Annex H

What works to prevent violence against women and girls?

Evidence review of the effectiveness of response mechanisms in preventing violence against women and girls

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Drawing on a review of evidence conducted by Seema Khan, Federica Busiello, Erika Fraser and Lyndsay McLean Hilker

Contents

1.0 INTRODUCTION

This paper examines the evidence base on the effectiveness of response mechanisms for violence against women and girls (VAWG) in preventing the occurrence or reoccurrence of violence. Along with the other evidence papers in this series, this rapid assessment of existing evidence aims to:

- Inform the development of the research agenda and priorities for innovation for *What Works to Prevent Violence Against Women and Girls: A Global Programme*
- 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

VAWG response mechanisms include a variety of interventions implemented by formal institutions, as well by informal institutions and civil society organisations, across the security and justice, health and social sectors. Their primary purpose is to ensure that women and girls experiencing violence receive support, affirmation and advice about 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 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 engaged in extensive awareness raising work at community level to break the silence surrounding VAWG and encourage women to seek support from these response mechanisms. The results of this advocacy have been varied among 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 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 a primary goal of strengthening the response of the police and criminal justice system, health system or social sector to violence against women and girls. The question of the ability of these mechanisms to support VAWG prevention has rarely been asked and, as this paper will show, research in this area is limited. In most cases prevention is not an explicit aim of response interventions; in others, especially in the police and criminal justice system through the idea of deterrence, it has been assumed to be a consequence of strengthened response mechanisms - yet this has often not been established through research. As this review will show, interventions have also often focused on one part of a response system, for example training a part of the police force, without reflection on the degree to which systems support new ways or working, or whether interventions can be effective at all without scale up and social norm change within the institution affected.

In this paper, we review interventions that are designed primarily to respond to VAWG, but which have a secondary or parallel primary aim of preventing VAWG or targeting key risk factors that contribute to the perpetration (by men) or experience (by women) of VAWG. The interventions reviewed are within the police and justice sector, the area of crisis intervention, the health sector and the social sector. 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 description of the intervention type; a summary of the types and extent of evidence found; and a synthesis of what the evidence suggests in terms of the effectiveness of the intervention in preventing VAWG. The second half of the paper discusses the findings, presenting 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.

2.0 METHODOLOGY

2.1 Search process and inclusion criteria

This paper is based on a rapid review of existing evidence on interventions that are designed primarily to respond to VAWG, but which have a secondary or parallel primary 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.

The starting point for the paper was a database developed for a 'review of reviews' of interventions to prevent VAWG that was conducted by the Global Women's Institute of George Washington University, from which we identified relevant reviews and studies dating from 1998. The review has drawn extensively from existing systematic and comprehensive reviews as well as relevant individual studies and impact evaluations identified through academic databases and Google Scholar. We also searched for grey literature dating from 2005 such as individual programme evaluations by visiting the websites of bilateral and multilateral donors, 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 any unpublished materials, but this yielded only a few additional studies. A full list of search terms is available at Annex 1; a full bibliography is attached at Annex 2, and tables with summary information on studies and reviews analysed is available on request and online.

Our inclusion criteria consisted of the following:

- *Completed* reviews or individual studies (including RCTs, quasi-experimental studies, cohort evaluations, qualitative studies, pre- 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 inteventions in either preventing/reducing further VAWG *or* reducing risk factors for violence in responding to survivors' needs.
- Studies from high-, medium- and low-income, and from development, humanitarian and conflict-affected contexts.

For each intervention, we include a topline summary of : (i) types of evidence; and (ii) evidence of effectiveness of intervention. To do this we have adapted the evidence criteria from the Canadian Task Force on Preventative Health Care, ensuring that they were broad enough to cover different sectors and intervention types (i.e. not just health).

2.2. Limitations of the review

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

- **Much of the research reviewed has methodological weaknesses**. Where possible, we have included in footnotes, brief commentary about any key methodological limitations with the studies reviewed.
- 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, some can only be used in combination or as part of a system. In evaluating combinations of interventions, or interventions in complex systems, it is difficult to distinguish with confidence the impact of different components (although a multi-arm study can do this to some extent) – so in some cases, evaluations of individual interventions really reflect a package of interventions or an intervention in a system.
- Most interventions were developed to provide response mechanisms and services to VAWG survivors; very **few have been designed with a view to preventing VAWG** and 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, to sustain impact over the long-term, many interventions require the effective operation of systems beyond the control of the intervention.
- 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 and where women's reports are also available, it is sometimes found that these substantially differ from police reports. The effect of using a crude, lower frequency measure of violence such as police reports will be to bias findings towards showing no effect, and this **may under-estimate the impact of interventions**.
- There have been **few RCTs and few evaluations of any type with a proper control arm**. The disadvantage of uncontrolled research 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.
- There is limited evidence on the effectiveness of response mechanisms to reduce violence occurrence in **vulnerable groups**, and acknowledgement that this may be different from other groups.
- Most rigorously evaluated studies and evidence included in this review are from the US, out of context from most lower or middle income countries. It is therefore unclear to what extent these findings are generalisable to other settings, especially in the police and justice sector where in the US the engagement of the sector in VAWG is much higher (arrest rates for domestic violence for example are higher)
- This review only includes a limited number of qualitative evaluations of interventions from NGOs and donor agencies, primarily because they are unpublished and difficult to access.

For the evidence ratings, we adapted the evidence criteria from the Canadian Task Force on Preventative Health Care, ensuring that they were broad enough to cover different sectors and intervention types (i.e. not just health) and would capture: (i) types of evidence; and (ii) evidence of effectiveness of intervention. The ratings are shown in the table below.

Key to evidence statements and grading of recommendations which is based on the Canadian Task Force on Preventive Health Care

Quality of evidence assessment	Classification of Recommendations
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II–1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II–2: Evidence from well-designed cohort (prospective or retrospective) or case-control	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II–3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	E. There is good evidence to recommend against the clinical preventive action
	F. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

3.0 ASSESSMENT OF THE EVIDENCE BASE

3.1 POLICE AND JUSTICE SECTOR RESPONSES

3.1.1 Police and Security Personnel Training and Capacity Building

Types of Evidence:
II–3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline - endline comparisons)

Evidence of effectiveness of intervention:
F. There is insufficient evidence to make a recommendation.

Description of the 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 the self-awareness (e.g. interpersonal and communication skills, stress and anger management, and attitudes towards women) and life skills 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]

Types of evidence available:

Police training and capacity building programmes are widely implemented but infrequently evaluated. We identified two comprehensive reviews (Heise, 2011; Morrison et al., 2007) and three studies of police training programmes in Pakistan, the Pacific Islands (Cook Islands, Kiribati, Samoa, Tonga, Vanuatu) and Honduras (Khalique et al., 2011; Turnbull, 2010; UNFPA, 2009). T

Effectiveness of the interventions:

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 or the intervention. However, there is some evidence that training programmes may be able to bring about changes in attitudes and behaviours of police and security personnel, and may have increased credibility among survivors. (Khalique et al, 2010; UNFPA, 2008).

Issues emerging from the evidence base

Implementation weaknesses are the key factors affecting the outcomes from 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 with no refresher trainings or follow-up (Heise 2011[2]; Khalique et al, 2010).[3] This is particularly problematic as police personnel frequently change postings. This is echoed by an evaluation of a police training programme in Pakistan (Khalique et al, 2010). Programmes are often delivered by people who lack first-hand knowledge of police culture and are

[1] Security Knowledge Module, Endvawnow.org: http://www.endvawnow.org/en/articles/1078-set-clear-objectives-for-different-types-of-training.html?nex

[2] Heise draws on Wernham (2005) for her findings in training programmes. This is 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 trainings in Ethiopia and Bangladesh.

[3] Heise relies on Wernham (2005) for her findings in training programmes. This is 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 trainings in Ethiopia and Bangladesh.

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 which is provided to new recruits and as part of in-service training

(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:

I: Evidence obtained from at least one properly randomized controlled trial (RCT)

Evidence of effectiveness of intervention:

C. The existing evidence is conflicting and does not allow to make a recommendation for or against the intervention.

Description of intervention

Proactive arrest policies are based on laws empowering the police to make arrests either without a warrant or with a pre-issued but not served warrant in cases of previously-reported domestic violence. These preferred arrest laws instruct the police that arrest is the preferred response.

Summary of evidence available

Three comprehensive reviews (WHO review 2013; Heise, 2011; and Fisher, 2004) on a range of police response and advocacy interventions including pro-active arrest policies.

Effectiveness of the intervention

There is some evidence that they may have a modest effect on preventing violence perpetration amongst some men, but it is unclear whether proactive arrest policies are more effective than other police responses in preventing violence. There may be some benefit for those who are first-time domestic violence offenders and have no other criminal history, but regardless of whether they were arrested, more than half of men do not commit domestic violence again. Most cases of domestic violence reported to the police are perpetrated by a very small group of men who are repeat offenders – most likely 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, if perhaps ineffective, none of the research suggests that proactive arrest policies are harmful or increase women's exposure to violence.

3.1.3 Mandatory Reporting and Arrest

Types of Evidence:

I: Evidence obtained from at least one properly randomized controlled trial (RCT)

Evidence of effectiveness of intervention:

D. There is fair evidence to recommend against these interventions.

Description of intervention

Mandatory arrest is a legal provision requiring police to arrest in all cases of domestic violence. *Mandatory reporting* is a legal provision requiring healthcare workers, or other professions who learn a person is experiencing domestic violence to report it to the police.

Summary of evidence available

- Three comprehensive reviews (WHO review 2013; Heise, 2011; and Fisher, 2004) on a range of police response and advocacy interventions including mandatory arrest policies.
- Four studies of mandatory reporting and arrest policies (Chesney-Lind, 2002; Gielen et al., 2000; Malecha et al., 2004; and Rodriguez et al., 2001)

Effectiveness of the intervention

Mandatory arrest policies have been shown to increase arrests in the US, as well as cases brought into the criminal justice system and to the attention of prosecutors and therefore can disrupt violence in the short term. However, prosecutors have often found survivors who are coerced to bring cases reluctant to testify (Epstein 2003 cited in Goodmark 2007) due to reluctance to use the legal system against their partners, mistrust of the judicial system, or fear that perpetrators may become more violent as a consequence. There is **evidence that some perpetrators may become more violent after arrest or prosecution**, especially those who were 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 they are also arrested for committing violence acts in self-defence (Chesney-Lind, 2002; Goodmark, 2007).

No study was found that measures the effects of *mandatory reporting* by healthcare workers or other professionals on the occurrence of VAWG. Some studies have found that fears of negative consequences may discourage women from disclosing domestic violence to healthcare providers with a mandatory reporting policy (Gielen, 2000; Rodriguez, 2001; WHO, 2013). Research findings conflict as to whether a majority of abused women support mandatory reporting (e.g. Rodriguez et al 2001 finds a majority of women in favour), 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 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.

3.1.4 Protection orders

Types of Evidence:
II–3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline - endline comparisons)

Evidence of effectiveness of intervention:
B. There is fair evidence to recommend the intervention although violence does not always stop after a protection order is issued

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 then made permanent after a hearing. In the Philippines, *barangay* (community) officials in Panang can grant 'barangay protection orders' which last 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 (Heise, 2011; Kelly et al, 2013). In 2004, 20% of women experiencing domestic violence in the US obtained protection orders (Holt, 2004).

Summary of evidence available

- Two comprehensive reviews covering civil law remedies (Goodmark, 2007 and Heise et al., 2011)
- Three individual studies (Cesario et al., 2014; Mathews & Abrahams 2001; and Kelly et al., 2013) - the studies from the US and UK were based on a prospective cohort methodology and the South African study was qualitative.

Effectiveness of the intervention

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 five studies from the United States, which report rates of re-abuse of 23% to 70% (McFarlane et al, 2004; Holt et al, 2003; Carlson et al, 1999; and Logan and Walker, 2010, cited in Heise, 2011). A further review cited – which reviewed 32 studies - found that on average 40% 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[4] to assess their effect 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 those 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 in about half of cases where temporary protection orders and 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 the impact of protection orders was short and others mentioned a shift to emotional abuse. Protection orders are hard to implement in low and middle-income settings where options for independent residence are limited due to economic and socio-cultural constraints.

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% saying that the order was either "extremely" (51%) or "fairly" (27%) 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 (2007) argues that protection orders "*interrupt the pattern of domination and control by directly restructuring the relationship level between the victim and abuser.*" (p.11)

However, the Goodmark (2007) review highlights **some risks of over-reliance on protection orders.** Where a woman fails to secure one – because of safety concerns, lack of legal representation, losing a hearing – she can be assumed not to have taken the required steps to protect her children, and can have child abuse or neglect proceedings started against her. In the District of Columbia for example, filing for a civil protection order is considered proof that a mother has tried to protect her child - reflecting a value judgement that battered women should turn to the legal system for help – as opposed to shelters, community organisations or counsellors.

3.1.5 Second responder programmes

Types of Evidence:

[4] This 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.

I: Evidence obtained from at least one properly randomized controlled trial (RCT)

Evidence of effectiveness of intervention:

C: The existing evidence is conflicting and does not allow to make a recommendation for or against the intervention

Description of 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, they 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

- Three comprehensive reviews (WHO review 2013; Heise, 2011; and Fisher, 2004) on a range of police response and advocacy interventions including second responder programmes.
- One systematic review (Davis et al, 2008) which found a significant increase in research on second responder programmes, and generally that this has been of high quality. Half of the tenstudies included in that review were RCTs, most with large sample sizes.
- One individual study (Hovell et al., 2006).

Effectiveness of the intervention

There is conflicting evidence about whether second responder programmes 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, two studies from second responder programmes implemented in the United States, found that the treatment groups were more likely to experience violence than the control group (Davis et al 2008; and Hovell et al 2006). 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).

3.1.6 Sex offender policies and disruption plans

Types of Evidence:

I: Evidence obtained from at least one properly randomized controlled trial (RCT)

Evidence of effectiveness of intervention:

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 to playgourps to foster parents. Additional strategies used against known sexual offenders include home confinement, electronic monitoring and residence restrictions (Levenson and D'Acora, 2007).

Disruption plans use surveillance measures and information about risky adults' association with vulnerable children to 'disrupt' abuse attempts without involving the child. Specific strategies can include: observation of risky adults; formal warnings to risky adults within legislative frameworks; application of prevention orders; and investigation of other criminal acts including immigration and money laundering offences (Radford et al, 2014).

Summary of evidence available

Levenson and D'Amora (2007) found limited research on sex offender management policies. The only evidence found was:

- One comprehensive review of disruption plans (Radford et al. unpublished);
- One comprehensive review of sex offender policies (Levenson and D'Amora, 2007)

Effectiveness of the intervention

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; Schram and Milloy, 1995, all in 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 (particularly given the overall low rate of sex offense recidivism). It further found that notification has detrimental effects on the rehabilitation of sex offenders (Tewkesbury et al, 2012, cited in Radford, 2014). The researchers concluded that targeted sex offender registration and notification may be a better policy option. 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 interview research[5] 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 and in low resource settings disruption plans may be difficult to implement.

3.1.3 Community policing

Types of Evidence:
II–3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline - endline comparisons)

Evidence of effectiveness of intervention:
F. There is insufficient evidence (in quantity or quality) to make a recommendation.

Description of intervention:

There is no clear definition of the term 'community policing', but it can involve police departments organising their management, structure, personnel, and information systems in a way that supports partnerships with women's advocates, traditional and community leaders and other community members and enables proactive problem-solving focused on survivor safety.[6]

Type of evidence available:

We identified two studies on community policing (Giacomazzi et al., 2001; Robinson et al., 2000), both from the US, and neither of these studies assessed the impact of interventions on preventing violence.

Effectiveness of interventions:

The impact of community policing on reducing violence against women 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).

[5] The 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.
[6] Security Knowledge Module, Endvawnow.org: http://www.endvawnow.org/en/articles/1095-community-based-policing-.html

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.

3.1.4 Women's police stations or specialised response units

Types of Evidence:
III: Qualitative studies, ethnographies

Evidence of effectiveness of intervention:
F. There is insufficient evidence (in quantity or quality) 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 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.

First established in Brazil in 1985, they have 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. 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.[7]

Types of evidence available:

No studies were found which 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.

Effectiveness of the interventions:

No studies found directly measured the impact of women's police stations on the occurrence of violence. There is also no evidence that they guarantee timely and effective access to justice for women, and punishment for perpetrators. There is some evidence that WPS increase reporting of abuse, as well as women's access to care services. 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.

A 2005 study on WPS in Tamil Nadu, which included interviews with 60 dowry victims[8] found that half of the women interviewed indicated that partner violence had decreased, with most believing that this was due to the intervention by the women police. However, 5% 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)

3.1.5 Specialised courts

[7] Security Knowledge Module, Endvawnow.org: http://www.endvawnow.org/en/articles/1093-womens-police-stations-units.html
[8] The sample was randomly selected from a pool of 474 survivors whose case records were also analysed for the study.

Types of Evidence:
II–3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline - endline comparisons)

Evidence of effectiveness of intervention:
F. There is insufficient evidence (in quantity or quality) to make a recommendation;

Description of 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, coordination with other justice sector actors, and reduce delays and rates of victimisation (Cook et al, 2004). Sexual offences courts have operated in South Africa and Liberia.[9] Specialist domestic violence courts have operated in parts of the United States, Canada and the UK for over ten years.

Types of evidence available:
The search uncovered three individual studies (Cook et al, 2004; Gover et al, 2003; Sadan et al, 2001). Most studies focus on specialised courts in urban areas in high-income countries.

Effectiveness of the intervention

Specialised courts have not generally been evaluated for their impact in reducing violence against women. However, the Spangaro et al (2013) found that special courts in humanitarian and post-conflict contexts were not associated with reduced risk or incidence of violence. Some of the studies 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, 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).

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 rearrests 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% 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).

3.1.6 Legal interventions in conflict or humanitarian crises

Types of Evidence:

III: Qualitative studies, ethnographies

Evidence of effectiveness of intervention:
C. The existing evidence is conflicting and does not allow to make a recommendation for or against the intervention

Description of the intervention:

[9] South Africa Department of Justice and Constitutional Development (2013): http://www.justice.gov.za/reportfiles/other/2013-sxo-courts-report-aug2013.pdf

Legal interventions include: specialist prosecution units/ tribunals; indictments through the International Criminal Court; legal education; legal aid services; training for judicial officials; and rights awareness (Spangaro, 2013; IDLO, 2013).

Types of evidence available:

We found only two comprehensive reviews which cover legal interventions (Spangaro et al., 2013; and Morrison et al., 2007). A further three studies (Griffen, 2009; IRC, 2012; and Sotirovic, 2012), covers interventions implemented in the US, the UK, Tanzania, as well as the International Criminal Tribunals of Rwanda and the former Yugoslavia.

Effectiveness of the intervention:

Spangaro et al (2013) found that legal interventions in humanitarian and post-conflict contexts were not associated with reduced risk or incidence of violence. Some of the studies 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, 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).

While Morrison et al (2007) does not provide any information about the impact of judicial services on reducing violence, it highlights evidence which indicates that survivors' access to justice cannot be achieved without broad reform of the judicial system which addresses issues of corruption, procedural delays, lack of transparency and the lack of a formal judicial presence in poor and rural settings.

3.1.7 Paralegal and community-based legal interventions

Types of Evidence:
I: Evidence obtained from at least one properly randomized controlled trial (RCT)

Evidence of effectiveness of intervention:
F. 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).

Types of evidence available:

Three individual studies (Bell and Goodman, 2001; Chibuta, 2011; Hester and Westmarland, 2005), one was an RCT.

Effectiveness of the intervention:

There is some evidence that training advocates/paralegals to support women in accessing the legal system can increase women's access to justice, and even 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 - at six week follow up – 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 (Bell and Goodman, 2001).

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

evaluation[10] 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 evaluation[11] of 27 domestic violence projects implemented across the UK in 2000 onwards found that 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 at court. Providing targeted legal support to black and ethnic minority women increased their engagement with the criminal justice system (Hester and Westmarland, 2005).

Morrison et al (2007) highlight evidence, however, which indicates that survivors' access to justice cannot be achieved without broad reform of the judicial system addressing 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.

3.2 CRISIS INTERVENTION

3.2.1 Hotlines

Types of Evidence:
III: Qualitative studies, ethnographies

Evidence of effectiveness of intervention:
F. There is insufficient evidence (in quantity or quality) to make a recommendation.

Description of the intervention:

Telephone hotlines enable survivors, and their family or friends, to speak about the violence they are experiencing, and to get information about how to address specific issues, such as housing or childcare. 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).

Types of evidence available:

One evaluation of a hotline combined with multiple services (counselling, advocacy, and shelter) across 54 domestic violence programmes operating in the state of Illinois in the United States asked users statements at the end of a call (Bennet et al., 2004).

Effectiveness of the intervention:

The impact of the hotline on violence occurrence has not been measured. Survivors calling gained information about violence, and felt they had more support. Hotlines in South Africa for violence against children (Childline) and women do receive a great number of calls, however, there is considerable frustration when clients are not able to get a response to their calls from the supposedly 24 hour service.

3.2.2 One Stop Centres (+Sexual Assault Centres and other Women's Support Centres)

Types of Evidence:
II–3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline - endline comparisons)

Evidence of effectiveness of intervention:
F. There is insufficient evidence (in quantity or quality) to make a recommendation

[10] The evaluation collected qualitative and quantitative data through key informant interviews, focus groups discussion, field observation, and collecting case studies and testimonials

[11] A 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.

Description of intervention:

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

Box: Isange One Stop Centre, Kigali, Rwanda

An example of a well-resourced and functioning OSC is the Isange One Stop Centre (IOSC) in Kigali, set up by jointly by the UN and Government of Rwanda. Located in in the Kacyiru Police Hospital (KPH), the OSC is staffed by one coordinator, nine psychologists, one gynaecologist, six social workers, three medical doctors with 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 in the IOSC is initially seen by a social worker that 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).

Summary of evidence available

We found 11 studies, 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). Only two studies were based on a non-randomised control design (Grisurapong, 2012 and). The project evaluations are from a range of countries and regions – Indonesia, Malaysia, Nepal, Occupied Palestinian Territories, Thailand, Zambia, and Melanesia. None of the individual studies assess the impact of OSCs on preventing violence.

Effectiveness of interventions:

None of the studies assess the impacts of OSCs on reducing violence. There is some limited evidence that the 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 also 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 can feel more empowered. A 2010 evaluation of one-stop Child Sexual Abuse Centres in Zambia found that there were high levels of satisfaction amongst survivors of the quality of services, with many noting that of the inclusive and consultative way in which staff behaved and the services were provided made them feel empowered (Morel-Seytoux, 2010). A 2009 UNFPA case study[12] of the PUSPITA programme in Indonesia which located women's crisis centres in *pesantren* (Islamic boarding schools) highlights that survivors feel supported by the highly influential *pesantren* leaders, and as a result feel more able to disclose the violence (UNFPA, 2009).

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 referral system to external support services (Colombini et al, 2012; Ellsberg et al, 2012; Chepuka et al, 2011).

3.2.3 Shelters

Types of Evidence:

II–3: Evidence obtained from comparisons between times or places with or without the intervention (e.g.

[12] This 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.

baseline - endline comparisons)

Evidence of effectiveness of intervention:
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 abusing partner after a period in shelters.

Description of intervention:

Shelters provide alternative housing from women experiencing violence, and are designed to accommodate women and children for emergency stays, and to allow women time to consider their options, and make alternative arrangements. Shelters can 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 on 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.

Type of evidence available:

Three comprehensive reviews (Morrision et al., 2007; Straka, 2006; and Sullivan, 2012) and one study (Bennet et al., 2004) were found.

Effectiveness of the intervention:

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 US in 1984 and 2004 in which the majority of women (72% and 79% women respectively) reported that use of the shelter had been effective in reducing violence against them. However, a small proportion of women (6% and 10% respectively) stated that violence against them had increased. Morrison et al (2007) cites 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 in the short-term, but less violence after two years (Sullivan and Bybee, 1999, cited in Morrison et al., 2007).[13] Bennet et al (2004) cite a 1988 study from the US, which found that shelters can have beneficial effects for those women who have already started to make changes in their lives before entering the 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, 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, cited in Sullivan, 2012).

The use of shelters is also associated with the women deciding to leave abusive relationships. A 2007 study found that for women experiencing moderate to severe violence, shelter was significantly related to ending the relationship (Panchanadeswaran and McCloskey, 2007, cited in Sullivan, 2012). A 1992 study also found that that the more types of services women used while in 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 shelters can help women to feel safer, more hopeful, and more knowledgeable about safety strategies once they leave.**

Specific limitation of shelter research include the observations that those studies which compare those women who use shelters with those who do not are compromised by the other variables that affect shelter use, for example income level, education levels, 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 within them. 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

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

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 in the shelter.

3.3 HEALTH SECTOR RESPONSES

3.3.1 Healthcare Professionals' Training and Screening Interventions

Types of Evidence:
I: Evidence obtained from at least one properly randomized controlled trial (RCT)

Evidence of effectiveness of intervention:
D. There is fair evidence to recommend against universal screening

Description of intervention:

These interventions involve training health care professionals on intimate partner violence with the aim of building their knowledge and skills so that they can undertake screening, which is the process of identifying women who are experiencing, or have recently experienced intimate partner violence (IPV) when they attend health services. 'Routine' or 'universal' screening occurs when all women consulting a healthcare provider are asked about partner violence. This is 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.

The training usually includes 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 programmes are often provided in-service, with sessions lasting from an hour or hours, to a number of days, and there have been efforts to integrate training into undergraduate or basic training curricula for healthcare providers.

Types of evidence available:

A large number of studies have looked at the impact of screening initiatives on reducing violence against women. There have been three very large and well conducted RCTs. We found eight systematic reviews (Coulthard et al., 2010; Feder et al., 2009; Kataoka et al., 2004; Nelson et al., 2012; O'Reilly et al., 2010; Ramsay et al., 2002; Taft et al., 2013; and Wathen and Macmillan, 2003), six comprehensive reviews (Chepuka, 2013; Evanson, 2006; Garcia-Moreno, 2002; Guedes, 2004; Plichta, 2007; and WHO, 2013) and six individual studies that were not included in the reviews. The majority of the evidence is from on programmes from the US, UK, Canada, Australia and New Zealand. However there are a small number of mainly qualitative studies from Tanzania, South Africa and India. 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).

Effectiveness of interventions:

There is no evidence of the impact of training interventions on their own on intimate partner violence occurrence for women, and this is rarely measured in evaluations of training. Similarly there is no evidence of effect on referrals to services, or attitudes and beliefs.

There is no evidence, however, that screening leads to a reduction in violence, or improves health outcomes 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). 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 uptake of specialist services.

The key finding emerging from almost all the reviews is that **screening interventions clearly increase identification of women experiencing intimate partner violence (**Nelson et al, 2012; Taft et al, 2012;

O'Reilly et al, 2010; Plichta, 2007; Guedes, 2004). Taft et al. (2013) found that screening is particularly effective in increasing the identification of women experiencing IPV in antenatal settings, but this is only of value if combined with an intervention that is useful for women.

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.

3.3.2 Referral and Case Management

Types of Evidence:
I: Evidence obtained from at least one properly randomized controlled trial (RCT)

Evidence of effectiveness of intervention:

C There is conflicting evidence, however, most studies indicate that it is ineffective

Description of intervention:

Screening interventions by healthcare professionals can be linked to referrals to care, follow-up and support services. These can include the provision of safety information, counselling and referrals to shelters, and further healthcare. It is hoped that such programmes can go beyond increasing the identification of women experiencing domestic violence, to improved outcomes for women.

Type of evidence available:

Our research found two comprehensive reviews covering programmes which link screening to some sort of follow-up interventions (WHO, 2013; and Nelson et al., 2012). Five additional individual studies (Jackson et al., 2012; Tumbewaze et al., 2009; Hegarty et al 2013 and Krasnoff et al., 2000) were also found. There were six RCTs, three of which were targeted to pregnant and post-partum women in the US, UK, Canada and Australia. One cohort evaluation and qualitative study from South Africa and Uganda respectively were also included.

Effectiveness of the intervention:

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 referrals to social workers or professional advocates – found that none of these studies demonstrated a reduction in recurrence of intimate partner violence. Two studies have looked at health outcomes and found no differences (Macmillan et al, 2009, cited WHO, 2013).

There is a possibility that offering interventions for pregnant women may be of more value, but there is insufficient evidence. Nelson et al (2012) argued that that screening followed by counselling may reduce intimate partner violence (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.

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 for resource-constrained contexts**. A 2009 study which aimed to assess the management of GBV survivors in health facilities of Kabarole District, western Uganda found that respondents experienced long waiting times at the health facilities they were referred to. Shortages of staff, lack of privacy and 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 by 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 attend.

3.4 SOCIAL SECTOR INTERVENTIONS

3.4.1 Counselling, Therapy and Psychosocial Support

Types of Evidence:
I: Evidence obtained from at least one properly randomized controlled trial (RCT)

Evidence of effectiveness of intervention:
F. There is insufficient evidence (in quantity or quality) to make a recommendation, although some studies have found positive effects

Description of intervention:

Counselling, therapy and psychosocial support are similar types of mental health interventions, and 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 specific problems.

(3) Psychosocial support includes providing practice assistance in the form of care and support to victims of violence and may include counselling and therapeutic intervention in addition.

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

Types of evidence available:

Several studies have looked at the impact of counselling, therapy and psychosocial support on violence against women. We found two systematic reviews (Wathen and MacMillan, 2003; Tol et al, 2013) and three comprehensive reviews (McCollum and Stith, 2008; Keesbury and Askew, 2010; World Health Organisation, 2013; and Spangaro et al., 2013) plus three further studies (Hester and Westmarland, 2005; Crespo, 2010; and Spratt, 2012). 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 vs. 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, 2013).

Effectiveness of the intervention:

There is no conclusive evidence of impact on reducing violence against women, but some studies have found positive effects. 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% of controls reported reabuse vs 75% of women in the intervention group) (Sullivan and Bybee, 1999, cited in Wathen and MacMillan, 2003).

There is some evidence of positive impact on communication in relationships as well as on the psychological health or women and children. For example, a mid-term evaluation of the *Ending Domestic Violence project in Rwanda* found that 44.4% of participants felt that counselling services helped them improve dialogue in addressing issues that may lead to violence (Omollo-Odhiambo and Odhiambo, 2011)[14]. Most of the reviews conclude that there is a need for a more robust evidence base (Keesbury and Askew, 2010; Tol et al, 2013; World Health Organisation, 2013). Several studies looking at the long-term

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

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).

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 lack of high-quality studies looking at the impact of the counsellor/therapists' training, including the use of volunteers or lay counsellors. **Although several studies mention the possible effect of individual, couple or group treatment, no study was found comparing outcomes between the different treatments.** Couples treatment is widely used in substance abuse programmes, but considered to be controversial for intimate partner violence (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. Best practices include careful assessment and screening of couples for inclusion in couples' treatment, modification of typical couples approaches to promote 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. A study of domestic violence counselling in Rwanda 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 fellow men (Omollo-Odhiambo and Odhiambo, 2011 – see the evidence review on prevention approaches in this series).

3.4.2 Advocacy and support to access services

Types of Evidence:
I: Evidence obtained from at least one properly randomized controlled trial (RCT)

Evidence of effectiveness of intervention:
C . The evidence is conflicting

Description of intervention:

Advocacy interventions aim to help abused women directly by providing them with information and support to help access resources in the community, especially legal redress. Many interventions also provide safety-planning advice and seek to empower women to achieve their goals (Ramsay et al, 2009). Some advocacy programmes 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. The 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.

Types of evidence available:

Several studies have looked at the impact of advocacy interventions on violence against women. We uncovered two systematic reviews (Ramsay et al. 2009; Wathen and MacMillan, 2003) and two comprehensive reviews (Sullivan, 2012; World Health Organisation, 2013), plus four further studies that were not included in the reviews (Tan et al, 1995; Sullivan et al, 1999; Hester and Westmarland, 2005; and Chang, 2005). Most studies have been conducted in the United States, with one from Hong Kong.

Effectiveness of the intervention(s):

The evidence is conflicting. There may be some reduction in physical IPV but not sexual and emotional, and it may be greater in the short term. The most recent and comprehensive systematic review is Ramsay et al's review (2009) of randomised controlled trials comparing advocacy interventions for women with experience of intimate partner abuse against 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). 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 years follow up), but there is inconsistent evidence on other forms of abuse, including emotional and sexual abuse. A longitudinal study aiming to assess the effectiveness of three interventions – briefing; counselling; and outreach – amongst 329 pregnant Hispanic women in the US found that the severity reduced significantly across all the interventions with no difference between arms at 18 months, although arguably the study design was weakened by the overlap between the three intervention types (McFarlane, 2000). **There is also some evidence that brief advocacy increases the use of safety behaviours by abused women.**

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 for advocacy to have an effect (WHO, 2013).

3.4.3 Perpetrators' (Batterers') programmes

Types of Evidence:
I: Evidence obtained from at least one properly randomized controlled trial (RCT).

Evidence of effectiveness of intervention:
C. The evidence is conflicting and weaknesses in study design hamper our ability to make a recommendation, nonetheless, there is fair evidence of benefit to men who attend and are retained in perpetrator programmes.

Description of intervention:

Perpetrators' programmes (also known as batterers' programmes) consist of treatment or rehabilitation interventions for perpetrators of domestic violence, which can be mandated by court order, or perpetrators can choose to attend voluntarily. Typically these interventions involve the use of psycho-educational methods, which aim to (i) help men to understand how their behaviour stems from patriarchal gender norms and beliefs about men's power and control over women; and (ii) help them to develop skills to handle their anger without resorting to violence (Feder et al, 2008; Babcock et al, 2004). Treatment can last anywhere between eight and 26 weeks, and can be delivered to individuals, couples or groups.

Types of evidence available:

A large number of studies have looked look at the impact of perpetrators' programmes on whether individuals return to domestic violence, i.e. above and beyond what would have been expected to occur as a result of arrest and associated legal procedures. We uncovered three systematic reviews (Smedslund et al., 2011; Feder et al., 2008; and Wathen and Macmillan, 2003) and three comprehensive reviews (Sartin et al., 2006; Babcock et al., 2004; Feder, 2005) plus two further individual studies that were not included in the reviews (which included one quasi-experimental study, and one cohort evaluation). The large majority of the evidence focuses on programmes implemented in the US.

The most recent and comprehensive systematic review is the Smedslund et al. (2011) study, which located six RCTs, all from the US, which 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.

Effectiveness of the intervention:

Overall there is a suggestion of a modest effect on reducing recidivism among those who attend and are retained in longer duration programmes, but the findings are inconclusive. A weakness of the evidence is that most studies rely on criminal justice records to assess recidivism, whereas much violence is not

reported.[15] 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%).[16] 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 (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-assaults (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, but it seems that relatively longer duration programmes are more successful (compared to e.g. 8 weeks or less). A 2003 case series of four programmes 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 sustain non-violent behaviour (Gondolf 2003).

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 (Davis et al, 2000, Gondolf 2003), levels of risk monitoring, 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. Johannson 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.

3.4 ALTERNATIVE / RESTORATIVE JUSTICE MECHANISMS

Types of Evidence:
II–3: Evidence obtained from comparisons between times or places with or without the intervention (e.g. baseline - endline comparisons).

Evidence of effectiveness of intervention:

F. There is insufficient evidence to support this, it is mostly from very small studies and high income countries. Most studies indicate that to be effective, individual- 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 very wide range of activities and systems. Essentially, these are legal, mediation or arbitration processes which occur in parallel to a mainstream legal system. They are often considered to be alternatives to the failures of the formal justice system where victims can be exlcuded from proceedings and where the court is more focussed on the potential harm to society rather compensating the individual for the particular harm

[15] Ibid. 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.
[16] This is distinct from partner violence which was the focus of the Smedslund et al. review

suffered. There is evidence from countries such as Afghanistan, for example, that women prefer informal justice systems because they believe it to be more effective and efficient.

The relationship between formal and alternative mechanisms varies in practice. A country like South Africa, which is a constitutional democracy with a conventional legal system based on Roman Dutch law, has a parallel system of traditional courts with limited jurisdiction both geographically and in terms of the types of cases that may be heard in them (which may include domestic violence but not sexual offences). Other countries may have a second system 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 which is akin to a diversion programme for offences which would be unlikely to gain a conviction or a custodial sentence in a normal court.

While the literature is often unclear on this, it is important to distinguish between the the following broad categories of alternative mechanisms:

Informal justice mechanisms are centred around 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 within a court-like setting, or other venue – such as a community gathering place of a private home. The wider community may also play a role in making, and enforcing, the decision.[17]

Restorative justice concepts are getting increasing attention (in some part as a response to women's preferences) in cases of domestic violence. There is no agreed definition of restorative justice. Its key principles are bringing together key stakeholders in a face-to-face meeting, to collectively decide how on its resolution, with a view to parties voicing their experiences and feelings. Restorative justice have taken various forms in different countries – 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).

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. They may also be courts which integrate indigenous case resolution mechanisms, such as in the US and Canada, of the gacaca courts in Rwanda.

There is fierce and ongoing debate about whether 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, New Zealand and Australia, Europe, as well as India and Africa. It is important to note the restorative justice can also be implemented within the formal justice sector.

Types of evidence available:

Our research found 12 comprehensive reviews which cover informal and restorative justice (IDLO, 2013; Gavrielides and Artinopoulou, 2013; Burgess, 2012; Heise, 2011; Stubbs, 2007; Cameron, 2006; Curtis-Hawley, 2005; Goel, 2005; Hopkins, 2004; Grauwiler, 2004; Hudson, 2002; Krieger, 2002; and Koss, 2000). Three individual studies on restorative justice were also found (Coker, 2006; Hopkins et al, 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[18] with some studies . Overall, these interventions are under-researched due to the heated

[17] Security Knowledge Module, Endvawnow.org: http://www.endvawnow.org/en/articles/881-informal-justice-mechanisms.html

[18] The few studies that do exist on restorative justice are based on small samples, and do not take a long-term approach that would 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 and most studies do not go beyond assessing women's satisfaction with the process to looking at

debate around the suitablility of restorative and alternative justice mechanisms for dealing with VAWG cases (Gavrielides and Artinopoulou, 2013).

Effectiveness of the intervention:

There is some evidence from case series that mediation approaches may reduce violence but the evidence is very limited. A review of 400 cases of youth sexual offences which were finalised through court or conference proceedings over a six and half year period in South Australia found that the prevalence of reoffending was higher for court (66%) than conference (48%) youth (Daly, 2006), although it was notable that it was high in both groups.

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

There are strong findings that women derive psychological benefits from restorative justice approaches although the elements vary, some women found getting an apology was restorative, whereas other research found that men who apologised more easier were much more likely to reoffend (Daly 2006). 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 tvictim 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)[19] [20].

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 meditors is important: Krieger (2002) found that mediators often lacked adequate training, and found the psychological effects of dealing with domestic violence difficult to handle. A case study of the Bougainville Centre for Peace and Reconciliation (PFM) showed that women mediators dealt with GBV cases differently to male mediators.[21] Women were more likely to recognise women's substantive legal rights, and to refer cases to the formal justice system where 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 by providing referrals to NGOs that offered support to them and arranging for trauma counselling.

4.0 DISCUSSION

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 it was voluntary and only offered to men who would probably get non-custodial sentences, or may not be convicted in criminal courts (MP Koss, personal communication).

[19] Koss (2000): http://www.mincava.umn.edu/documents/koss/koss.html#idp38053216
[20] The review does not, however, provide examples of specific harms
[21] The case study involved a survey administered to 394 people , but does not make clear how the sample was selected.

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

In reflecting on the value of strengthening response mechanisms for primary prevention it is important to consider the population accessing VAWG response mechanisms. Research on the prevalence of physical and sexual intimate partner violence globally suggests that about a third of women have been exposed to violence in their lifetime and global estimates suggest 7% 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 intimate partner violence, although these figures may be considerably higher in some high income settings. South Africa is a fairly typical middle income setting, and there research shows that about one in 13 women who have experienced non-partner rape have ever reported it to the police (1 in 25 of those who have experienced any rape). Domestic violence is even less often reported, with only 0.3% of women experiencing it reporting (Machisa et al 2012). What is critical to understand is that interventions to strengthen responses at best only help those women and girls who have experienced violence and come forward to the police or services. Where interventions to strengthen these services show any impact on violence occurrence, it is a small impact on this small subgroup of all women and girls experiencing VAWG. Thus interventions may show benefit to those using the services but the potential for population-based impact on VAWG may still be limited.

4.1 POLICE AND JUSTICE SECTOR RESPONSES

The category of police and justice sector responses to violence against women and girls is broad. It spans training for police, specialised police units or courts, legislated tools such as protection orders or pro-active arrest and interventions to assist access to justice, such as paralegal services or second responder interventions. The body of research evidence is very largely from the United States, with some evidence on protection orders notably from the UK. Research from other parts of the world is mostly qualitative or other non-controlled studies. Many of the interventions have been developed for major institutions such as the police or health sector, without being nested within a systems wide intervention. Yet research in major social institutions, such as the police and health sector, has increasingly concluded that successful interventions require system-wide change.

The fundamental element of the criminal justice system that is required for these interventions to be effective is a solid legislative frame work that allows for redress through criminal law for intimate partner violence and marital or partner rape. This does not exist in many countries, for example over 50 still no legal provision criminalising marital rape, and so there is no effective capacity for using police and the law to protect women from domestic violence.

Where they are used, the evidence indicates that protection orders are effective in preventing some women's exposure to intimate partner violence. Proactive arrest policies, second responder interventions and legal interventions in conflict and humanitarian settings may be useful, but there is some conflicting evidence. Mandatory reporting of intimate partner violence and arrest is not recommended. There is insufficient evidence to determine whether most of the other police and legal interventions are effective in preventing VAWG, including police training, sexual offender policies, disruption plans, community policing, women's police stations, specialised courts and paralegal interventions.

i) Protection orders and proactive arrest

Within this group of interventions, protection orders are the only intervention where there is fair evidence to recommend the intervention. Research on protection orders is mainly from high income countries but they are used widely in middle income countries. It generally shows high levels of protection order violation, but not withstanding this there is evidence from a number of studies that the partner violence exposure of women with protection orders is lower than that of similar women without them. There is

limited evidence on the use of protection orders in low and middle income settings. A concern is that they may be much less effective where it is hard for women to 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 orders are available, only a minority of women who experience violence seek a protection order, so at a population level having the legal provision for protection orders is useful for a few, and may particularly benefit women experiencing more severe violence, but probably impacts little on less severe violence. There has been 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 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. it has been 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.

ii) Second responder programmes and paralegal interventions

Second responder interventions and paralegal interventions both have similarities in that they involve non-police and non-legal personnel facilitating and encouraging access to legal protection and redress after violence. Second responder programmes may involve a police office in addition to a women's advocate. There is conflicting evidence about whether second responder programmes are helpful for survivors, or lead to increased violence. Paralegal programmes improve access to justice in the short term for women, 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. Research evidence would support further evaluation through their inclusion in a package of interventions that were used to strengthen the police and justice system, or in a country where the system was already relatively strong and incremental improvement was sought, but they are unlikely to be very 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.

iii) Legal interventions in conflict and humanitarian settings

Research on legal interventions after sexual violence in conflict and humanitarian settings shows that these are supported by survivors and they provide a perception that there is an opportunity for justice and removing impunity, but there is no evidence that they do reduce sexual or other violence. Some research has suggested that women have been subject 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 further researched as women favour them as part of response strategies.

iv) Mandatory reporting and arrest

One group of interventions, mandatory reporting of domestic violence by health sector staff and mandatory arrest of offenders by the police has sufficient research to recommend against it. In both cases these mandatory interventions show some benefit to a group of domestic violence survivors, but others experience adverse effects with escalating violence. Further women experience mandatory reporting and arrest 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. There is sufficient evidence of adverse consequences to recommend against these interventions.

All interventions evaluated seem to work better at a stage where both partners, or either the woman and man, are/is ready for change. Research repeatedly reminds us that this readiness needs to be achieved

through a process and cannot be forced on individuals, however attractive the idea of making men attend interventions to teach them how to stop being violent or making them change their behaviour after one encounter with the police and arrest.

v) Police training interventions and community policing

Police training on violence against women and girls has never been evaluated for its effectiveness in preventing violence against women and girls. This omission does suggest that police training is not conducted with the intention of it reducing violence against women and girls overall, but in strengthening responses to individual cases. Research suggests that many of the police training interventions are rather limited in their own right because they are delivered outside the context of systemic intervention within the police services and not taken to scale. To be effective as part of responses, research is needed on how to optimise systemic intervention models within the police which includes training as a component. For prevention, the evidence suggests that police training alone is not an appropriate avenue for investment of resources intended for prevention. There is no clear definition of community policing to prevent VAWG, with models including enhanced liaison and community outreach. There is no evidence of impact on occurrence of VAWG.

vi) Women's police stations (or units), and specialised courts

Women's police stations (or units) and specialised courts have been developed generally as part of a package of interventions to strengthen the police response to VAWG. These 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. The population level impact of this is uncertain. Overall there has been insufficient research into Women's Police Stations or units and sexual offences courts, although insiders perceive them to be of value.

Research has shown that creation of women's police stations (or units) does not necessarily solve the problems which are systemic in many police services. For example female officers do not automatically demonstrate better attitudes towards survivors simply because of their sex; 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 have experienced; and these units can be severely underfunded, 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 a fairly to evaluate interventions to change social norms within the police force as an institution 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 that 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 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.

vii) Other policing measures

Two interventions for child abuse prevention: placing known sex offenders on registers and having interventions to disrupt access of potential sex offenders to victims have been used in some settings. 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 opened result in a conviction. Since only convicted offenders are included in registers, they include the names of a very small proportion of those potentially at risk to children. Thus their potential for impact on violence prevention at a population-level is very small.

Most sex offender initiatives seek to limit contact of children 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 recidivsim 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.

4.2 CRISIS INTERVENTION

Within this group of interventions, shelters are the only one for which there is fair evidence of their impact on preventing partner violence. 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 and on their readiness to make changes to their lives and leave their partner. Shelters are provided as isolated interventions, women who enter them receive shelter packages which vary, but usually includes counselling, information and practice 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 use of them.

Hot lines 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 occurring is unknown and this is not their primary objective, which is generally to enable access to services.

One Stop Centres are available in some countries and are intended to assist survivors of rape and domestic violence with immediate needs. Prevention of violence is generally not an objective of these services, or is very much a secondary objective for those services 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.

4.3 HEALTH SECTOR RESPONSES

The health sector interventions to prevent VAWG have three building blocks: training of health care providers to ask about IPV and sensitisation towards it; 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 the third component is identification of women who have VAWG exposure when this is necessary for optimising their clinical care. Although training is sometimes discussed as a separate intervention, health workers are general not trained on VAWG without advice to screen or promote clinically-indicated case identification. As a result training is rarely evaluated alone for its impact on women's experience of violence, and other interventions have a training component. Given the large amount of research in this area and the negative findings, health sector interventions are not a priority for primary prevention of VAWG.

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 are in currently abusive relationships, unless this is relevant to clinical care, does not provide health benefits for women or reduce their violence exposure.

The impact of screening interventions maybe 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 and this 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 services and when discussing disclosure of results with women who have tested for HIV. This activity is not considered as screening and may be better conducted by health workers who have been trained.

4.4 SOCIAL SECTOR INTERVENTIONS

The most promising social sector interventions are advocacy interventions, although the evidence for them is conflicting. All evidence comes from high income settings. 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 interventions in most communities for VAWG. It is a very broad category of interventions and includes advice provision and counselling of different durations, delivered by differently skilled individuals and enables access to different types of services and resources. The research base of rigorous evaluation is geographically very limited. Research from the United States has generally not shown that advocacy interventions reduce the occurrence of violence, although benefit was found in three studies in Hong Kong. Advocacy interventions are one component in response and their effectiveness will depend on the quality of the services they enable access to.

Batterers' (or perpetrators') programmes aim directly to prevent violence and characteristically target more violent men, who have been identified by courts or through restorative justice models. They often consist of cognitive behavioural therapy interventions, which can be mandated by court order or voluntary. Most of the programmes evaluated have been in the United States, but the research has many limitations. 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, although studies are conflicting on whether attendance reduced recurrence of violence.

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

Therapeutic interventions with women have been used for many years and may take the form or brief individual or group counselling to more lengthy cognitive behavioural therapy (CBT) interventions. Many women who start counselling programmes do not complete them, so research with programme completers may be biased. Overall there is no conclusive evidence of impact on reducing violence against women.

4.5 ALTERNATIVE OR RESTORATIVE JUSTICE

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 very mixed. Larger studies from Australia have not been randomised and so the difference between groups in re-offence, rates of which were around 50% in all study arms, may have been due to selection bias. There are considerable ethical concerns and other difficulties in these approaches and so overall we conclude that we

do not know enough about them to recommend their use. The complexity of the issues around these suggest that alternative or restorative justice approaches should not be recommended as priorities for research to prevent VAWG.

5.0 CONCLUSIONS

There should not be great expectations that interventions to strengthen responses to VAWG will substantially contribute to preventing VAWG at a population level. However providing access to justice and legal protection and social support to survivors of violence is a critical aspect of overall responses to VAWG and is an important element in communicating non-acceptability of VAWG, which ultimately influences social norms. The degree of contribution to social norm change, however, has never been established.

All of the police and justice sector interventions require a supportive legislative framework within which they may work. They all require research in different contexts to optimise their delivery and evaluate their impact, but we suggest this is only worthwhile in countries that have the necessary legislation to enable police responses to be effective. In order to maximise impact, interventions need to be systemic and we recommend that the package which is most likely to provide benefit include: a comprehensive legal framework, protection orders and proactive arrest, training on VAWG and social norm change interventions throughout the police ranks, specialised units (or women's police stations), paralegal or other lay support in accessing justice, and specialised courts. These interventions are primarily established to strengthen responses to VAWG, and we suggest that their impact on population-based prevalence of VAWG is too uncertain for them to be a priority for investment of resources for research on primary prevention of VAWG.

Counselling and other therapeutic interventions may be useful in the absence of a comprehensive legal framework, and they deserve further research. Two interventions have greater potential for prevention of VAWG occurrence. The first is the impact of psychotherapeutic interventions that involve both men and women. This needs to be evaluated in rigorous research in a range of settings, using couples counselling and/or CBT interventions provided by lay staff. The second is the impact of shelters on violence prevention through combining with gender and economic empowerment interventions. Although few women use shelters, where they are provide it is important to understand how to optimise their ability to enable women to leave abusive relationships. This will contribute to assisting some women experiencing violence of highest severity.

6.0 RECOMMENDATIONS

Overall, this evidence review suggests that interventions to improve the role of response mechanisms in preventing VAWG should not be a major priority compared to the promise of various community-level prevention mechanisms. This is both because of the limited number of men and women that can be impacted through response mechanisms as well as various limitations in what such interventions can achieve. Nonetheless, there may be a case for limited further work in this area.

1. Evaluation of 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:

I. A legal framework criminalising domestic violence including marital rape, and which allows for protection orders and proactive arrest
II. 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 which undermine gender equity
III. Specialised units or 'police stations' for VAWG staffed by trained officers

IV. Having paralegals or women's advocates to enable access to justice and support, explain and accompany women in legal processes
V. Community awareness raising and information provision, including through Hotlines
VI. Specialised courts for VAWG offences

2. 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

3. 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

GENERAL

Violence against women + developing countries response
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

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 EVAW, 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