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Violence Against Women & Girls

VAWG

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HEALTH SECTOR BRIEF

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The Global Women's Institute
THE GEORGE WASHINGTON UNIVERSITY

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KEY POINTS

- Violence against women and girls (VAWG) has negative impacts on their physical and mental health. Health care settings provide a unique opportunity to identify VAWG survivors, provide critical support services, and prevent future harm.
- While the majority of survivors of VAWG never seek help, the health sector is often the first point of contact for those who do seek care and support services.
- Health care costs for survivors of violence are high and can impose significant burdens on health systems. For example, the 2011 household survey in Vietnam estimated that out of pocket expenditures for accessing services and replacing damaged property averaged 21% of women's monthly income.[1]
- VAWG has intergenerational effects: boys who witness intimate partner violence (IPV) at home are more likely to grow up to perpetrate violence themselves. And girls with childhood exposure to IPV are more likely to experience violence in later relationships.[2]
- Children living in homes with IPV also face greater likelihood of experiencing physical abuse, which increases their risk-taking behaviors in adolescence, including drinking, drug use, and early initiation of sex.[3]
- Violence in the home also has negative effects on children's mental and physical health, including higher infant mortality, lower vaccination rates, and lower birth weight.
- The health sector can play a role in educating clients and the broader community about VAWG as a human rights violation and major public health issue.

INTERSECTION BETWEEN HEALTH AND VAWG

The health sector is often the first point of contact for survivors of VAWG and is a key entry point into the referral pathway to other sectors. For example, one study examining emergency department utilization by women who were ultimately killed by an intimate partner found that 44% of the women had sought help in an emergency department within the two years prior to their death.[4] Consequently, the health sector, in collaboration with other sectors, can contribute significantly to preventing and responding to VAWG at various stages of the cycle of violence:

- **Primary prevention**: refers to efforts to prevent violence from occurring in the first place. Examples of primary prevention activities include increasing community awareness of VAWG risk factors, healthy conflict resolution, challenging harmful gender norms, etc.
- **Secondary prevention:** focuses on early identification of survivors (via screenings in emergency departments and reproductive, maternal and child services, for example), responding to their physical, mental, and reproductive health care needs, and referral to appropriate services.
- **Tertiary prevention**: serves to mitigate the negative impacts of violence that has already occurred. Examples include long-term counseling, HIV post-exposure prophylaxis, and emergency contraception for rape victims.
- **Referral to social, economic and legal support**: given that women experiencing physical violence will likely seek health services at some point, health care providers are favorably positioned to refer survivors to other services to address their immediate needs and prevent future incidents of violence from occurring. (Adapted from Heise, 2011)

Exposure to violence has been linked with a multitude of adverse physical health outcomes for women, including acute injuries, chronic pain, gastrointestinal illness, and gynecological problems. Mental health consequences can include increased risk of depression, post-traumatic stress disorder, and substance abuse. A recent systematic review found that VAWG increases a woman's risk of experiencing depression two- to three-fold. VAWG has also been linked to increased risk of contracting HIV and other sexually transmitted infections, as well as the risk of having unintended pregnancies and attempting to and/or completing an abortion. Survivors of violence are also 2.3 times more likely to have alcohol use disorders.

Source: Klugman, J., Hanmer, L., Twigg, S., Hasan, T., McCleary-Sills, J., and Santa Maria, J. (2014). *Voice and Agency: Empowering Women and Girls for Shared Prosperity.*

ETHICAL AND SAFETY RECOMMENDATIONS FOR VAWG INTERVENTIONS[5]

Any intervention that aims to prevent or address VAWG should include precautions above and beyond routine risk assessment to guarantee no harm is caused. This includes following ethical guidelines related to: ***respect for persons***, ***non-maleficence*** (minimizing harm), ***beneficence*** (maximizing benefits), and ***justice*** to protect the safety of both service providers and the survivors. The sensitive nature of collecting information about VAWG demands additional precautions above and beyond routine risk assessments to guarantee no harm is caused. Interventions should:

- Assess whether the intervention may increase VAWG
- Minimize harm to women and girls
- Prevent revictimization of VAWG
- Consider the implications of mandatory reporting of suspected VAW cases

- Be aware of the co-occurrence of child abuse
- Minimize harm to staff working with survivors
- Provide referrals for care and support for survivors

For further details on these Ethical and Safety Recommendations, visit the Ethics section of our website.

RAPID SITUATION ANALYSIS

Integrating VAWG prevention and response into a project requires an understanding of the legal, social and epidemiological context as in the sector, and how these influence and are influenced by violence. To conduct the rapid situation analysis, work with governments, private sector partners, non-governmental organizations, local experts, and other counterparts in the country to answer some or all following questions:

Specific questions for the sector:

- What obligations do health service providers have with regard to identifying and responding to VAWG?
- Does the health sector have any responsibilities for collecting forensic evidence in cases of sexual and physical violence?
- What protocols and norms exist regarding identification of and care service provision for survivors of violence?
- Does the health sector have a system of referrals and counter-referrals to provide comprehensive care to survivors?
- What programs exist for training and sensitizing the health sector personnel on addressing VAWG?
- What are inter-institutional coordination mechanisms for addressing VAWG in which the health sector is participating?

For further details about how to conduct a rapid situation analysis, please return to the Introduction to this resource guide.

KEY AREAS FOR INTEGRATING VAWG IN HEALTH

Violence against women and girls is a complex public health and human rights issue that affects hundreds of millions of women and girls around the world. This epidemic is best addressed through multi-sectoral coordination at all stages of intervention, ranging from the micro to the macro level. In the health sector, VAWG prevention and response efforts should be incorporated into health plans, policies, and guidelines at the national level, institutional protocols, medical and nursing curricula, healthcare sites[6], and everywhere health is addressed.[7] Additionally, buy-in from the legal, judicial, and other social services sectors at all levels is essential to ensure the survivor is seamlessly referred through the complete pathway of services needed to address violence, healing, and recuperation.

Drawing on the ecological framework presented in Annex 2, below we present some key steps international financial institutions and other development agencies can take to integrate VAWG into the health sector through actions at the policy, institutional, and community levels and through specific survivor-centered interventions.

Policy Level

- **Enable a space for dialogue on VAWG prevention and response:** Once key stakeholders have been identified, establish a forum for discussion between the health sector, different ministries responsible for justice, education, and social services, and other key partners to develop a national action plan for VAWG. See Box 1.

Box 1. *Promising practices…* Liberia's Multi-Sectoral Plan To Prevent and Respond to Gender-Based Violence (2006-2011)

Liberia's plan includes strategies to improve and strengthen the ability of the health care system to respond adequately to VAWG. Activities include developing national guidelines on the clinical management of violence against women and the training of health care providers in their use. Training for medical staff, including auxiliary and community health workers, is also included, as well as the improvement of referral mechanisms among police stations, health centers, referral hospitals, and counseling centers.

Source: UN Women. (2012). *Handbook for National Action Plans on Violence Against Women*

- **Develop clear policy guidelines and protocols to identify and respond to the physical and mental health needs of survivors of physical and sexual violence,** including the prevention of HIV/STI infection and unwanted pregnancies following sexual assault. The WHO clinical and policy guidelines on responding to intimate partner violence and sexual violence against women are the international standard for health sector response to VAWG. Protocols should be developed in alignment with these guidelines and in collaboration with the Ministry of Health and other stakeholders and partners. Services outlined in the protocols should be offered free of charge. If feasible, urge hospital accreditation processes to call for the development of written protocols for identifying and treating survivors of VAWG.[8]

- **Work with government partners and key stakeholders to reform education curricula for health care providers** and include VAWG awareness and response training. Incorporating even one module on VAWG in the curricula may enable healthcare providers to better recognize key signs and symptoms and more adequately treat and/or refer survivors.[9]

Institutional/Sectoral Level

- **Work with government partners and key stakeholders to include data on physical and sexual violence** disaggregated by sex and age group in the routine data collection of the national health information system.[10] Developing safe and ethical data collection systems is crucial for monitoring the prevalence of VAWG and maintaining a strong evidence base. A good example of an integrated data collection system is the Web-based version of the Gender-Based Violence Information Management System (GBVIMS) currently used in Colombia, which collects data from all service providers and integrates them into one system.

Box 2. *Promising practices…* Routine Screening for IPV in Health Clinics

At Kenyatta National Hospital in Nairobi, Kenya, researchers implemented and evaluated a routine screening program beginning in April 2012. A total of 121 providers from the antenatal care clinic (ANC), the HIV comprehensive care center (CCC), and the youth clinic attended one-day training sessions on IPV screening techniques. After training was completed, providers performed routine screening over the following seven months and referred women who reported violence to the GBV Recovery Center (GBVRC) affiliated with the hospital. At the youth clinic and CCC, providers were able to offer confidential and private sessions appropriate for screening. This was more difficult at the ANC. As such, ANC providers found it most appropriate to screen for IPV during HIV pre- and post-counseling. Overall, a total of 1,210 women were screened in the three clinics, with 95 (7.9%) reporting IPV. This study provides preliminary evidence of successful capacity building for routine screening in the health sector and of patients' willingness to disclose IPV to these trained staff.

Source: Undie, C., Maternowska, C., Mak'anyengo, M., Askew, I. (2013). *Feasibility of Routine Screening for Intimate Partner Violence in Public Health Care Settings in Kenya*. Nairobi: Population Council.

- **Ensure that health care providers receive pre- and in-service training and mentoring in protocols on VAWG response.[11]** Health providers often share the same stigmatizing attitudes as the population at large, which can impede survivors from seeking services and can affect quality of care.[12] Providers may also lack the knowledge or confidence to ask their patients about their history of violence.[13] Provide training for health care providers to recognize key signs, symptoms, and health consequences of VAWG and to respond to disclosures of violence appropriately, ensuring privacy and confidentiality, with a non-judgmental attitude and support for the victims. Include other staff, such as home visitation nurses, emergency technicians, and traditional birth attendants in such training.[14] Other staff, such as those involved in hospital administration and management, should be included in most, if not all, of the training, particularly where VAWG treatment and referral protocols are concerned.
- **Support the provision of trained on-site counselors, social workers, or nurses to provide individual counseling and/or group psychosocial support to identified VAWG survivors.**

Evidence has demonstrated that tailored, extensive interventions are generally more effective for reducing violence. However, in the absence of longer, dedicated support, one study found that even a 20-minute counseling session with a nurse can be effective for reducing revictimization.[15] Another study, in Hong Kong, provided pregnant women screened positive for IPV with either a 30-minute "empowerment intervention" or the standard of care for abused women.[16] Women in the intervention group reported significantly less psychological abuse and minor physical violence at six weeks post-partum compared to women in the control group.[17]

- **Design and implement a support system for health staff involved in the provision of services to survivors.** Professionals' well-being may be at risk due to the emotional exhaustion caused by exposure to the pain and suffering of survivors on a daily basis. This vicarious trauma can have serious effects on both the health and performance of staff. Unless this is addressed, staff may become desensitized to or minimize the suffering of survivors; they may omit aspects of their intervention or eventually leave their jobs.[18]
- **Invest in linkages among the health sector and law enforcement and other survivor services,** such as shelters and safe housing, as well as in research to build the evidence base about how best to integrate VAWG in health services.[19] Establish referral pathways among the different services and responders.[20] At a minimum, encourage the development and distribution in each municipality of a directory of violence-related resources available for survivors (discussed further in the community level section).[21] See Box 2.
- **Support the development of a victim advocate program to work in collaboration with health services.** The responsibilities of victim advocates vary depending on the country or context; however, their primary role is to offer survivors information regarding the different options available to them and to support their decision-making processes. They may also assist survivors of violence by contacting social services on their behalf, explaining the various steps involved in the criminal justice process, helping them fill out paperwork, etc. Studies have found that victim advocates can make a considerable difference in a survivors' ability to navigate and access important services such as shelters, protection orders, and psychosocial support.[22]
- **In the absence of victim advocates, allow health care providers to accompany women to the various services included in the referral pathway.** Survivors greatly appreciate this support, and it often leads to an improvement in the treatment they receive from providers and duty bearers, especially by police officers.[23]
- **Ensure that health facility infrastructure projects include safe, private spaces** for health care providers to confidentially ask patients about violence and provide other services, including counseling, as needed.

For survivors of sexual violence/abuse

Women living in situations of physical abuse often concurrently experience sexual and emotional violence and may have difficulty negotiating contraception and condom use. Health care providers should be aware that emergency services may be needed by *any* survivor of sexual violence or

coercion (i.e., those assaulted by husbands, partners, relatives, and acquaintances), not just those raped by a stranger. In addition to post-traumatic stress, survivors of sexual violence may experience unintended pregnancy, sexually transmitted infections (STIs) including HIV/AIDS, and complications from an incomplete or unsafe abortion.

- Support key partners and stakeholders in the development of a comprehensive package of emergency services for survivors of sexual violence that includes the provision or referral for the following: treatment for physical injuries, preservation of forensic evidence, emergency contraception, safe abortion (where legal and available), post-abortion care, testing and counseling for HIV/AIDS, and STI prophylaxis and treatment.
- Ensure that trained or specialized staff are available to provide crisis counseling and/or psychosocial support. Providing survivors with non-judgmental, emotional support is as vital for their recovery as treatment of physical injuries. See Box 3.

Box 3. *Promising practices…* Counseling for sexually exploited girls in the DRC

To assess the impact of counseling on survivors, a randomized control trial was carried out in the Democratic Republic of Congo with war-exposed, sexually exploited girls from 12 to 17 years of age living in foster care. The girls had been orphaned or abandoned by their parents because of the stigma of sexual exploitation; through the program they received vocational training from an NGO. The participants suffered from high levels of posttraumatic stress, anxiety, depression, and conduct problems. Girls were randomized to receive trauma-focused cognitive behavioral therapy (TF-CBT) three times a week for five weeks, or a no-treatment wait-list condition. Given that trained mental health therapists are scarce in the DRC, the counselors did not have mental health backgrounds but received training to provide TF-CBT. At the end of the intervention, **TF-CBT group participants experienced significant reduction in posttraumatic stress disorder,** depression, anxiety, and conduct symptoms, and improved pro-social behaviors compared to girls in the wait-list group, including at the three-month mark.

Source: Cohen, D. (2013). Explaining Rape during Civil War: Cross-National Evidence (1980-2009). *American Political Science Review 107*(03), 461-477.

- Request that emergency contraception kits and STI and HIV prophylaxis be included in the country's national list of essential medicines, and work towards guaranteeing free access to this medicine as women may not have access to funds to purchase them.
- Ensure the availability of forensic nurses or health personnel trained in the medical forensic care of survivors of physical and sexual assault or abuse (and the collection of medical evidence for prosecution, if requested by the survivor) in each major health care setting.[24] Depending upon the local and national regulations, health care providers may or may not be able to collect forensic evidence without special certification. Promote the establishment of training programs for health

providers who are responsible for collecting evidence on protocols in forensic examination for sexual assault, including collection and proper handling of medical evidence.

The above section on sexual violence was adapted from Bott, S., Guedes, A., Claramunt, M.C., Guezmes, A. (2010) *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries*.

Community Level

Work with local partners and stakeholders to help survivors to make the best use of existing services and resources, including those offered within healthcare settings. Raising community awareness of VAWG, challenging harmful gender norms, and creating spaces for community dialogue may increase health-seeking behavior and challenge the acceptability of violence. On the supply side, establishing strong partnerships and low-cost strategies can improve response to survivors and strengthen referral pathways. (For detailed instructions on the points below, please see Bott et al., 2006, in the resource section).

Build alliances among the health sector, NGOs, and local/community partners to:

1. Identify existing programs and services for survivors.

- Work with partners to compile information on NGO programs, government services such as police, public prosecutors, and forensic medical exams, as well as information on services related to custody, divorce, property settlements, and protection orders. In resource-limited settings in particular, record information on the service the organization provides, opening hours, and fees.[25]
- Assemble this information into a referral directory and make at least one copy per health care setting. This is an inexpensive and helpful step for facilitating referrals.
- If adequate external referral services are unavailable in the community, establish basic services in the health center, such as crisis intervention, emotional support,

Box 4. *Promising practices…* Designing and distributing materials on VAWG services

Consider women's safety when designing and distributing materials. Remember that a woman living in situations of violence may be at risk of further violence if her partner finds the pamphlet or card with information about services. Additionally, women may come to the clinic with their partners and may not feel free to pick up materials in waiting rooms. One strategy is to develop small cards that women can hide in their clothing. Sometimes it is helpful to include only the address and phone number of referral services on a card, rather than an explanation of the services provided. This way, a perpetrator will not realize what the referral is for if the card is found. Other health programs have found that placing information (whether cards, pamphlets, or posters) in bathrooms, where women can look at them without being observed by a male partner, can be helpful.

(*Source*: Bott, et al., 2010)

and support groups for women. (See Chapter V in Bott, et al., 2006)

2. Disseminate information on available services.

- Materials can include videos for clients and providers, pamphlets that discuss issues related to VAWG, referral cards with information about local services for survivors, and/or posters that can be displayed in clinics or other places in the community.[5] See www.endvawnow.org for existing materials.
- Other topics for materials could include patient rights within health services (e.g. for privacy and confidentiality), the different types of violence, child sexual abuse, laws about violence against women, sexual and reproductive rights, and human rights in general.[26] See Box 4.

Box 5. *Promising Practices…* Mobilizing communities against violence: Lessons from SASA!

SASA!, which means "Now!" in Kiswahili, is a program developed by Raising Voices and implemented in Uganda by the Center for Domestic Violence Prevention. It is the first community-based violence prevention program in Sub-Saharan Africa to be rigorously evaluated. The program employs multiple strategies to build a critical mass of engaged community members, leaders, and institutions, including local activism, media and advocacy, communication materials, and training. The Activist Kit that is central to SASA! community engagement and mobilization involves four phases: Start, Awareness, Support, and Action. The content evolves with each phase, with power as a central theme. Initial results from a randomized controlled trial show positive effects after almost three years of programming. Compared with control communities, people in SASA! communities have more gender-equitable attitudes and a reduced prevalence of past-year physical violence by an intimate partner. Compared with control communities, SASA! communities report the following striking results:

- Levels of violence against women were 52% lower.
- 28% more women and men believe it is acceptable for women to refuse sex.
- 50% more men and women believe physical violence against a partner is unacceptable.

Source: Abramsky, T., Devries, K., Kiss, L., Nakuti, J., Kyegombe, N., Starmann, E., Cundill, B., Francisco, L., Kaye, D., Musuya, T., Michau, L., and Watts, C. (2014). Findings from the SASA! Study: A Cluster Randomized Controlled Trial to Assess the Impact of a Community Mobilization Intervention to Prevent Violence against Women and Reduce HIV Risk in Kampala, Uganda. *BMC Medicine* 12:122.

3. Carry out educational/behavior change interventions.

- Address the underlying gender norms that support violence and other detrimental health-related behaviors in the community.[27] Studies have found that merely changing legislation or carrying out a campaign is less effective for transforming harmful gender norms than community-based initiatives that simultaneously address a variety of social issues.[28] [29] Wherever possible, work with NGOs and community groups to integrate VAWG awareness-raising or education activities into existing groups, such as microcredit or savings groups. See Box 5.

- Encourage the creation of safe spaces where both men and women can discuss values, practices, and behavior, ensuring these discussions are grounded in human rights discourses.[30] See Box 6.

Box 6. *Promising practices…* Program H/Program M

Program H/Program M is a community education approach originally developed in Brazil to promote gender-equitable attitudes and action among young men. The program has gradually evolved to include a program also focusing on young women, and in certain settings, it has implemented both simultaneously. The program has been carried out in India, Tanzania, Croatia, Vietnam, and Central America. It encourages boys and young men to question traditional views on what it means to be a man by using a small-group format and a no-words cartoon video titled "Once Upon a Boy." Using a participatory curriculum, trained facilitators serve as mentors and meet with the group (often weekly) over four to six months.

Impact evaluations of Program H have found that young men report greater acceptance of domestic work as men's responsibility, improved relationships with their partners and friends, higher rates of condom use, and reduced rates of self-reported sexual harassment and violence towards women. In India, for example, the proportion of men in the urban intervention sites (two slums in Mumbai) who reported sexual or physical violence against a partner in the last three months decreased by more than half to less than 20% at follow-up. In the project's rural intervention site, partner violence also decreased from 50% to 37%.

Source: Verma et al., 2008 and Ricardo et al., 2010, as cited in Heise, Lori L. (2011). *What works to prevent partner violence: An evidence overview.*

RECOMMENDED RESOURCES FOR INTEGRATING VAWG INTO HEALTH SECTOR PROJECTS

Guidance/Tools

Bott, S., Guedes, A., Claramunt, M., Guezmes, A. (2010). *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. An excellent manual for integrating VAWG prevention and response into the health sector. Very detailed with practical information, including checklists and sample questionnaires.

Khan, A. (2011). *Gender-Based Violence and HIV: A Program Guide for Integrating Gender-Based Violence Prevention and Response in PEPFAR Programs*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Velzeboer, M., Ellsberg, M., Arcas, C. C., & García-Moreno, C. (2003).Violence against women: the health sector responds. Pan American Health Organization, Pan American Sanitary Bureau.
UNFPA. (2010). *Addressing Violence against Women and Girls in Sexual and Reproductive Health Services: A Review of Knowledge Assets*.
UNHCR. (2008). *UNHCR Guidelines on Determining the Best Interests of the Child*.

U.S. Agency for International Development (USAID). (2006). *Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers*.

World Health Organization (WHO). (2005). *Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals: Module on Gender-Based Violence*.

WHO. (2004). *Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons*.

WHO. (2013). *Responding to intimate partner violence and sexual violence against women: Clinical and policy guidelines for DV and sexual violence*.

Mental Health and Psychosocial Support

IRC and UNICEF. (2012). *Caring for Child Survivors of Sexual Abuse, Guidelines for Health and psychosocial service providers in Humanitarian settings*..

WHO, UNFPA, and UNICEF. (2011, November). *Responding to the psychosocial and mental health needs of sexual violence survivors in conflict-affected settings: A Summary Report*.

IRC. (2008). *Clinical Care for Sexual Assault Survivors: A Multi-Media Training Tool*.

IASC. (2007). IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*.

All of the above can be found on gbvaor.net under tools and resources

Data sources

Demographic and Health Surveys including questions on VAWG.
WHO. (2005). *WHO's Multi-Country Study on Women's Health and Domestic Violence Against Women*.

Research

Barker, G., Ricardo, C., and Nascimento, M. (2007). *Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions*. Geneva: WHO.

Evanson, T. A. (2006). Addressing domestic violence through maternal-child health home visiting: what we do and do not know. *Journal of Community Health Nursing 23*(2), 95-111.

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Nelson, H. D., Bougatsos, C., and Blazina, I. (2012). Screening women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force recommendation. *Annals of Internal Medicine 156*(11), 796-808.

O'Reilly, R., Beale, B., and Gillies, D. (2010). Screening and Intervention for Domestic Violence During Pregnancy Care: A Systematic Review. *Trauma, Violence & Abuse 11*(4), 190-201.

Ramsay, J., Richardson, J., Carter, Y. H., Davidson, L. L., and Feder, G. (2002). Should health professionals screen women for domestic violence? *British Medical Journal 325*(7359).314-318.

Ramsay, J., Rivas, C., and Feder, G. (2005). *Interventions to reduce violence and promote the physical and psychosocial well-being of women who experience partner abuse: A systematic review*. Barts and the London, Queen Mary's School of Medicine and Dentistry.

Sharps, P. W., Campbell, J., Baty, M. L., Walker, K. S., and Bair-Merrit, M.H. (2008). Current evidence on perinatal home visiting and intimate partner violence. *JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing 37*(4),pp 480-491.

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Taft, A., O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L., and Feder, G. (2013). Screening Women for Intimate Partner Violence in Healthcare Settings. *Cochrane Database of Systematic Reviews 4*.

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[3] World Bank. (2003). *Caribbean Youth Development: Issues and Policy Directions*.

[4] Boinville, Madeleine. *Screening for Domestic Violence in Health Care Settings.* ASPE Policy Brief, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, August 2013

[5] Adapted from Ellsberg, M., and Heise, L. (2005). *Researching Violence Against Women: A Practical Guide for Researchers and Activists.* Washington, DC: World Health Organization, PATH.

[6] ***For example***: sexual and reproductive health centers, maternal and child health centers, adolescent and youth health services, emergency departments, patient treatment centers, and the offices of primary care clinicians.

[7] Tropp, S. and Ellsberg, M. *Sectoral Operational Guides: Health, Education, Justice and Multi-Sector Responses to Violence Against Women.* World Bank/PRMGE, 2006.

[8] Boinville, 2013.

[9] USAID (2009). *A Guide to Programming Gender-based Violence Prevention and Response Activities.*

[10] Bott, S., Guedes, A., Claramunt, M., Guezmes, A. (2010). *Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Care Professionals in Developing Countries.* IPPF/WHR Tools, 2010

[11] Bott et al., 2010.

[12] Tropp and Ellsberg, 2006.

[13] Boinville, 2013.

[14] Bott et al., 2010.

[15] ***Note***: Two interventions were tested: a wallet-sized referral card and a 20-minute nurse case management protocol. Two years following treatment, both treatment groups of women reported significantly ($p < .001$) fewer threats of abuse ($M = 14.5$; 95% CI 12.6, 16.4), assaults ($M = 15.5$, 95% CI 13.5, 17.4), danger risks for homicide ($M = 2.6$; 95% CI 2.1, 3.0), and events of work harassment ($M = 2.7$; 95% CI 2.3, 3.1), but there were no significant differences between groups. (McFarlane, J. M., Groff, J. Y., O'Brien, J. A., & Watson, K. (2006). Secondary prevention of intimate partner violence: a randomized controlled trial. *Nursing research*, *55*(1), 52-61.).

[16] ***Note***: The intervention consisted of advice in the area of safety, decision-making, and problem-solving. It also included an "empathic understanding" component, derived from client-centered therapy.

[17] Tiwari A., Leung, W. C., Leung, T. W., Humphreys, J., Parker, B., and Ho, P. C. (2005). A randomized controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG: An International Journal of Obstetrics and Gynaecology* 112(9),1249-1256.

[18] Bott et al., 2010.

[19] Velzeboer et al., 2003.

[20] Bott et al., 2010.

[21] Bott et al., 2010.

[22] Bybee, D.I. and Sullivan, C.M. (2002). The process through which an advocacy intervention resulted in positive change for battered women over time. *American Journal of Community Psychology 30*, 103-132.

[23] Tropp and Ellsberg, 2006.

[24] Bott et al., 2010.

[25] Tropp and Ellsberg, 2006.

[26] Tropp and Ellsberg, 2006.

[27] Heise, Lori L. (2011). *What works to prevent partner violence: An evidence overview.*

[28] Diop, N. J., Faye, M. M., Moreau, A., Cabral, J., and Benga, H. (2004). *The TOSTAN Program. Evaluation of a community-based education program in Senegal.* New York: Population Council.

[29] ***See***: Pande, 2006, Erulkar, 2007, and DuFlo, 2006, cited in Lee-Rife, S., Malhotra, A., Warner, A., & Glinski, A. M. (2012). What works to prevent child marriage: A review of the evidence. *Studies in family planning*,*43*(4), 287-303.

[30] Bott et al., 2010.

PHOTO CREDITS

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