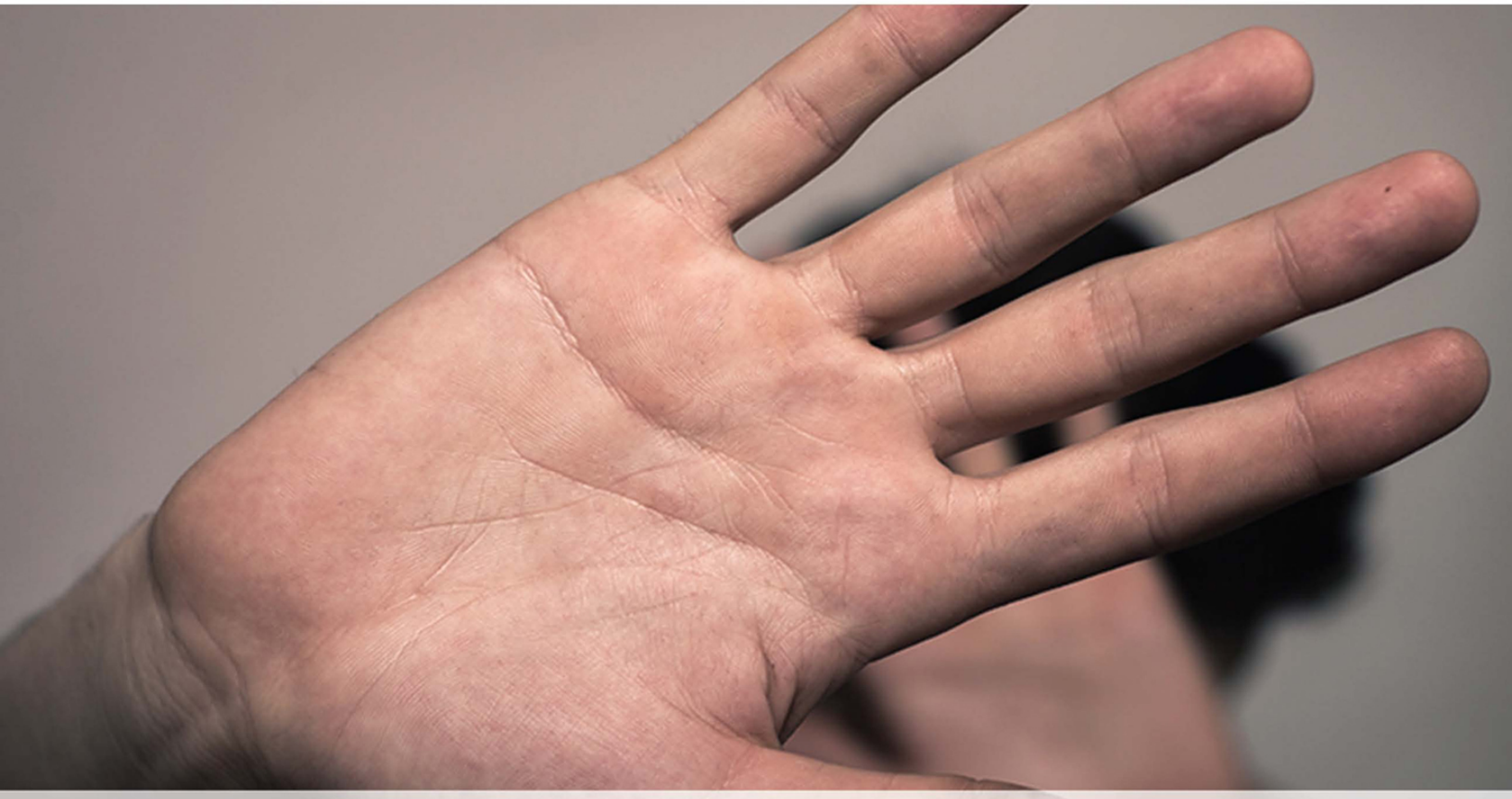
ABC of Domestic and Sexual Violence

Edited by Susan Bewley and Jan Welch



WILEY Blackwell www.abcbookseries.com BMJ Books

This edition first published 2014© 2014 by John Wiley & Sons, Ltd.

BMJ Books is an imprint of BMJ Publishing Group Limited, used under licence by John Wiley & Sons.

Registered office: John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Editorial offices: 9600 Garsington Road, Oxford, OX4 2DQ, UK

The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

111 River Street, Hoboken, NJ 07030-5774, USA

For details of our global editorial offices, for customer services and for information about how to apply for permission to reuse the copyright material in this book please see our website at www.wiley.com/wiley-blackwell

Library of Congress Cataloging-in-Publication Data

ABC of domestic and sexual violence / edited by Susan Bewley, Jan Welch.

p. ; cm.

Includes bibliographical references and index.

ISBN 978-1-118-48218-6 (paperback)

I. Bewley, Susan, editor of compilation. II. Welch, Jan editor of compilation.

[DNLM: 1. Domestic Violence. 2. Sex Offenses. 3. Battered Women. 4. Crime Victims. WA 308]

RC569.5.F3

616.85′822–dc23

2013044785

A catalogue record for this book is available from the British Library.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Cover image: Photograph by Jade Turnbull, Copyright© 2014, Jade Photography

Cover Design by Andy Meaden.

1 2014

Contributors

Gwen Adshead

Forensic Psychiatry

Southern Health Foundation Trust

UK

Rasha Al Dabaan

Department of Pediatric Dentistry and Orthodontics

King Saud University, College of Dentistry

Saudi Arabia

Loraine J. Bacchus

Department of Global Health and Development Gender Violence and Health Centre

London School of Hygiene & Tropical Medicine

UK

Jackie Barron

Women's Aid Federation of England

UK

Susan Bewley

Women's Health Academic Centre

King's College London

UK

Nicole Biros

Victim Witness Advocacy
Boost Child Abuse Prevention and Intervention Canada

Emmeline Brew-Graves
General Practice
Southway Surgery
UK

Bernadette Butler
The Haven Camberwell Sexual Assault Referral Centre
King's College Hospital NHS Foundation Trust
UK

Wendy Cottee
Crown Prosecution Service UK

Sarah M. Creighton
Department of Women's Health
University College London Hospital
UK

Maureen Dalton
SARC Commissioning South West
UK

Fiona Duxbury
General Practice
Oxford UK

Gene Feder

Centre for Academic Primary Care
School of Social and Community Medicine
University of Bristol
UK

Colin Fitzgerald
Respect
UK

Andrea Goddard
Department of Paediatrics
Imperial College London
UK

Louise M. Howard
Institute of Psychiatry
King's College London
UK

Emma Howarth
Centre for Academic Primary Care
School of Social and Community Medicine
University of Bristol
UK

Medina Johnson
Next Link Domestic Abuse Services
UK

Michael King
Mental Health Sciences Unit
University College London Medical School
UK

Marai Larasi
Imkaan
UK

Hannah Loftus
Genitourinary Medicine
Sheffield Teaching Hospitals NHS Foundation Trust
UK

Finbarr C. Martin
Department of Geriatrics
Guys and St Thomas' NHS Trust
UK

Ali Mears
Genitourinary Medicine and HIV
Imperial College Healthcare NHS Trust
UK

Tim Newton
Dental Institute
King's College London
UK

Karen Rogstad
Genitourinary Medicine
Sheffield Teaching Hospitals NHS Foundation Trust
UK

Alex Sohal
Centre for Primary Care and Public Health
Queen Mary University of London
UK

Lindsey Stevens
Department of Emergency Medicine
Epsom and St Helier University NHS Trust
UK

Fiona Subotsky
Royal College of Psychiatrists
UK

Jo Todd
Respect
UK

Eleanor Turner Moss
Barts and The London School of Medicine and Dentistry
Queen Mary University of London
UK

Jan Welch

Caldecot Centre
King's College Hospital NHS Foundation Trust
UK and
South Thames Foundation School
UK

Catherine White
Sexual Assault Referral Centre
St Mary's Manchester
UK

Foreword

Professor Sir George Alberti

King's College Hospital NHS Foundation Trust, UK

Domestic and sexual violence have almost certainly been with us ever since human history began. For centuries they have been largely ignored and even now all we see is the tip of the iceberg. Fortunately more attention is now focused on them as major societal problems. Nonetheless there is still widespread ignorance, particularly in the health professions, as to the nature and scale of the problem. I recently chaired a Department of Health Taskforce on Violence Against Women and Children and was appalled by the numbers of people affected – not just by serious sexual crimes but also by all forms of domestic violence. I was particularly impressed by the numbers of unrecognised cases in general practice, emergency departments and hospital outpatient services even when obvious triggers were present—with some notable exceptions. I was also disappointed by the lack of attention given to sexual and domestic violence in medical school curricula and postgraduate training programmes. There should be much more focus on multidisciplinary working with close contact between different agencies. Often mechanisms are in place but are underused.

The Taskforce brought some attention to the issues involved but did not solve the many problems. The present volume goes some way to rectifying this. It is a superb vade mecum which should be required reading at an early stage for all health professionals but particularly those working in general practice and long-term conditions. It should also

be freely used in training health care professionals. I cannot commend it to you strongly enough!

Introduction

Susan Bewley[1] *and Jan Welch*[2,3]

[1]Women's Health Academic Centre, King's College London, UK
[2]Caldecot Centre, King's College Hospital NHS Foundation Trust, UK
[3]South Thames Foundation School, UK

Purpose

Why do health care professionals need to know about domestic and sexual violence? Surely these are either private issues or someone else's business (e.g. the police)? In recent years it has increasingly been recognised that this is not the case. ‘Privacy’ has allowed serious crime to go undetected and perpetrators to act with impunity. Health care professionals look after patients whose lives are blighted by violence and abuse, whose health is impacted – and who can be helped if the professionals understand how.

Even though domestic and sexual violence affect far more people than do conditions such as diabetes and inflammatory bowel disease, they have featured much less on medical school and postgraduate curricula, and are sometimes entirely absent. Many doctors are not aware of how common these problems are, how to identify them or what to do next. This book aims to provide practical support to learners early in their careers.

Historical perspective

Allusions to domestic and sexual violence occur in some of the earliest written works and feature in ancient stories, such as the rape of Antiope by the Greek king of the gods and sexual predator Zeus. While rape was recognised as a crime in ancient Rome, ‘wife beating’ for correctional purposes was criminalised only much more recently and remains the norm in some cultures today. Rape is an expression of power. It has long been both a weapon of war and a means of oppressing the vanquished – men as well as women. Following the capture of Berlin by the Red Army in 1945, an estimated 2 million German women and girls were raped by Soviet troops. More recently, in the Rwandan genocide of 1994, many thousands of Tutsi women were subjected to rape, many acquiring HIV as a result. Some were also sexually mutilated in order to destroy their future reproductive capabilities.

Women's position in society has changed over the centuries. In most countries, women are no longer considered to be legal minors: the possessions initially of their fathers and then of their husbands. Attitudes to violence against women have changed in parallel and legislation has followed; for example, during the last 30 years marital rape has been criminalised in most Western countries.

Modern relevance

Sadly, abuse and rape remain common in modern societies, whether resource-poor or heavily industrialised. Much is covert, as victims experience fear and shame, which often inhibit disclosure. Many victims wait until the right moment to disclose – perhaps to a practitioner they trust. The health impacts can be immediate or can only become evident much later. In the UK each week two women are killed by their partners, but this is just the tip of the

iceberg: many more seek help for nonspecific physical symptoms or mental health problems related to previous abuse.

While anyone can be assaulted or abused, the presence of co-vulnerabilities increases the likelihood. Perpetrators are adept at identifying those with vulnerabilities, whether long-term (e.g. learning or other disability), situational (e.g. being in a conflict zone) or transient (e.g. when someone is under the influence of alcohol or drugs).

Language

Language is dynamic and nomenclature can be problematic, as words inevitably carry connotations (or ‘baggage’) with them. For example, some writers prefer the term ‘abuse’ to ‘violence’ as it is more inclusive; it may make it clearer that the damage is not merely physical, but mental, lasting longer than the processes of physical healing and going deeper than the outward, superficial scars.

The term ‘survivor’ is generally preferred to ‘victim’ when discussing people who have been subjected to domestic violence, as it recognises the individual strength necessary to carry on in difficult circumstances and often to protect others, such as children. When encountering people who have suffered extreme human rights abuses or torture at the hands of others, however, this could seem trite.

‘Empowerment’ might be trivialised by cosmetic product advertising slogans (‘because you're worth it’), but is a real process for the most disadvantaged, abused and voiceless members of society. Other terms, including ‘patient’, ‘complainant’ and ‘client’, vary in their suitability and acceptability. Although there are gender differences in the perpetration and experience of violence, abuse has no

limits for people of any age, sex, race, sexuality, class, creed or political persuasion.

The National Health Service has a ‘universalist’ perspective; that is, it is available to all on the basis of need. We have tried to maintain this stance throughout, although most case studies refer to women and children. The chapter authors come from a wide variety of backgrounds: professional and voluntary sector; medical, legal, academic and lay. They bring different values and ‘cultures’ with them, reflecting the fact that a multi-agency response is required for these persistent societal wrongs. Thus, although terminology varies throughout the book, we have tried to ensure that the words used are appropriate for the context, while recognising that others may disagree.

We hope that the variety of examples of questions and responses given in the chapters will act as templates while you develop your own strategies and practice styles. Reflective practitioners pay careful attention to the exact words patients use, as well as to gaps, silences and alignments with nonverbal cues. They also choose their words carefully, while modulating their tone and body language, in order to build rapport, diminish fear, overcome stigma and prejudice and demonstrate trustworthiness. Lessons learned from this book can be applied to many other settings.

The role of doctors

It is important for future good doctors to recognise their role, which is to *recognise*, *empathise* and *witness* and to *refer* to appropriate multi-agency services. Violence does not fit the traditional ‘medical model’ of diagnosis, prognosis and plan, and should not be ‘medicalised’ as something that can be ‘fixed’ by doctors using conventional treatments. However, it may coexist with other

conventional comorbidities, may explain patient presentations and behaviours and may interfere with the ability of patients to trust or comply with their doctor's advice.

Uncovering our patients' narrative, or story, may make sense of otherwise unresolvable medical presentations (and explain the old maxim that ‘there is no such thing as a difficult patient, only a patient with difficult problems’). Even when there are time constraints, or when patients are unwilling to talk or disclose, an acknowledgment can help a patient feel known and understood. Kindness costs nothing; compassion takes no time. They may make all the difference to a vulnerable person feeling empowered to speak now or at a later date. Whether abuse, violence, mental illness, substance misuse or another ‘life problem’ lurks in your patient's or their family's background, failure to respond sensitively may lead to misattribution or dismissal of symptoms, misdiagnosis of disease, repeated inappropriate investigation and at worst, retraumatisation or even abuse by professionals.

Boundaries and difficult issues

Both patients' and doctors' interests are protected by the vital professional promises of confidentiality and boundaries of consent. It is within these formal, legally and professionally binding constraints of the doctor–patient relationship that value, skills and even creativity lie. Only very occasionally can they be broken, and this must only be done with transparency and senior and expert support.

Some readers will inevitably have experienced violence themselves, first-hand or in their friends and families, or will experience it in the future, either on the giving or the receiving end. Doctors may be fearful of involvement with the topic or may have personal concerns for their own

safety. Alternatively, they may be fearful of raising concerns about patients or team dynamics if they fear reprisals or are being bullied at work. Doctors may find they feel powerful negative emotions towards patients, including hostility, anger or frustration, or even unanticipated or inappropriate feelings of intimacy or attraction. The art of professionalism is to recognise and control these feelings, to put them to one side and not to act on them. But we are not automatons. We need quiet time and 'headspace' to recover and reflect both 'on practice' and 'within practice'. '*What do such feelings say about the patient and about me, the practitioner?*' '*What do the team behaviours, dynamics and "jokes" say about us and our ability to empathise?*' '*Where can I find reliable sources of support, learning, guidance and wisdom?*'

Lifelong learning

As doctors who had virtually no knowledge of or training in domestic and sexual violence as students, we learnt the hard way – from our patients and from our mistakes, by trial and error and by carving out services and research from scratch. Looking back over our combined 6 decades of medical practice, we dreamt of a book that we wished had existed when we started out. Although few readers will end up majoring in responses to violence (as we have), everyone will encounter it – whether explicit or hidden – in the clinics and wards, and everyone can make a positive health contribution. Our authors have distilled their accumulated wisdom in the hope of accelerating your learning and making you better practitioners. We hope that the lessons in this book will stand you in good stead and that you find fulfilling careers wherever you end up. Keeping the care of your patient as your first concern and

safety at the forefront of your mind will also act as a reliable guide.

Chapter 1
The Epidemiology of Gender-Based Violence

Gene Feder and Emma Howarth
Centre for Academic Primary Care, School of Social and Community Medicine, University of Bristol, UK

OVERVIEW

- The most consistent risk factor for domestic and sexual violence is being a woman; most severe domestic violence and most sexual violence is perpetrated by men
- Hence, sexual and domestic violence are gender-based, although men can also be victims of interpersonal violence
- The term ‘gender-based violence’ highlights the roots of violence against women in gender inequality
- Gender-based violence is both a breach of human rights and a major challenge to public health and clinical practice

What are domestic violence and sexual violence and why are they gender-based?

This chapter outlines the epidemiology of gender-based violence in the UK and internationally in terms of

prevalence, community vulnerability and health impact. It concludes with reflections on why it remains so hidden from doctors and other clinicians and the need for robust research on effective health care responses.

In the UK, domestic violence is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between people aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality.

This can encompass, but is not limited to, the following types of abuse:

- Psychological.
- Physical.
- Sexual.
- Financial.
- Emotional.

Sexual violence is a major component of domestic violence, often co-occurring with other forms of abuse, and includes sexual abuse from carers, strangers, acquaintances or friends. It is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comment or advance, attempt to traffic, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting.

Gender-based violence is not confined to domestic and sexual violence. It includes:

- Female genital mutilation (see Chapter 17).
- Femicide, including (so-called) honour- and dowry-related killings (see Box 3.2).

- Human trafficking, included forced prostitution and economic exploitation of girls and women (see Box 3.3).
- Violence against women in humanitarian and conflict settings.

The World Health Organization (WHO) definition of gender-based violence explicitly includes its impact: '…*[it] is likely to result in physical, sexual or mental harm or suffering to women*…' As discussed later in the chapter and elsewhere in this book, the health impacts are substantial and often persistent.

Gender-based violence is best understood in terms of the ecological model presented in Figure 1.1, which highlights factors at all levels from the societal to the individual.

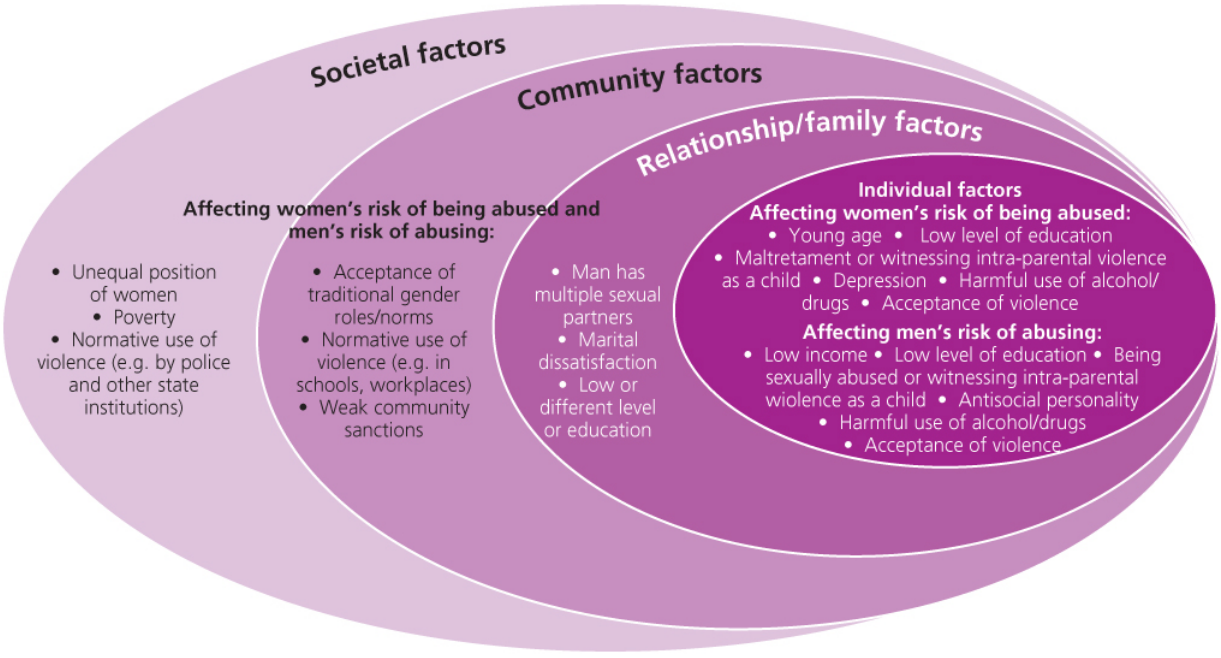


Figure 1.1 Factors associated with violence against women.

Source: WHO 2012 Understanding and addressing violence against women: overview. Reproduced by permission of the World Health Organization.

Globally, men are more likely to die violently and prematurely as a result of armed conflict, suicide or

violence perpetrated by strangers, whereas women are more likely to die at the hands of someone close to them, on whom they are often economically dependent. In much of the world, prevailing attitudes justify, tolerate or condone violence against women, often stemming from traditional beliefs about women's subordination to men and men's entitlement to use violence to control women.

Prevalence in the UK

The Crime Survey for England and Wales (formally known as the British Crime Survey) is the most reliable source of community prevalence estimates of domestic violence and sexual violence in the UK. The 2011–12 survey reports lifetime partner abuse prevalence of 31% for women and 18% for men; 7 and 5% respectively had experienced abuse in the previous 12 months. The definition of partner abuse includes nonphysical abuse, threats, force, sexual assault or stalking. The Crime Survey for England and Wales also measures *nonpartner* domestic violence (termed ‘family abuse’), reporting a lifetime prevalence of 9 and 7% for women and men, respectively. The starkest gender difference in prevalence revealed by the Crime Survey for England and Wales is for sexual assault: 20 and 3% lifetime prevalence for women and men, respectively, although these figures include assaults by partners, ex-partners, family members or any other person. A more detailed examination of nature of physical abuse incidents recorded in 2001 also shows a greater gender asymmetry than the headline prevalence figures. Women, as compared to men, were more likely to sustain some form of physical or psychological injury as a result of the worst incident experienced since the age of 16 (75 vs 50% and 37 vs 10%, respectively), and more likely to experience severe injury such as broken bones (8 vs 2%) and severe bruising (21 vs

5%). Moreover, 89% of those reporting four or more incidents of domestic abuse were women. Data reported in 2010 showed that the majority of violent incidents against women are carried out by partners/ex-partners/family members (30%) or acquaintances (33%) rather than by strangers or as part of mugging incidents (24 and 19% respectively). In contrast, the majority of incidents against men are categorised as stranger victimisation or mugging (44 and 19%, respectively, vs 6% domestic and 32% acquaintance, mirroring the international data on murder discussed earlier).

The Crime Survey for England and Wales module on sexual assault reported that 2.5% of women and 0.4% of men aged 16–59 had experienced a sexual assault (including attempts) in the previous 12 months. It also showed that 0.6% of women and 0.1% of men had been the victim of a serious sexual assault in the year prior to interview. It did not distinguish between sexual violence as part of domestic violence and that perpetrated by a friend or stranger.

Domestic violence internationally

The WHO multicountry study conducted in 2000–03 estimated the extent of physical and sexual intimate partner violence against women in 15 sites across 10 countries (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Tanzania and Thailand). This study, involving 24 000 participants aged 14–59 years and using standardised survey methods, is the most robust comparison between countries conducted to date, although figures do not represent national prevalence rates as the samples were based in specific rural or urban settings.

The reported lifetime prevalence of physical and/or sexual violence for ever-partnered women varied from 15 to 71%;

12-month prevalence rates varied from 4 to 54%. The percentage of ever-partnered women in the population who had experienced severe physical violence ranged from 4% in Japan (city) to 49% in Peru (province). The proportion of women reporting one or more acts of their partner's controlling behaviour (including isolation from family and friends and having to seek permission before seeking medical treatment) ranged from 21 to 90%. These wide-ranging rates may reflect cultural differences in the normative level of control in intimate relationships. However, the finding that women across all sites who suffered physical or sexual partner violence were substantially more likely to experience severe controlling behaviours compared to nonabused women concurs with the view that coercive control is a defining feature of interpersonal violence, irrespective of culture. Moreover, the WHO study revealed consistent health consequences supporting their reference to impact in the definition of interpersonal violence.

Health impacts

Disease burden

The WHO multicountry study also measured health status, in order to assess the extent to which physical and sexual violence were associated with adverse health outcomes. The survey focused on general health and disabling symptoms, and found significant associations between lifetime experiences of interpersonal violence and self-reported poor health and specific health problems in the previous 4 weeks: difficulty walking, difficulty with daily activities, pain, memory loss, dizziness and vaginal discharge. The increased risk varied by symptom, ranging from 50 to 80%.

The first burden-of-disease analysis was conducted in Australia, reporting that interpersonal violence contributed 8% of the total disease burden in women aged 15–44 (3% in all women) and was the leading contributor to death, disability and illness for that age group, ahead of higher-profile risk factors such as diabetes, high blood pressure, smoking and obesity (see Figure 1.2).

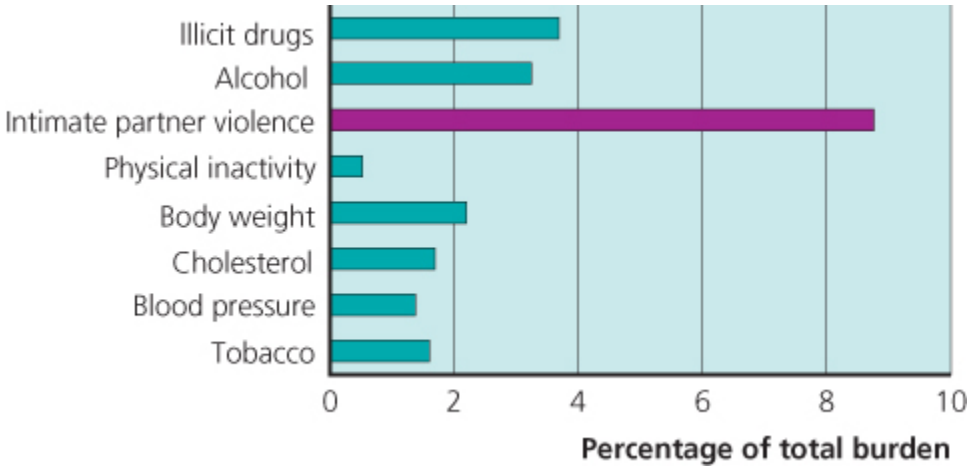


Figure 1.2 Top risk factors contributing to the disease burden in women aged 15–44 years in Victoria, Australia.

Data from Vos *et al.* (2006).

Reproductive health problems

All studies of maternal mortality find that a substantial proportion of deaths result from assault by a partner. There are consistent findings of lower-birthweight babies for women who reported physical, sexual or emotional abuse during pregnancy. Other adverse pregnancy outcomes such as miscarriage and stillbirth may be associated with violence in pregnancy, although the associations are less consistent across studies. Gynaecological symptoms, sexually transmitted infections (STIs) and urinary tract infections (UTIs) are increased two- to threefold in women experiencing domestic and/or sexual violence (see Chapters 16 and 17).

Injuries

Injuries vary from minor abrasions to life-threatening trauma. While there can be overlap between injuries resulting from interpersonal violence and injuries from other causes, the former are more than 20-fold more likely to involve trauma to the head, face and neck. Multiple facial injuries are suggestive of interpersonal violence rather than other causes. The most specific for interpersonal violence include zygomatic complex fractures, orbital blow-out fractures and perforated tympanic membrane. Blunt-force trauma to the forearms should also raise suspicion of interpersonal violence, suggesting defence wounds (see Chapters 12 and 13).

Primary care

Common presenting complaints and chronic physical conditions are more likely in women who have experienced domestic violence (Box 1.1). In one US study, women who experienced intimate-partner violence after controlling for potential confounders such as age, race, income and childhood exposure to intimate-partner violence, had an increased risk of a wide range of debilitating complaints (see Chapters 3, 7 and 11).

Box 1.1 Women who experience intimate partner violence have increased risk of:

- Disability preventing work (1.5×).
- Chronic neck or back pain (1.5×).
- Chronic pelvic pain (1.5×).
- Arthritis (1.5×).

- Hearing loss (2×).
- Angina (2×).
- Bladder and kidney infections (2×).
- Stomach ulcers (2×).
- Sexually transmitted infections (STIs) (3×).
- Irritable bowel syndrome (IBS) (4×).

Mental health

The long-term mental health consequences of domestic and sexual violence overshadow the substantial impact of the physical health consequences (see Box 1.2). Systematic review of the (mostly) cross-sectional studies of women experiencing domestic violence show consistently raised risk of a wide range of mental health conditions (see Chapters 4 and 15).

Box 1.2 Women who experience domestic violence have increased risk of:

- Depressive disorder (3×).
- Anxiety disorder (4×).
- Alcohol and substance abuse (5×).
- Post-traumatic stress disorder (PTSD) (7×).

Experience of violence increases the likelihood of mental health problems (see Chapter 15), and it is also likely that

people with these problems are more at risk of suffering domestic and sexual violence.

Intergenerational impact

Exposure to interpersonal violence during childhood and adolescence increases the risk of negative health outcomes across the lifespan. There is a moderate-to-strong association between children's exposure to interpersonal violence and internalising symptoms (e.g. anxiety, depression), externalising behaviours (e.g. aggression) and trauma symptoms. Children exposed to domestic violence are estimated to be two to four times more likely than children from nonviolent homes to exhibit clinically significant problems. Links are also demonstrated between children's exposure to violence and social development, academic attainment, engagement in risky health behaviours and physical health problems. While exposure to domestic violence undoubtedly represents a significant stressor in children's lives, studies indicate considerable variation in children's reactions and adaptations following exposure to this risky family context. Heterogeneity in children's adaptations is in part explained by the presence or absence of other adversities. Children exposed to domestic violence may also experience direct maltreatment, neglect, poverty, parental mental ill health, substance misuse and antisocial behaviour, which may compound the effect of exposure. The more adversities a child is exposed to, the greater the risk of negative outcomes (see Chapter 5).

Intersections with other adversity

The gendered nature of domestic and sexual violence reflects a power disparity between men and women

globally. But gender is not the only social identity that makes people vulnerable to domestic violence. Disability, lesbian or gay sexual orientation, membership of an ethnic minority group, homelessness and uncertain migration status may increase vulnerability. There is uncertainty about whether the prevalence of violence is increased in these relatively marginalised groups. But there is growing evidence that it is even more difficult for individuals from these communities to disclose violence in health care settings and engage with domestic violence services post-disclosure. The intersection of class, ethnicity, sexuality and gender affects how domestic violence is experienced and how health care services respond. Any training of doctors and other health care professionals to ask about violence and respond appropriately needs to take into account the additional vulnerabilities of some patients who have experienced violence (see Chapter 2).

Epidemiological research

Although there are relatively robust estimates of the prevalence of domestic and sexual violence among heterosexual women, there are few studies of male victims or of men who have sex with men and women who have sex with women. With regard to health impact, we need more longitudinal studies if we are to understand vulnerability and protective factors. Such studies are particularly difficult to conduct, as are intervention trials with prolonged follow-up of participants, not least because victims of domestic and sexual violence often have difficult and disrupted lives. Yet if we are going to respond to their needs safely and effectively, this research is needed to guide the development of good practice and domestic violence-competent clinical services.

Further reading

Garcia-Moreno, C., Jansen, H.A., Ellsberg, M., Heise, L. & Watts, C.H. (2006) Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *Lancet*, **368**(9543), 1260–1269.

Vos, T., Astbury, J., Piers, L.S., Magnus, A., Heenan, M., Stanley, L. & Webster, K. (2006) Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. *Bulletin of the World Health Organization*, **84**(9), 739–744.

The World Bank (no date) Health and the role of the Health Sector, http://go.worldbank.org/C1UQRGBCE0 (last accessed 12 February 2014).

World Health Organization (no date) Gender-based violence, http://www.who.int/gender/violence/gbv/en/index.html.

World Health Organization (2012) Understanding and addressing violence against women: overview, http://www.who.int/reproductivehealth/topics/violence/vaw_series/en/index.html (last accessed 12 February 2014).