion is therefore that we do not know enough about them to make a recommendation for or against their use. However, it is important to note that many programming approaches seek to work with traditional or alternative justice systems, and thus more robust evaluation would be useful in this area.

4.3 Recommendations for violence prevention and the global research agenda

Response mechanisms are a vital part of a holistic approach to addressing VAWG, because women who have experienced violence need timely and quality health care, social support and access to justice. However, we cannot assume that these interventions will necessarily also prevent violence.

In fact, this evidence review suggests that interventions to improve the role of response mechanisms as a means of preventing VAWG from happening in the first place should not be a major priority when compared to various community-level prevention mechanisms (see the evidence review on prevention interventions – paper 2 of this series). This is both because of the limited number of men and women who can be impacted through response mechanisms, as well as the limitations in terms of what such interventions can achieve.

Nonetheless, based on this review, we make the following recommendations for funding, programming and for the global research agenda to advance the violence prevention field.

1. **INCREASE INVESTMENT:** There is a great need to increase investment in the evaluation of response mechanisms, particularly in low-income and middle-income countries, and we recommend a focus on the specific areas indicated.
2. **USE CONSISTENT RESEARCH METHODS:** More consistent and rigorous methods for evaluation of violence response programmes should be developed and implemented, so as to ensure comparability across studies and interventions.
3. **MEASURE IMPACT ON VAWG:** Evaluation of response mechanisms would benefit from also measuring the impact of the intervention on rates of VAWG, even if it is not the primary outcome or goal of the intervention.
4. **EVALUATE COMPREHENSIVE INTERVENTIONS ACROSS THE POLICE AND CRIMINAL JUSTICE SYSTEM:** There is no reasonable basis for police and criminal justice system strengthening interventions without legislation rendering VAWG illegal and outlining sanctions against offenders. In contexts where this exists, the following package of services should be evaluated:
 - a. A legal framework criminalising domestic violence including marital rape, and which allows for protection orders and proactive arrest.
 - b. Interventions to secure social norm change related to gender within the police, including training of the police at all levels to understand gender inequalities and empathise with and respond to VAWG and addressing practices that undermine gender equity.
 - c. Specialised units or ‘police stations’ for VAWG, which are staffed by trained officers.
 - d. Having paralegals or women’s advocates to enable access to justice and support, explain and accompany women in legal processes.
 - e. Community awareness raising and information provision, including through hotlines.
 - f. Specialised courts for VAWG offences.
5. **MEASURE COMMUNITY LEVEL IMPACT:** More interventions should aim to have a broad impact on community level violence, not just the individual behaviour of those undergoing the intervention; similarly, evaluations should measure the impact on community level and population level violence.
6. **ASSESS COSTS AND SCALABILITY:** Given the high prevalence levels of VAWG, any response intervention needs to be implementable and scalable in LMICs. There is great need for more research to understand what interventions are scalable, how they can be scaled and if they can be implemented affordably.
7. **IMPLEMENT AND EVALUATE PROGRAMMES FOR SPECIFIC POPULATIONS:** More interventions targeting vulnerable populations, ethnically diverse populations and older populations, should be developed and evaluated. While the focus of prevention should be on impacting the largest number of people, more research is needed to understand the types of interventions that would be most relevant for different population groups, including particularly vulnerable groups of women and girls.
8. **RESEARCH ON HOW TO OPTIMISE THE IMPACT OF SHELTERS** on violence prevention through combining with gender and economic empowerment interventions in a range of settings.
9. **EVALUATE PSYCHOTHERAPEUTIC INTERVENTIONS** that involve both men and women need to be evaluated in rigorous research in a range of settings, using couples counselling and/or CBT interventions provided by lay staff.

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Annex 1. Keyword searches

HEALTH

Violence against Women health response mechanisms

Violence against women health policy

VAW + health services prevention

Violence women + health services intervention

VAW + health programme effectiveness

Sexual assault centres

One stop VAW

Violence women community support

Violence women health Rape crisis centres support

Violence women victims survivor psychosocial support

Health sector VAW

Violence women Sexual and reproductive health

Gender violence health intervention

Gender violence Sexual and reproductive health response

Violence against girls health sector response

Violence against children health sector

Health sector training vaw child protection health sector response intervention

SOCIAL SERVICES

Child protection response mechanisms

Child violence intervention

Violence against children programme

Child protection officer

VAW shelter

Women shelter effectiveness

Women shelter response

Shelter programme impact

VAW social services evaluation

Violence women counseling evaluation

VAW advice services impact

VAW helpline assessment

COMMUNITY

Safe spaces violence

Gender violence Dialogue spaces

Gender violence safe space assessment

Gender violence community response mechanism

Gender violence community response evaluation

Community based organizations VAW

VAW community organization evaluation

VAW community services impact

Safe public transit GBV

Safe public spaces GBV

GBV lighting response

GBV water sanitation

Rape and public spaces
Community patrol impact VAW
Public spaces intervention impact
Making cities and urban spaces safer for women

SECURITY

Violence women security justice response
Women police station review
Violence women police officer
Violence Case management protocol
Violence women legal aid
Violence women mobile court
Violence women sexual offence court
Violence women court evaluation
Violence women protection order
Violence women preventative patrolling
Police community mechanism violence women
Violence women traditional justice
Violence women customary justice mechanism review
Police gender training
Police GBV training
Perpetrator programme

ADDITIONAL SEARCHES

Violence Women Second Responders
Sex Offenders

Sex offenders intervention
Civilian crisis counsellors in police stations
Crisis response police violence women
Sexual crime unit
Sexual crime unit police
SGBV crime unit
Violence women mandatory reporting
Violence women pro arrest
Women police station
Women police station response violence
Violence women training paralegal
Violence women training legal advocate
Sexual violence legal response
Domestic violence legal intervention
Violence women legal response
Violence women criminal sanctions
Training for judicial officials violence women
Impacts of judicial services on reducing violence women
Impact legal response violence women
Legal advocacy violence women
Violence women intervention legal worker
Law response violence women
Restorative justice violence women
Communitarian justice violence women
Violence women justice hybrid model
Justice hybrid model of dispute resolution gender

Informal dispute resolution violence women
 Gacaca court Uganda
 Gacaca court Uganda violence women informal justice violence women
 Informal mechanism violence women
 Violence women mediation
 Violence women arbitration

Violence against women responses
 Vaw response effectiveness
 Vaw response evaluation
 Violence women response evaluation
 Violence women response impact assessment
 Violence women mechanism impact
 Violence women intervention assessment
 Violence women response review
 Violence women response case study

GENERAL

Violence against women + developing countries response

DONOR AND OTHER WEBSITES THAT WERE HAND SEARCHED:

Donors (bilateral and multilateral)	DFID, USAID, World Bank, AusAID, CIDA, Danida, EU, GIZ, NORAD, Sida, Irish Aid
UN agencies	World Bank, UNWomen, UNAIDS, UNHCR, UNFPA, UN Trust Fund on EAW, UNICEF, WHO, www.endvawnow.org; partners for prevention, UNITE
INGOs	ActionAid, Amnesty International, Comic Relief, Human Rights Watch, International Rescue Committee, IPPF, Oak Foundation, Oxfam, Plan International, Population Council, Womankind
Research institutes	London School of Medicine and Tropical Hygiene, MRC, Overseas Development Institute, Yale University, Harvard’s School of Public Health, International Center for Research on Women, George Washington University, IDS – including Pathways of Empowerment



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