Violence against women. Assumptions for a model of care for women victims of violence: the "task force" [*]

Anna Coluccia[†], Lore Lorenzi[‡], and Monica Bianchi[§].

Summary. *The phenomenon of violence against women has become a social emergency as evidenced by the severity of its consequences on the psychological and physical integrity of victims and society as a whole. This makes it necessary to acknowledge the priority of the problem both in terms of public health and of socio-economic costs in order to provide effective intervention and create prevention programmes. It is advisable that any models of intervention are aimed at reducing the fragmentation of responsibilities as well as at strengthening integration between healthcare and social policies. In this regard, the Task Force of Grosseto's Local Health Authority, where the ER Pink Code is automatically activated when there are instances of violence, is emerging as an inter-institutional model integrated into the provincial anti-violence network, formalized by a Memorandum of Understanding between the Local Health Authority and the Public Prosecutor's Office.*

Keywords: violence; women; models of intervention; task force

[*]*Received: 17/01/2010 – Revision: 5/03/2010 – Accepted:24/1/2011*
Self-declaration of compliance with ethical standards: 5/03/2010

[†] Università degli Studi Siena, Dipartimento Patologia Umana e Oncologia, Sezione di Criminologia (Tel/fax 0577-233271)
Policlinico Le Scotte Viale Bracci, Siena. E-mail: anna.coluccia@unisi.it
[‡] Università degli Studi Siena, Dipartimento Patologia Umana e Oncologia, Sezione di Criminologia (Tel/fax 0577-233271)
Policlinico Le Scotte Viale Bracci, Siena. E-mail: lorenlo@unisi.it
[§]Università degli Studi Siena, Dipartimento Patologia Umana e Oncologia, Sezione di Criminologia (Tel/fax 0577-233271)
Policlinico Le Scotte Viale Bracci, Siena. E-mail: monica.bianchi@unisi.it

Interdisciplinary Journal of Family Studies, XVII, 1, 2012

Experts, health workers and scientists now agree that violence against women is a globally recognized problem that is a public health problem. Unfortunately, it has not yet been sufficiently recognized and denounced, as confirmed by extensive research and by many studies, which have been carried out in various contexts. We are talking about a phenomenon that lacks organized data both at an international and at a national level. It is estimated that eight and a half million women worldwide are victims of abuse and violence perpetrated by their current or former partner each year. Statistics of the European Union (Caritas Ambrosiana et al., 2007) – that is surveys carried out on crime-related data in Member States – reveal that violence is the leading cause of death among women aged from 16 to 50 in Europe, and that one out of three violent deaths in Italy involves a woman killed by either her husband, or her partner or her boyfriend. In Italy, most of the quantitative data about violence against women (if not the only available data) is collected and processed by anti-violence centres, which have been active since 1980 in many Italian cities, and by some surveys and studies carried out by the Italian National Institute for Statistics (ISTAT, 2007; 2008) on special issues related to the perception of domestic violence and more generally in the frame of "gender studies". It is therefore without a doubt a phenomenon which deserves a public health approach, since it greatly impacts on the health of people – not only women but also children – living in a climate of constant violence, and suffering both short and long-term adverse consequences from the so called "witnessed violence". Studies about this issue (WHO, 2002) show that children witnessing violence between their parents are at a higher risk for a multitude of emotional and behavioural problems including anxiety, depression, poor school performance, low self-esteem, disobedience, nightmares and physical disorders. In addition, it is believed that violence can directly or indirectly affect infant mortality.

According to the World Health Organization, negative implications go beyond the health and happiness of individuals because they affect the welfare of entire communities: living in a situation featured by violence limits the sense of self-esteem in women and their ability to participate in social life. Many international studies (WHO, 2005) reveal that women victims of abuse are hampered in their ability to access information and services, more generally, to take part in public life and even to receive active support from friends and relatives and therefore, they experience an inability to care for themselves and their children, to get a job and to have a professional life allowing them to reach economic independence.

The identification of the underlying causes of violence against women is not an easy task; many scholars, both at an international and at a national

level, now increasingly agree on the interplay of multiple complex and interconnected factors of individual, institutional, social and cultural nature found in the socio-economic strengths, in the institution of the family, in the fear and desire of controlling women's sexuality, in the physical superiority of the male, as well as in laws and cultures that have always denied a legal and social status of autonomy and freedom to females.

The World Health Organization notes that despite the efforts carried out by many researchers in studying the factors affecting violence – especially domestic violence – there are many difficulties in comparing those studies because the analysis of risk factors is strongly affected by differences between developing countries, industrial countries and pre-industrial societies. One method seems to be provided by the WHO, which points out that the current base of knowledge is more focused on the study of individual factors than on community or society as critical aspects of the likelihood of abuse.

The above observations prove that this phenomenon has all the features of a real social emergency, when we take into consideration its direct negative effects not only on the psycho-physical integrity of the victims, but also on society as a whole. Here, we are talking about the costs of violence in socio-economic terms - which is finally catching the attention of many worldwide researchers, and individuals who must intervene in programmes, as well as work with prevention strategies at various levels (governments, healthcare workers, etc.).

In this context, in 1993, the World Bank estimates that both the industrialized and the developing countries bear an extremely high cost due to domestic violence. More precisely, those costs would amount to nearly one in five years of life calculated according to the incidence of mortality and morbidity (DALYs, Disability-Adjusted Life Year) lost by women aged 15 to 44 (UNICEF, 2000).

But this raises a new issue, and we naturally wonder how we can act on the phenomenon of violence in terms of prevention and intervention.

Certainly, the most relevant interventions are support activities for victims, assistance for legal and judicial interventions which is available in many countries (and we hope they will be available in other countries in the near future). In addition, treatment programs for perpetrators of violence which is a novel intervention for many countries, community commitments, as well as extremely important and valuable health service interventions through the intense activity carried out by healthcare workers and addressed to victims of violence.

All of these factors, however, are supposed to be included within specific models of intervention in order to unfold in all their effectiveness.

These efforts are taking place especially in the health sector and allow us to develop a set of models guiding the formulation of action plans, programmes and protocols as well as practical approaches.

Here we would like to get into further details describing the Tuscan reality within Grosseto's Local Health Authority, where a Task Force and an ER Pink Path have been implemented. We will discuss their experience, in working with certain models of intervention against violence.

Models of intervention for violence against women

As already mentioned before, violence against women is described in many countries as the most shameful human rights violation, denying women the right to equality, safety, dignity, self-esteem and the right to enjoy fundamental freedoms (WHO, 2005).

As showed by many recent studies, violence against women – and, in particular, violence perpetrated in the family nucleolus by intimate partners – has steadily increased thus becoming an urgent public health priority. The latter proves to be true also considering the weaknesses of prevention activities, especially those aimed at changing cultural and law regulations encouraging discrimination (WHO, 2005; Garcia-Moreno, Watts, 2011; Ellsberg, 2006). Yet, violence against women is still considered a relatively minor social issue, even though the efforts of many organizations, experts, and some governments committed to political action, have contributed to raising greater awareness of this problem. In terms of models of intervention, it is therefore necessary to address society as a whole, taking into account all the different socio-economic and cultural aspects affected by gender-based violence in order to create effective programs of action. Hence the need to carry out situational analysis aimed at identifying any active local organizations and institutions acting within the same framework of shared responsibility, while operating for their specific function.

A current strategy offering many advantages in addressing the problem of violence against women seems to come from a health viewpoint.

In this regard, several studies show that violence against women has profound implications on almost all aspects of health policy, whose programming ranges from primary care to sexual and reproductive health programs (Heise, Hellsberg, Grottemoeller, 1999; Ellsberg, 2006; UNFPA, 2006). Considering the fact that the health sector is most heavily involved in combating violence, by detecting not only physical violence caused by aggressions, but also the consequences of this aggression on mental health such as post-traumatic stress affecting women victims of domestic

violence. As highlighted by several studies on the services offered to abused women, we can see the great importance that health institutions play in the detection of undeclared cases of violence (Bernier, Bérubé, Hautecoeur, & Pagé, 2005; Reale, 2011).

It is then necessary to develop a correct healthcare response through the promotion of operational programmes based on models of intervention, which are able to guide the formulation of action plans and protocols in the health sector, as well as practical approaches applied to different national contexts in the healthcare framework. The first difficulty arises with the effective application of guidelines concerning situations in which health workers welcome victims of violence (Bernier et al., 2005). In those cases, for instance, it is imperative to have specific knowledge on how to convey to a woman the message that violence is unacceptable without making her feel inadequate and judged. In addition one must reassure the woman who is a victim of psychological violence who tends to deny or minimize the problem and also find a way to treat a woman who chooses in any case to remain in a violent situation; how to integrate the principles of empowerment, seen as a "process involving personal and collective components," (Ouellet, et al., as cited in Bernier, et al., 2005).

A good starting point for combating violence is certainly the identification of complex models of intervention, whose earlier and different theoretical perspectives taken as a reference provided interesting tools to carry out actions against gender-based violence. As reported by Dutton (as cited in Bernier et al., 2005), some examples of previous theoretical methodologies include cognitive-behavioural approaches that rely on measures aimed at reducing stress, developing skills and problem solving by means of relaxation techniques, role playing, use of images; experiential gestalt techniques, psycho-play, movement therapy; insight-oriented approaches including dynamic therapies and family genograms; and psycho-educational techniques, Finally, considering the high specificity of selected topics, feminist approaches are crucially relevant in analyzing the imbalance of power between genders and explaining the so called "cycle of violence", allowing us to understand the extreme difficulty in escaping a violent relationship (Reale, 2011).

In this article, we would like to describe in detail some theoretical models of intervention useful for the definition of a global approach applicable to health services involved in the fight against violence against women. Moreover, we believe that these should be highlighted and explained, since they are part of intervention programmes, and consider their possible integration.

The first model we want to illustrate is the ecological model. As reported by the World Report on Violence and Health issued by the World Health Organization (WHO, 2002), the ecological model was introduced in the late 70s and first used for childhood abuse and violence among young people. After that, it was subsequently applied in the study of violence against women, especially violence committed by partners. Specifically, this model considers violence as the result of an interaction – explored in all its complexity – of individual, social, cultural and environmental factors and analyzes the relationship between individual and contextual factors in order to verify possible conditioning on behaviour. According to various expert reports (Heise, 1998; Buvinic, et al, 1999), the ecological model provides an efficient way to understand some of the key elements contributing to women's and girls' risk of being victims of violence. This model is organized into four levels of risk (individual, relationship, community and society risks) and it emphasizes the importance of understanding the complex interplay of biological, psychological, social, cultural, economic and political factors that increase women's and girl's likelihood of experiencing violence (and men's likelihood for perpetrating it).

According to the ecological model, the health sector should effectively implement violence prevention and response programmes through an accurate analysis of all the factors contributing to violence perpetration, as well as through the development of identification and caring strategies for people at risk thus reducing and eliminating risk through broad-based prevention programmes. Thanks to the ecological model, health care providers can shift from an individualistic, bio-medical orientation to a more holistic approach of health interventions, not only targeting the individual's health needs, but also addressing the need for social change.

The second approach reported in this brief discussion, is the multi-sector model, which calls for a series of holistic inter-organizational and inter-agency actions promoting the participation of at-risk individuals, interdisciplinary and inter-organizational cooperation, collaboration and coordination across key sectors including (but not limited to) health, psychosocial, legal/justice and security (Bott et al., 2005). All the institutions, agencies, individuals and resources that are targeted towards a specific goal (for example, the health sector, including the Ministry of Health, hospitals, health care centres, health care providers, health care administrators, health care training institutions and health supplies, etc.) should take part in this approach (Ward, 2005).

The multisectoral model was born from the development of a coordinated community response to domestic violence originally introduced in industrialized countries and now being used all over the world. In general, the

multisectoral model is nothing but a coordinated community response at a national level .

The third model taken into consideration is the systems approach. This model speaks directly to the responsibilities across relevant health service-delivery organizations to develop effective, efficient and ethical services. This approach focuses on developing resources and skills across an entire organization, and it does not just train individual providers.

The experts (Bott et al, 2004) who developed this model identified the key elements as summarized below:

- Strengthen the institutional commitment to address gender-based violence.
- Collaborate with other organizations actively addressing gender-based violence.
- Strengthen privacy and confidentiality for all women who come for health services through infrastructure improvements and clinic policies.
- Improve health workers' and law enforcement's understanding of local and national laws and policies regarding violence against women and the health sector.
- Improve provider's knowledge, attitudes and skills.
- Strengthen referral networks and facilitate survivors' access to other services.
- Develop or improve written institutional policies and protocols for caring for women who have been victims of violence.
- Ensure the provision of emergency services and supplies.
- Ensure that up to date educational materials are available to clients on topics related to gender-based violence.
- Strengthen medical records and information system to enable staff to document and monitor cases of gender-based violence.
- Ensure adequate monitoring and evaluation related to gender-based violence.

Closely tied to this type of model is the integrated approach, since it focuses on health delivery organizations. However, in this case, integration refers more specifically to targeting various types of existing health providers (that is emergency rooms, clinics, sexual and reproductive health services, etc.) and determining how violence-related services can be incorporated to ensure that victims presenting for care (whether or not related to an incident of violence) receive the necessary assistance related to their exposure to violence as quickly as possible.

According to some scholars who studied this model in greater detail (Colombini, Mayhew, & Watts, 2008), this model includes three levels of integration, each with a corresponding approach. The first type of

integration takes place at a provider level (provider-level integration). At this level it is the same provider who offers a range of services during the same consultation. An example of such an intervention would be that of an accident and emergency nurse trained to screen for domestic violence, treating her client's injury, providing counselling and referring her to external sources of legal advice. The second type of integration happens at a facility level (facility-level integration). In this case, a range of services is available at one facility but not necessarily from the same provider. That could happen when an accident and emergency nurse may be able to treat a woman's injury, but not provide counselling to a woman disclosing domestic violence. On this occasion, it is necessary to refer her to the hospital medical social worker for counselling. The last type of integration happens at a systems level (systems-level integration), in which both facility-level integration and a coherent referral system between facilities are put in place in order to ensure the client is able to access a broad range of services in their community. As an example, we can report the case of a family-planning client disclosing violence, who can be referred to a different facility (possibly at a different level) for counselling and treatment. Moreover, this type of integration is multi-site.

According to the same scholars noted above, this model of intervention has not only positive aspects but also negative elements, since if on one side it is indeed a privileged context for emerging situations of violence, on the other it experiences several difficulties.

Within the health sector, most violence-related services involve a combination of provider- and facility-level integration; full systems-level integration is rare, in spite of the fact that systems-level integration likely offers the promise of the most comprehensive care within a community. Based on a review of integration efforts in various low and middle-income countries around the world, several key lessons learned about integration include:

- Development and implementation of policies, protocols, and other tools and procedures is important to help institutionalize services as part of care delivery.
- Staff training must be sustained over the long term and support and supervision must be available to providers.
- Integration plans must be careful to address facility infrastructure (including private counselling rooms, availability of appropriate equipment, etc.) as well as documentation systems.

Many other experts in this sector (IGWG of USAID, 2006) also believe that these obstacles are added to others, such as the lack of specific laws in some countries, the difficulty in applying laws and policies because of the

limitation of technical and financial resources, the lack of coordination and, last but not least, the extremely little attention devoted to this issue. These problems persist not only at an international level, but also within Europe, so much so that the Council of Europe through the Committee of Ministers adopted a Recommendation to Member States in 2002, in which they suggest a series of measures, which can actually contribute to protect the interests of victims, to ensure the protection of rights and to ensure the prevention of any type of violence against women

In addition to implementing information and awareness-raising activities extremely crucial for prevention, the recommendation on European best practices provide precise pieces of information about the protocols that must be followed by professionals in working with victims, in view of possible judicial proceedings. Moreover, it underlines the importance of promoting emergency services such as free and anonymous emergency telephone lines, specialized services in the context of victims' care, as well as to ensure the welcome of victims and an accurate treatment that depends on the severity of the reported situation. A recent study commissioned by the Council of Europe (Kelly, 2008) shows that many European countries have not formally adopted real standards yet.

It is also important to consider that the lack of accurate training and ongoing supervision reflects negatively on health service workers that do not always know how to deal with victims of violence. It is then clear that useful interventions for victims cannot be guaranteed and that we cannot expect any big changes without a program including support actions specially addressed to them (UNFPA, 2006).

The Inter-institutional Taskforce

Thus, what emerges from the previously reported information in this article, in recent years, a global public health approach emphasizing the importance of collective action and joint efforts of different sectors has become increasingly adopted along the healthcare sector and includes education, social services , justice and policies in an attempt to address not only “medical” issues.

To overcome the obstacles faced by the healthcare system, it is essential to evaluate the health facilities and to enhance policies and protocols aiming to fix any administrative deficiencies in terms of the fight against violence. The key to success in achieving the objectives of specific programs is to work in an inter-institutional network perspective, because alone we can do little or at least nothing lasting, also considering the

difficulty of being involved in preventive primary care, which should be an integral part of programmes.

For the healthcare sector, therefore, we do not suggest a single model to combat violence against women, but we are developing approaches that tend to be within the framework of an integrated approach to intervention, with the health sector synergically connected to other sectors.

An example of an approach described here is that of the Task Force and the so called Pink Path carried out in the Emergency Department of Grosseto’s Local Health Authority. This model's application represents an inter-institutional experience activated between ASL 9 and the Public Prosecutor's Office of Grosseto for assistance to victims of violence addressed to the so called vulnerable groups (women, elderly and children) (Meucci, et al, 2011).

This experience reflects the guidelines of the regional legislation specifically providing for the establishment of a network of relationships between Municipalities, Regions, Local Health Authorities, Hospital-University Organizations, the Regional School Office and the Provincial Education Offices, the Police, the Territorial Officers of Government, the Judiciary and Anti-Violence Centres, in order to create and offer a widespread and comprehensive service to women victims of violence.

Those actions should carry out a close examination of the phenomenon; they should spread information and offer awareness-raising activities to victims and citizens, as well as organize health worker training courses in terms of prevention measures, support and reintegration of victims. In more detail, this regulation provides the signing of Memoranda of Understanding between the Region and the Public Prosecutor's Office with the purpose of establishing a project for the testing of a regional network for the promotion of joint strategies precisely aimed at preventing and fighting the phenomenon of violence against vulnerable groups of the population.

According to this Memorandum of Understanding, the parties are engaged in several aspects, such as:

- ❖ Promoting the establishment of a working group with the purpose of optimizing resources thus improving the responses provided to victims, in addition to maintaining a relationship of constant interlocution between the different components involved in this field. This working group is coordinated at a regional level and is composed of representatives of the Region, the Public Prosecutor's Office, Local Health Authorities and any other Public Prosecutor responsible for the territory;
- ❖ Establishing inter-institutional Task Forces in every Local Health Authority working in close contact with local Public Prosecutors, with

the task of ensuring coordination among the "Coordination Centres for Victims of Violence" and other facilities in the area;

- ❖ Organizing a regional network of Task Forces established at a local level in order to develop a plan for shared programming, with periodic meetings for the study of the activities carried out, in order to assess the impact of the activity conducted considering any pros and cons;
- ❖ Implementing data collection on sexual and domestic violence through the joint monitoring of the phenomenon (made by the Coordination Centre for Victims of Violence of any Local Health Authority and passing that data to the Public Prosecutor's Office for the activation of a Joint Task Force in case of emergency);
- ❖ Promoting public intervention strategies against violence and action on specific problems;
- ❖ Promoting training courses for life-long professional training of Task Force's staff and other operators working in various sectors of this framework;
- ❖ Promoting information campaigns to raise awareness, addressed both to the general population and to specific groups of people (such as schools, at-risk groups, etc.).

This Task Force is just an example of a model to combat violence against women. It was created in 2010 and it involves the participation of various health professionals (the Co-ordination Centre for Victims of Violence of ASL 9 in this case), the Judiciary (pools of magistrates for offenses against vulnerable groups), the Police, but also social workers and voluntary organizations as well as all those involved in projects aimed at protecting victims of violence, and last but not least, ensuring the punishment of criminals.

As for the implementation of the project, the Pink Path is an excellent tool for women victims of gender-based / family violence and provides a valuable aid in the selection of the type of path to be followed after a first treatment (judiciary, social welfare), in compliance with the privacy and the wishes of the victim.

At the Emergency Department, the victim is placed in a restricted area that can be accessed only by specialists who are going to examine the patient. In this area, the equipment necessary to carry out biological tests and detection of Criminal Investigation Department materials. This route provides not only proper treatment by medical staff fully respecting the victim, but also a significant decrease in investigation and trial times, and it allows for prompt action in these situations. The work carried out by this Task Force thus allows to obtain a considerable flow of information shared by the Public Prosecutor's Office, the Police and the Local Health Authority, obtaining a broad and

comprehensive knowledge of at-risk situations, thus enabling a more accurate and complete monitoring and control on the territory, even when the victim decides not to report the accident to the Police.

In the first year of testing, the Task Force achieved significant results in terms of harassment, stalking and abuse crimes, registering a growth trend that did not mean a real increase in cases but a gradual acknowledgment by the victims, a greater focus by health care workers involved in terms of their ability to detect situations of violence by giving victims more opportunities to be assisted and supported (Meucci et al., 2011).

Moreover, it is crucial to remember that the adoption of shared procedures to define and report crimes to the Prosecutor's Office helped to decrease inquiry times and to speed up the process itself. Therefore one cannot but come to a positive conclusion in the direction of a growing commitment in addressing the serious problem of violence against women in a systematic and continuous way and with various synergistic activities, particularly in the field of domestic violence, which is the most hidden and less known violence in the world (WHO, 2005; Reale, 2011).

Thanks to the results obtained from this experience, as a "domino effect" (Meucci et al., 2011) new Task Forces are becoming operational in the Tuscany region with the creation of a Memoranda of Understanding between institutions that establish collaborations of all active forces in the recognition, acceptance and care of abused women.

Conclusions

Drawing the conclusions of this dissertation – that cannot be exhaustive for such a complex and problematic topic like violence against women – we would like to add some brief remarks.

The issue of violence against women is surely a problem which lacks a single strategy applicable to every situation, due to a number of reasons: the variety of contexts in which it occurs, the variety of ways in which it is perpetrated and the variety of causes triggering the event. Just considering the interrelationships among the factors responsible for violence, especially the cultural and economic factors – as well as those on power dynamics featuring the relationship between genders – we can affirm that the emphasis is increasingly on the need to include strategies and interventions in integrated contexts. As we have already highlighted in this article, both national and international bodies studying this phenomenon emphasize the importance of a multi-tiered strategy addressing the structural causes of

violence against women, while ensuring the availability of necessary services to victims.

When we consider health, legal, economic, educational, developmental and, last but not least, human rights responses to this problem, the strategies and interventions must be guided by basic principles fostering prevention, protection, early intervention, reconstruction of victims' lives, assumption of responsibility, and ensuring the punishment of the guilty. The considerable and constant effort exerted on a large scale is essential to lay the foundations, on which to build programs recalling policies of peace and safety with the aim to develop effective, coordinated strategies that tend increasingly to the implementation of global models.

The inter-institutional Task Force model showed that it has the potential to address the problem not only in terms of efficacy but also in terms of respect for the victims, while performing synergistic and integrated activities, which are a crucial element in the broader landscape of actions to fight violence against women.

References

Bernier, D., Bérubé, J., Hautecoeur, M., & Pagé, G. (2005). Intervenir en violence conjugale: la demarche d'une équipe interdisciplinaire en périnatalité [Intervene in domestic violence: The gait of an interdisciplinary team perinatal], *Collection Etudes et Analyses*, *33*. Quèbec: CRIVIFF .

Bott, S., Morrison A., & Ellsberg M. (2005). Preventing and responding to gender-based violence in the middle and low-income countries: A global review and analysis. *World Bank Policy Research Working Paper* 3618. Washington, DC: World Bank.

Bott, S., Guedes A., Claramunt C., & Guezmes A. (2004). Improving the health sector response to gender-based violence: A resource manual for health care professionals in developing countries. *International Planned Parenthood*. New York: Western Hemisphere Region.

Buvinic, M., & Morrison, A. (1999). *Violence as an obstacle to development*. Washington DC*:* Inter-American Development Bank.

Caritas Ambrosiana, Centro Aiuto Donne Maltrattate di Monza, Coop Soc. Cerchi d'Acqua, Centro Ambrosiano Documentazione per le Religioni, Casa delle Donne Maltrattate di Milano, Servizio Politiche di Genere e Progetti Speciali della Provincia di Milano (2007). *Rapporto su donne italiane e straniere maltrattate in famigli [Report on Italian and foreign women abused in the family].* In temi.provincia.milano.it/donne [visited on 19/03/2012]

Colombini, C., Mayhew, S., & Watts C.. (2008). Health-sector responses to intimate partner violence in Low- and middle-income settings: A review of

current models, challenges and opportunities. *Bulletin of the World Health Organization, 86*(8), 635-642.
Ellsberg, M. (2006). Violence against women and the millennium development goals: Facilitating women's access to support. *International Journal of Gynecology and Obstetrics, 94*, 325-332
Garcia-Moreno, C., & Watts. C. (2011). Violence against women: an urgent public health priority. *Bullettin World Health Organisation*, January 1, 89:2.
Heise, L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women*. 4 (3): 262-290.
Heise, L., & Ellsberg M., & Gottemoeller M., (1999). *Ending violence against women*. Baltimore, MD: Johns Hopkins University School of Public Health, Center for Communications Programs.
IGWG of USAID (2006). Addressing Gender-based Violence through USAID's Health Programs:A Guide for. Health Sector Program Officers. Washington, DC, Interagency Gender Working Group.
ISTAT (2008). *La violenza contro le donne. Indagine multiscopo sulle famiglie "Sicurezza delle donne" [Violence against women. Multipurpose survey on families "safety of women"]. Roma*: ISTAT.
ISTAT (2007). *La violenza e i maltrattamenti contro le donne dentro e fuori la famiglia [Violence and abuse against women inside and outside the family].* Roma: ISTAT.
Kelly, L. (2008). *Combating violence against women: Minimum standards for support services*. Strasbourg: Council of Europe.
Meucci, G., Doretti, V., & Coniglio, G. (2011). *Codice rosa. Il magico effetto domino [Code Pink. The magic domino effect].* Ospedaletto (Pisa): Pacini.
Reale, E. (2011). *Maltrattamento e violenza sulle donne. La risposta dei servizi sanitari [Violence against women. The response of health services].* (Vol. 1). Milano: FrancoAngeli.
UNFPA (2006). Ending Violence against Women. Programming for prevention, protection and care. New York: United Nations Population Fund. Retrieved from:http://www.unfpa.org/public/publications/pid/399 [2007] .
UNICEF (2000). La violenza domestica sulle donne e sulle bambine [Domestic violence against women and girls]. *Innocenti Digest, 6*, Firenze Centro di Ricerca Innocenti.
Ward, J. (2005). "Conducting population-based research on gender-based violence in conflict-affected settings: An overview of a multi-country research Project." Prepared for "Violence against women: a statistical overview, challenges and gaps in data collection and methodology and approaches for overcoming them" Expert Group Meeting. UNDAW, Economic Commission for Europe (ECE) and World Health Organization (WHO), Geneva. Retrieved from: http://www.un.org/women-watch/daw/egm/vaw-stat-2005/docs/expert-papers/Ward.pdf
WHO (2002). *World Report on violence and health*. Geneva (Switzerland): World Health Organisation.
WHO (2005). *Multi-country Study on women's health and domestic violence against women*. Geneva (Switzerland): World Health Organisation.