RESPECT WOMEN

STRATEGY SUMMARY

Services ensured

UN WOMEN

World Health Organization

STRATEGY SUMMARY

Services ensured

OBJECTIVE OF STRATEGY: To meet the needs of survivors of violence against women (VAW) and seek to prevent further violence through provision of essential services,[1] including police, legal, health and social services. These services may include: those providing care and support to survivors; those that aim to prevent, repeat or reduce violence; those that offer psychosocial support, prevent alcohol misuse and substance use for at risk men, women, children/adolescents and families, which work to improve mental health, reduce relationship conflict and reduce substance abuse.

Rationale

Providing quality services to those who have experienced violence is an important contribution to the continuum of VAW prevention. Firstly, prevention interventions often increase the numbers of women who speak out about the violence they suffer and seek help. It is therefore essential that there are safe, confidential mechanisms in place for women to report violence and be referred to the services they need and want. Secondly, there is evidence that when quality services are delivered in ways that respect women's rights, they can reduce risk factors and enhance protective factors for VAW (although the evidence is more mixed on whether services can play a direct role in preventing reoccurrence or deterring new cases of violence). Thirdly, police, legal, health and social services can mitigate the negative effects of violence on the health, safety and wellbeing of survivors. They can provide entry points for early identification of violence and responses to reduce reoccurrence, and entry points or large-scale platforms to integrate VAW prevention and response.

Supporting the delivery of **police and legal services** is critical to ensure that laws against VAW are enforced and can signal to societies that such violence is unacceptable. These laws aim to keep women and girls safe and end impunity of perpetrators, holding them accountable. The actors delivering these types of services are sometimes referred to as justice service providers to encompass the various formal and informal justice actors across different cultural, religious, traditional and legal contexts.[2] Informal justice providers, such as religious or community leaders, may sometimes hear cases of VAW in traditional courts and/or act as mediators in cases of VAW. However, mediation needs to be viewed with caution, as in some settings and due to the patriarchal nature of the informal justice system, mediation can be used to preserve the unity of the family or in cases of rape can end up in the woman marrying the perpetrator.[3]

High quality **health services**[4] are vital for survivors requiring access to medical treatment, including psychological and mental health care. They are also important entry points for programming as health care providers are frequently the first contact survivors have with formal service providers after they experience violence, whether women disclose the violence or not. Health service interventions can address the physical, mental and sexual and reproductive health needs of survivors, including through treatment for injuries, psychological support, post-rape care, emergency contraception, safe abortion (to the full extent of the law) and STI prevention and treatment, HIV post exposure prophylaxis.[5] They can also address the short and long-term mental health needs of survivors.

Social services support the wellbeing, health and safety of survivors of violence through a number of different activities, including crisis counselling, information and assistance helplines, accompaniment to services, safe housing and access to shelters, provision of financial support, and advice about and support accessing legal and rights information and assistance.[6] Social services also include prevention-focused interventions that seek to address the psychosocial needs of at risk groups, including by reducing substance abuse and addressing mental health needs.

It is important that police, legal, health and social service provision is guided by the obligation of duty bearers to respect the rights of survivors and principles of survivor-centred care, including safety. These are articulated in the UN's Essential Services Package for all women and girls who have experienced violence.[7]

Risk and protective factors

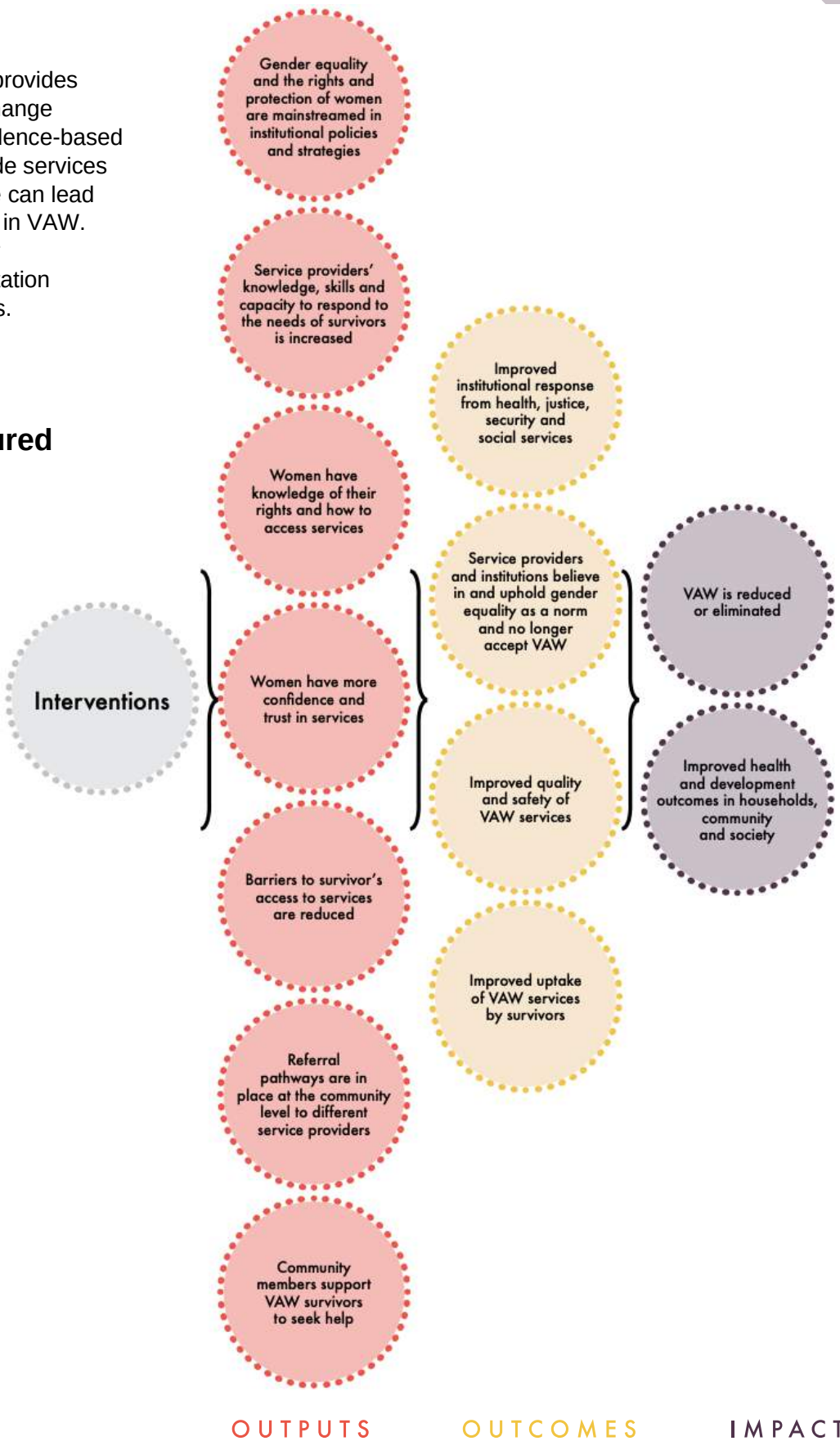
This strategy aims to address the following risk factors and promote the following protective factors for VAW:

Level	Risk factors	Protective factors
Individual	Attitudes condoning or justifying violence as normal or acceptable (men and women) Psychological dysfunction / poor emotional regulation (men) Harmful use of drugs and alcohol (men and women)	Gender-equitable attitudes (men and women) Psychosocial wellbeing (men and women)
Interpersonal	Poor communication, ineffective conflict resolution and problem-solving skills Women's isolation and lack of social support	Relationship skills to mitigate triggers of violence (e.g. conflict resolution, communication) Social connectedness
Community	Harmful gender norms that uphold male privilege and limit women's autonomy Norms that condone violence against women Availability of drugs, alcohol and weapons	Norms that support non-violence and gender-equitable relationships, and promote women's empowerment Social sanctions for VAW perpetrators
Societal	Absence or lack of enforcement of laws addressing violence against women Gender discrimination in institutions (e.g. police, legal, health)	Laws that: • Promote gender equality (e.g. land and inheritance rights) • Address violence against women

Theory of change

The following diagram provides a simplified theory of change demonstrating how evidence-based interventions that provide services for survivors of violence can lead to sustained reductions in VAW. This would need further development and adaptation for specific programmes.

S: Services ensured



Types of interventions

A number of different interventions have been implemented in high-income countries (HICs) and low- and-middle-income countries (LMICs) to strengthen access to services for survivors of violence. In this table, we summarise the evidence on how service interventions impact on VAW prevalence, intermediate outcomes addressing risk factors for VAW and secondary outcomes related to women's health, wellbeing and empowerment in HICs and LMICs.[8] The table describes the key types of service interventions highlighted in the RESPECT framework and provides a brief overview of the current evidence base and example programmes. Where available, we have prioritised programme examples from LMICs and/or women's rights organisations, who have a key role to play in delivering services to survivors of VAW in communities. The evidence is mainly derived from violence prevention reviews conducted in 2014-2015,[9] with more recent evidence included where relevant. For health services, evidence is based on WHO guidelines for responding to IPV and sexual violence against women .

LEGEND

- ● **promising**, >1 evaluations show significant reductions in violence outcomes
- ■ **more evidence needed**, > 1 evaluations show improvements in intermediate outcomes related to violence
- ◆ **conflicting**, evaluations show conflicting results in reducing violence
- □ **no evidence**, intervention not yet rigorously evaluated
- ▼ **ineffective**, >1 evaluations show no reductions in violence outcomes
- H World Bank High Income Countries (HIC)
- L World Bank Low and Middle Income Countries (LMIC)

Intervention type	Description	Evidence of effectiveness	Example programmes
Empowerment counselling interventions or psychological support to facilitate access to services and advocacy	This type of intervention involves providing women with information, support and accompaniment to access a broad range of possible services including counselling, psychosocial support or legal advice. Key service providers comprise survivor advocates who provide information and support to a woman so she can make informed choices about whether to seek help and from where. These service providers then often accompany women to services and advocate for their rights.	H There is **promising evidence** from HICs that this type of intervention can work to reduce women's experiences of some forms of IPV (including physical and emotional IPV) in the short term, particularly if advocacy is intensive. However, there is limited evidence of longer-term impact.[10] L **More evidence** is needed from LMICs as there have been very few evaluations of advocacy interventions, but at least one study shows improvements in intermediate outcomes related to violence, such as adopting some safety behaviours.[11] These interventions have been implemented largely in HICs, including in the context of antenatal care services, and are resource intensive. Therefore, their applicability in LMIC settings still needs to be established.	The Community Advocacy Project (USA) Empowerment intervention for pregnant women (designed in USA and adapted in Hong Kong, India and Peru)[12]

Intervention type	Description	Evidence of effectiveness	Example programmes
Shelters / safe accommodation	Shelter interventions provide emergency or transitional housing for women survivors of violence and their children, and usually also provide or coordinate access to other services, including psychosocial counselling, healthcare, employment, economic assistance and training.	L	**More evidence is needed**[1] in both HICs and LMICs of whether shelters lead to a reduction of violence for survivors, with some studies suggesting that it may increase violence in the short term but reduce it in the longer term. This can depend on whether women leaving shelters can live independently and leave their abusive partner, preventing future recurrence of violence. Shelters can also lead to improvements in secondary outcomes related to violence, including survivors feeling safer. However, there are a number of methodological limitations of research on the impact of shelters, including reliance on self-reported data.[13]	Maiti Nepal Transit Homes (Nepal)
Helplines	Telephone or online helplines are a form of crisis intervention where survivors of violence or those close to them can reach out to speak with someone and obtain information about how to access support.	H L	**More evidence is needed** in both HICs and LMICs to evaluate the effectiveness of helplines in reducing women's experience of violence. However, there is evidence in both types of settings that helplines can lead to improvements in secondary outcomes related to violence, including survivors feeling supported, and the need for them to be resourced.[14]	SAWA Women's Protection Helpline (Palestinian Territories)
One-stop crisis centres	One-stop (crisis) centres (OS(C)C) are part of a multi-sectoral approach that provide a variety of services in one location, usually including health, social and legal services. These centres can be standalone or may be located in health or legal facilities such as hospitals or courts. One-stop crisis centres are only one modality of providing coordinated multi-sectoral services.[15]	H L	**There is no evidence** available in HICs on the impact of one-stop crisis centres on women's experience of violence. **More evidence is needed** in LMICs. Two systematic reviews suggest that there are not many rigorous evaluations and among those that have been evaluated, there is no evidence that OSCCs improve access to uptake or quality of services or improve health or well-being.[16] Some project evaluations in LMICs suggest that they may improve user satisfaction, feelings of empowerment and increased comfort with disclosure.[17] They may be costly, however, and not suitable in all settings and hence, to be considered along with other service delivery approaches.	Isange One Stop Centre (Rwanda) Thuthuzela Care Centres (South Africa) Dilaasa Crisis Centres (India)

[1] Regardless of whether shelters/safe accommodation prevent violence, these services are essential in providing a safe space for women who may need to leave their homes and should be resourced.

Intervention type	Description	Evidence of effectiveness	Example programmes
Alcohol misuse prevention interventions	Alcohol or substance misuse prevention interventions target male perpetrators of IPV or non-partner sexual violence (NPSV) who abuse alcohol or substances. Some interventions may also target women at risk or survivors of violence who abuse alcohol or substances.	H L **More evidence is needed** from both HICs and LMICs that alcohol misuse prevention interventions can be successful in reducing IPV. When combined with other health or IPV prevention approaches, such as psychotherapeutic and gender-transformation approaches, or interventions with couples, there is evidence that alcohol misuse prevention interventions can be effective. However, the evidence of the effectiveness of standalone alcohol misuse interventions in reducing women's experience and men's perpetration of VAW is mixed. In both HICs and LMICs, alcohol misuse interventions can lead to reducing risk factors related to violence, including improved mental health or reduction in alcohol and substance use.[18]	Common Elements Treatment Approach (CETA) (Zambia) Women's Health Co-op (South Africa)
Perpetrator interventions	Interventions targeting male perpetrators of violence attempt to reduce reoffending and often target men who have been court-mandated to participate as a result of an arrest. These interventions can include sessions on anger management or cognitive behavioural therapy that focus on the use of violence, or psycho-educational approaches, including feminist approaches that focus on power and control in relationships. These interventions are sometimes linked with alcohol and substance misuse interventions (see above).	H There is **conflicting evidence** of whether male perpetrator interventions are successful in preventing VAW in HICs, with some significant methodological challenges in the available evidence. Some interventions combine male perpetrator interventions with alcohol/substance abuse programmes or couples counselling, although these combined interventions have also had mixed results.[19] L **More evidence is needed** in LMICs of the effectiveness of perpetrator interventions, with the available evidence focusing specifically on alcohol and substance use interventions with perpetrators, with some evidence of impact on reducing risk factors, as outlined above.	
Women's police stations / units	These interventions typically involve establishing police units that provide specialised services for women (and sometimes also children), particularly those who have experienced violence. They are often staffed by female police officers who	H There is **no evidence** testing the efficacy of these interventions in HICs, either on reducing VAW or improving intermediate outcomes related to violence. **More evidence is needed** from LMICs. There is evidence showing that establishing women's police stations or units can	Comisaría de la Mujer (Argentina) Delegacias Especualizad

Intervention type	Description	Evidence of effectiveness		Example programmes
	have received specialist training in handling VAW cases. Such units can perform a range of functions, including receiving complaints and reports of violence, providing referrals to other services and assisting the initiation of legal action. These units may also sometimes mediate cases or do preliminary investigations in cases of VAW.	L	lead to improvements in secondary outcomes related to violence, including reporting of abuse.[20] However, there has been little evidence to suggest that women's police stations or units can lead to a reduction in VAW or risk factors for VAW, although a recent study in Brazil has linked the presence of women's police stations with a reduction in female homicides among some groups of women.[21]	as de Atendimento das Mulheres (Brazil)
Screening in health services	Screening interventions involve asking all women whether they have experienced IPV when they present for health services, by using a range of standard tools, protocols or questions prior to or during health care consultations.	H	Evidence from HICs suggest that screening interventions are **ineffective** in reducing VAW. Although screening may increase women's disclosure of violence, there is no evidence that this leads to increased referrals and uptake of services.[22]	
		L	There is **no evidence** available on the effectiveness of screening interventions on reducing VAW or VAW risk factors in LMICs.[23]	
Sensitisation and training of institutional personnel (without changing the institutional environment)	This type of intervention involves conducting sensitisation and skills-based training with institutional actors, such as police, justice and health service providers on VAW awareness, prevention and response.	H L	Evidence from HICs and LMICs suggests that training institutional actors on its own is **ineffective** in reducing violence outcomes. However, training accompanied by system-wide institutional change along with content that addresses gender attitudes, institutional policies and support for programme staff can improve survivor-centred responses.[24]	

Example programmes

The following table summarises three different programmes which have been shown to deliver reductions in VAW prevalence within programmatic timeframes. The table should be reviewed alongside the **design and implementation checklist** on page 9, as well as the **guiding principles of effective programming** provided in the RESPECT framework when adapting any of these methodologies. More detailed information on each programme is provided in the **programme summaries.**

Approach	Description	Location	Target	Core activities	Duration	Evaluation and Impact
Healthy Activity Programme	A psychological treatment intervention adapted from 'behavioural activation' and delivered by lay counsellors to patients with depression	Goa, India	Patients from eight primary health-care clinics with moderately severe to severe depression. Lay counsellors are members of the community.	Psychological treatments, delivered by lay counsellors, comprise sessions driven by core strategies, including behavioural assessment and self-monitoring, psycho-education, activity structuring and problem-solving.[25]	Up to 8 sessions delivered over 2 to 3 months, with each session lasting between 30 and 45 minutes.	**Type of evaluation:** Randomised controlled trial (RCT)[26] **Main findings:** Participants in the intervention group had significant larger reduction in severe depressive symptoms (primary outcome) when compared with the control group, and significantly lower prevalence of disability, fewer days off work, fewer suicidal thoughts and lower prevalence of physical IPV experience (in women).[27]

Approach	Description	Location	Target	Core activities	Duration	Evaluation and Impact
Violence and Alcohol Treatment Trial (VATU) of Common Elements Treatment Approach (CETA)	Aims to improve mental health, and reduce substance use and IPV by pairing a Common Elements Treatment Approach with an alcohol reduction programme[28]	Three urban neighbourhoods in Lusaka, Zambia	Three individuals from families, including: an adult woman, her male husband or partner and one male or female child (aged 8-17)	Group sessions are run separately for men, women and children. Alcohol reduction component focuses on awareness of alcohol as a problem and its link to violence, and gender norms. CETA content focuses on substance use, positive parenting and family relationships, conflict management, and attitudes and beliefs about violence.[29]	6-12 weekly sessions with exposure for 1-2 hours per week.	**Type of evaluation:** RCT[30] **Main findings:** Men reported significant reduction in alcohol use, harmful alcohol use and perpetration of IPV. Women reported significant reduction in alcohol use, harmful alcohol use and experience of physical and sexual IPV. Both men and women reported significantly reduced symptoms of poor mental health.[31]
The Safe Homes and Respect for Everyone (SHARE) intervention	Community-based mobilisation integrated into routine HIV prevention and treatment services	Uganda	40 community volunteers – local men and women. 12 volunteer community counselling aides (CCAs)	The programme combined community-based mobilisation to shift attitudes and norms that contribute to IPV and HIV risk, with screening of women for IPV followed by an intervention to reduce HIV disclosure-related violence and risks for women seeking HIV counselling and testing. SHARE was modelled on the SASA! and Stepping Stones approaches and curricula, integrating high-quality, culturally appropriate, violence prevention activities into a pre-existing health and social support structure.	5 years	**Evaluation type:** Cluster randomised cohort study **Impact:** Reduced prevalence of women reporting past year physical and sexual IPV. Reduction in HIV prevalence and HIV disclosure rates among both women and men.[32]

Design and Implementation Checklist

Common elements and principles of effective approaches to service provision include:

Programme design and adaptation

1. **Implement interventions that combine primary prevention and service elements.** High quality, survivor-centred VAW services can help women to speak out and seek help and create an enabling environment to reduce stigma and contribute to prevention goals. Combining primary prevention with services recognises that in any community with high prevalence of VAW, prevention interventions will create demand for services as women speak out and therefore these services must be in place. The UN's Essential Services Package and for the health component, the WHO tools on responding to violence against women, together provide useful guidance on providing quality services (e.g. prioritising safety, survivor-centred approaches, confidentiality, privacy and autonomy) and linking with other sectors and agencies through coordination.

2. **Use system-wide approaches to health care provision for survivors of violence.** A system-wide approach requires attention to policies, protocols, infrastructure, resources, staff capacity, staff attitudes towards gender and VAW, case documentation and data systems, and referrals.[33] Ensuring that adequate health infrastructure and systems are in place is particularly important when considering scaling up health sector services for survivors of violence.[34]

3. **Embed ongoing training of service providers into wider institutional structures.** Training service providers (such as police or health care providers) on violence prevention, violence response or positive social norms as a standalone, 'one-off' activity does not sustain changes in provider practice. In order to be impactful, training needs to be embedded into institutional structures, frameworks, policies or curricula and to be 'gender transformative' seeking to shift individual attitudes and gender norms as well as systems and structures that perpetuate violence, discrimination and inequality that are prevalent in the institutions.[35] Service providers should receive training in how to provide survivor-centred care that considers the multiple needs of survivors and minimises secondary victimisation. Service providers should have a clear understanding of roles and guidelines to ensure safe, quality services and coordination across sectors. In-service training carried out with multiple sector service providers as a multi-sectoral team also seems to positively influence coordinated response provision.

Implementation and scale-up

4. **Strengthen community-based care and support for survivors of VAW.** Women's rights organisations have a strong track record of providing services and well-established community networks.[36] Community volunteers can serve as an important bridge between community members and state agencies and other non-governmental service providers, by providing referrals, accompaniment and support for survivors who disclose and wish to access health care, security, social welfare and legal services.

5. **Carefully select, train and supervise community volunteers.** Community volunteers can also play an important role in delivering certain types of services in resource-constrained settings, including psychosocial counselling. In such cases, community volunteers need to be carefully selected, trained and supported to ensure they are modelling gender-responsive behaviours, survivor-supportive attitudes, and have the necessary skills and knowledge to provide first-line psychological support and help survivors

access response services. One way to ensure volunteers get timely and responsive support is through a carefully developed supervisory/ mentor system with regular check-ins, refresher sessions on key concepts, and opportunities to talk through any specific challenges that they may be facing.

6. **Prioritise the physical and psychological safety of women and girls.** Ensure that regular monitoring and evaluation is identifying possible risks to women and girls in violence response and prevention interventions and that programmes have adequate mitigation systems in place to address these risks and avoid doing further harm.

7. **Ensure sufficient intensity and duration of some types of response interventions.** The evidence suggests that some types of response interventions require sufficient intensity and duration to lead to positive impact for women. For instance, advocacy interventions that involve empowerment counselling and psychological support appear to be more effective where advocacy is intensive, suggesting that 'light touch' interventions and short timeframes may be insufficient.

8. **Increase the accessibility, visibility and trust of service providers.** Women face many barriers to accessing VAW services and any intervention aiming to increase provision of quality services must attempt to address these challenges, which are contextual and vary both geographically and according to different populations. To improve access, services must be provided as close to the user as possible (e.g. primary health services, community policing, mobile courts). The visibility of service providers is also important and regular visits to engage in dialogue with communities can help to build awareness. Building trust in service providers is critical, especially when women have concerns about confidentiality, stigma and blame, and women's rights organisations can also help build this trust due to their community networks. Ensuring context specific entry points is also crucial. For example, where services for VAW providers may not be welcome but a health camp would face no scrutiny – building a health camp that has in-built support for medical, psychosocial, legal documentation and referral support can be a useful way to reach survivors in hard-to-reach places.

Entry points

Services can provide important entry points for survivors to access further GBV response options and can also provide entry points for primary prevention programming. The following table highlights key entry points for this strategy, including programme examples.

Entry point	Rationale
Health services including sexual and reproductive health (including maternal and child health), mental health services, and HIV services	The health system is an important entry point to reach survivors of violence because health care practitioners are often the first contact that survivors reach out to even if they do not explicitly disclose violence as the reason for using health services. WHO guidelines for responding to intimate partner violence and sexual violence against women recommend that care for VAW must be integrated into existing health services including sexual and reproductive health, HIV, mental health and adolescent health services at the primary health care level rather than be standalone centres. They also recommend that all health providers must be trained in identifying women experiencing IPV, offering first line support, and post-rape care. Training must also address their gender attitudes and be accompanied by changes in the health system procedures, including through: written protocols to guide care; establishing champions to support care provision; improvements in patient flow and infrastructure for privacy and confidentiality; strengthening of referral linkages; and integrating VAW documentation in health information systems.[37] WHO guidelines have been adapted and implemented in Afghanistan - training 5000+ health care providers over the past 5 years and improved health system readiness in most of the 34 districts. They are also being implemented in Uganda, Namibia, Zambia, Pakistan, India, and Cambodia among others. Trained community workers (including community health workers, midwives, community psychosocial workers) can raise awareness about the harmful impacts of violence against women, where to seek help, and help link survivors to services. In places like Nepal and Brazil, primary health care centres are using this cadre of frontline professionals to link the community with health services and to raise awareness of IPV and additional help seeking behaviour.[38]
Police services, including women's police stations/units	Police services, including women's police stations and units, can provide survivors of violence with an important entry point to the formal justice system, and can also be linked to primary prevention interventions. There is some evidence that women's police stations can increase survivors' perceptions of reduction of VAW, although there is little available evidence of whether this translates to actual reduction in prevalence of violence. However, the literature suggests that women's police stations can contribute to survivors' access to justice services, although this does not necessarily translate to prosecution of perpetrators.[39] Other police and justice response interventions include protection measures, such as Protection Orders, which can prevent the reoccurrence, escalation and threats of violence.[40] The Comisaria de la Mujer (women's police stations) in Argentina are mandated by a National Action Plan to prevent VAW through a model of police multi-sectoral service delivery alongside social workers, lawyers and psychologists. The police stations also work with schools, local community groups and local and provincial government organisations on violence prevention through awareness campaigns and the coordination of local prevention and response activities, with the aim of shifting negative social norms that drive VAW. A study of Comisaria de la Mujer presents several lessons about the implementation of women police stations, including the need to ensure adequate resourcing and the importance of providing counselling and self-care support to police and other personnel who are frontline first responders to VAW.

Useful Resources

Health services

Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organisation. 2013.
The WHO guidelines are targeted towards health care providers and aims to provide evidence-based guidance on good practice in responding to the health care needs of survivors of IPV and sexual assault, including in relation to clinical interventions and emotional and psychosocial support.

Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organisation. 2017
The WHO guidelines are aimed at helping front-line health workers, primarily from low resource settings, in providing evidence-based, quality, trauma-informed care to survivors. The guidelines emphasise the importance of promoting safety, offering choices and respecting the wishes and autonomy of children and adolescents.

Health care for women subjected to IPV and Sexual Violence: A clinical handbook. Geneva: World Health Organisation. 2014
This WHO clinical handbook is aimed at helping healthcare providers care for women who have been subjected to violence. It includes information on awareness about VAW, first-line support for IPV and sexual assault, additional clinical care after sexual assault, and additional support for mental health.

Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers. Geneva: World Health Organisation. 2017
This WHO manual is aimed at health managers to strengthen and enable health systems to provide confidential, effective and women-centred services to survivors of violence.

Caring for women subjected to violence: A WHO curriculum for training health-care providers. Geneva: World Health Organisation. 2019
This curriculum is designed to provide health-care providers with a foundation for responding to domestic/ intimate partner violence and sexual violence against women. The curriculum seeks to build skills and to address providers' attitudes towards survivors of violence.

Psychological therapies for women who experience intimate partner violence. Tan, M., O'Doherty, L., Gilchrist, G., Taft, A., Feder, G., Tirado Munoz, J., Chondros, P., Sadowski, L. & Hegarty, K., Cochrane Systematic Review. 2018.
This Cochrane review assesses the effectiveness of psychological interventions for women who experience IPV.

Screening women for intimate partner violence in healthcare settings. O'Doherty L, Hegarty K, Ramsay J, Davidson LL, Feder G, Taft A. *Cochrane Database of Systematic Reviews* 2015.
This Cochrane Review (update) examines the evidence on screening women for IPV in healthcare settings. It finds that screening increases identification of IPV, with pregnant women in antenatal settings more likely to disclose IPV when screened. However, there is insufficient evidence that screening has an impact on health outcomes and re-exposure to violence.

Police, justice and social services

Essential services package for women and girls subject to violence. UNWOMEN, UNFPA, WHO, UNDP and UNODC, 2015.
This is an extensive package of resources and guidelines focusing specifically on developing and implementing services for women and girls who experience violence. It includes modules on health, justice and policing, social services, and coordination and governance, with an additional module on implementation published in 2017 (available here).

UNWOMEN Virtual Knowledge Centre to End Violence against Women and Girls.
UNWOMEN's Virtual Knowledge Centre has a range of relevant resources, including guidance, case studies and examples of promising practice related to interventions targeting health, justice and security and shelter responses to VAW.

The implementation and effectiveness of the one stop centre model for intimate partner and sexual violence in low- and middle-income countries: a systematic review of barriers and enablers, Olsen, R.M, García-Moreno, C. and Colombini, M. BMJ Glob Health. 2020; 5(3): e001883
This systematic review identifies several barriers to the implementation and effectiveness of the one stop centre model, including staff time constraints and lack of basic medical supplies. It also highlights enablers such as standardised policies and procedures and regular interagency meetings.

Endnotes

[1] UN Women, UNFPA, WHO, UNDP and UNODC (2015) UN Essential Services Package and Guidelines. For the health sector, see WHO Guidelines and tools in the Useful Resources section above.
[2] UN Women, UNFPA, WHO, UNDP and UNODC (2015) Ibid.
[3] UN Women (2012) UN Handbook for Legislation on Violence against Women, New York: UN Women.
[4] These should be provided in line with the WHO clinical and policy guidelines for responding to intimate partner violence and sexual violence (2013)
[5] Ibid.
[6] Ibid.
[7] UN Women, UNFPA, WHO, UNDP and UNODC (2015) Ibid.
[8] Here we use the term intermediate outcome to indicate an outcome that is part of the theory of change or pathway to reducing VAW prevalence. Secondary outcomes are not necessarily part of a theory of change but are other desirable outcomes associated with women's rights and wellbeing.
[9] García-Moreno, C., Hegarty, K., Lucas d'Oliveira, A.F., Koziol-Maclain, J., Colombini, M. & Feder G (2014) The health-systems response to violence against women**.** *Lancet;* Jewkes, R., Mclean Hilker, L., Khan, S., Busiello, F & Fraser, E. (2015) Response mechanisms to prevent violence against women and girls. What works to prevent violence against women and girls – Evidence Review 3; Ellsberg, M., Arango DJ., Morton, M., Gennari, F., Kiplesund, S., Contreras, M. & Watts, C. (2015) Prevention of violence against women and girls: what does the evidence say? Lancet, 385: 1555-66.
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[11] Cripe, SM., Sanchez, S., Sanchez, E. et al. (2010) Intimate partner violence (IPV) during pregnancy: A pilot intervention program in Lima, Peru. Journal of Interpersonal Violence, 25(11): 2054-2076.
[12] Parker, B., McFarlane, J., Soeken, K. et al. (1999) Testing an intervention to prevent further abuse to pregnant women. Research in Nursing and Health, 22(1): 55-66; Tiwari, A., Leung, WC., Leung, TW. et al. (2005) A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. Obstetrics & Gynaecology, 112(9): 1249-1256; Cripe et al. (2010) Ibid; Sapkota, D., Baird, K., Saito, A. & Anderson, D. (2019) Interventions for reducing and/or controlling domestic violence among pregnant women in low- and middle-income countries: a systematic review, Systematic Reviews, 8(79).
[13] Jewkes et al. (2015) Ibid; Sullivan, CM. (2012) Domestic violence shelter services: A review of the empirical evidence. Harrisburg: National Resource Center on Domestic Violence.
[14] Jewkes et al. (2015) Ibid; Hayes, C. (2014) Tackling gender-based violence with technology: Case studies of mobile and internet technology interventions. STATT.
[15] UN Women, UNFPA, WHO, UNDP and UNODC (2015) Module 5: Coordination and Governance of Coordination; UN Women (2019) Coordinated Responses, Virtual Knowledge Centre to End VAW.
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