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Brittany McDermott Date

Gender-Based Violence in Global Perspective:
A Curriculum for the Hubert Department of Global Health
at the Rollins School of Public Health

By

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By

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Bachelor of Arts, Healthcare Studies
University of Richmond
2016

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An abstract of
a thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2018

Abstract

Gender-Based Violence in Global Perspective:
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By: Brittany McDermott

Given the current political climate and rise of mainstream feminist movements, *Gender-Based Violence in Global Perspective* is a much-needed addition to course offerings at Rollins School of Public Health (RSPH). Gender-based violence is defined as interpersonal acts or structural conditions that result in physical, emotional, sexual, or psychological harm and are derived from socially ascribed differences between men and women. After conducting a review of courses offered at RSPH, several curriculum gaps were identified, one of which being the omission of courses discussing the risk factors and long-term effects of violence. This curriculum addresses this need by providing students an overview of gender-based violence, detailing the prevalence rates, health impacts, and current challenges. The three lessons are titled: (1) Defining Gender-Based Violence, (2) Effects of Gender-Based Violence on Health Outcomes, and (3) Sexual Violence on College Campuses. This special studies project ensures that the Hubert Department of Global Health offers more comprehensive course content, aligning with the mission of RSPH to prepare the next generation of leaders in public health in health promotion and disease prevention.

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Acknowledgements

In the design of this special studies project, I have been blessed with the opportunity to receive guidance and support from experts within the Rollins School of Public Health. First, I would like to express my sincere thanks to my thesis committee chair, Cari Jo Clark, and committee member, Kathryn Yount, for their invaluable feedback, thoughtful advice, and continual mentorship. Your willingness to give so graciously of your time and expertise has not gone unnoticed or unappreciated, and I am so honored to have had the privilege to get to know you, both personally and professionally. I am also extremely grateful for all who have encouraged me during my two years as a student in the Department of Global Health, especially my loving family. I truly would not be where I am today without your unending support. Lastly, I would be remiss if I did not include a special thank you to my peers for sharing this journey with me. I look forward to seeing all that we will accomplish.

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Chapter 1: Introduction

In the wake of #MeToo, #TimesUp, and the global movement to end gender-based harassment in homes, schools, and workplaces, violence against women and other vulnerable groups (i.e. sexual minorities, gender-nonconforming individuals, and children) is slowly being recognized as a public health crisis. In spite of severe underreporting, variation across country contexts, and challenges measuring the pervasiveness of gender-based violence, data indicates that the global impact is substantial and necessitates the allocation of additional resources, both financial and otherwise. Additionally, it is becoming increasingly critical for researchers and practitioners to consider the issue from a multidisciplinary perspective, understanding that violence is closely associated with (and considered a predictor of) poor health outcomes and often contributes to widening disparities in health. Aligning with the mission and goals of the Rollins School of Public Health (RSPH), this special studies project aims to "build capacity in the public health workforce", providing students the opportunity to understand the ways in which deeply entrenched societal norms precipitate gender-based violence and creating a space to discuss primary, secondary, and tertiary prevention strategies.

Problem Statement

As one of the largest and most diverse academic departments at RSPH, the Hubert Department of Global Health offers Master of Public Health students the unique opportunity to personalize their course selection to best suit their individualized needs. While certainly an asset of the program, students often express concerns that course offerings are limited and, at times, repetitive in content, both within and amongst the four concentrations: Community Health Development, Infectious Disease, Public Health Nutrition, and Sexual and Reproductive Health

and Population Studies. Out of an estimated 80 classes offered within the department, very few discuss topics related to the global scope of violence and, even fewer, mention gender-based violence and its impact on women and girls worldwide. While it is understandable that course offerings are not exhaustive, it is both unreasonable and ill-advised to ignore such a glaring exclusion within the curriculum. Additionally, with the establishment of the Global Research for Women (GROW!) initiative spearheaded by the Hubert Department of Global Health's own faculty members, students are seeking opportunities to engage with these topics and discuss the gendered nature of violence in an academic setting. Within the span of one day, over 25 students expressed interest in a course discussing gender-based violence in global perspective, illustrating the interest in and pressing need for this addition to the curriculum. With the design of this course, the Department of Global Health is not only being responsive to the requests of its students, but also encouraging future practitioners to consider opportunities in an understudied field.

Purpose Statement & Objectives

With an intention to prepare students with interests in programmatic work and/or global research, the Sexual and Reproductive Health and Population Studies (SRP) concentration takes special interest in addressing current issues in the field, including discussions of gender identity and sexuality, sexual behavior, sexually transmitted infections, fertility, family planning and contraceptive decision-making, abortion, maternal and child health, and health across the life course. With a focus on the impact of violence on sexual and reproductive health, this special studies project aims to expand the knowledge base of students in the SRP concentration by meeting the following objectives:

- ❖ Fill the curriculum gap in the SRP concentration, Hubert Department of Global Health, and RSPH as a whole by expanding course offerings
- ❖ Cultivate an academic environment that is supportive, engaging, and student-centered to increase understanding of gender-based violence
- ❖ Increase student interest in courses, workshops, and trainings (in-person and online) on gender-based violence to continue knowledge-sharing within and beyond RSPH
- ❖ Build diverse workforce of researchers, practitioners, and subject-matter experts

Significance Statement

By adopting this curriculum, the Hubert Department of Global Health is addressing a need that has been identified by faculty and students alike and filling a significant gap that is present within the entire School of Public Health. Given the current political and social climate, a foundational understanding of the scope of gender-based violence and its associations with today's global issues, such as HIV/AIDS, maternal mortality, and human trafficking, is critical for all future public health professionals. As an institution striving to "train and support future leaders" in public health, RSPH will certainly benefit from this addition to its course offerings.

Chapter 2: Literature Review

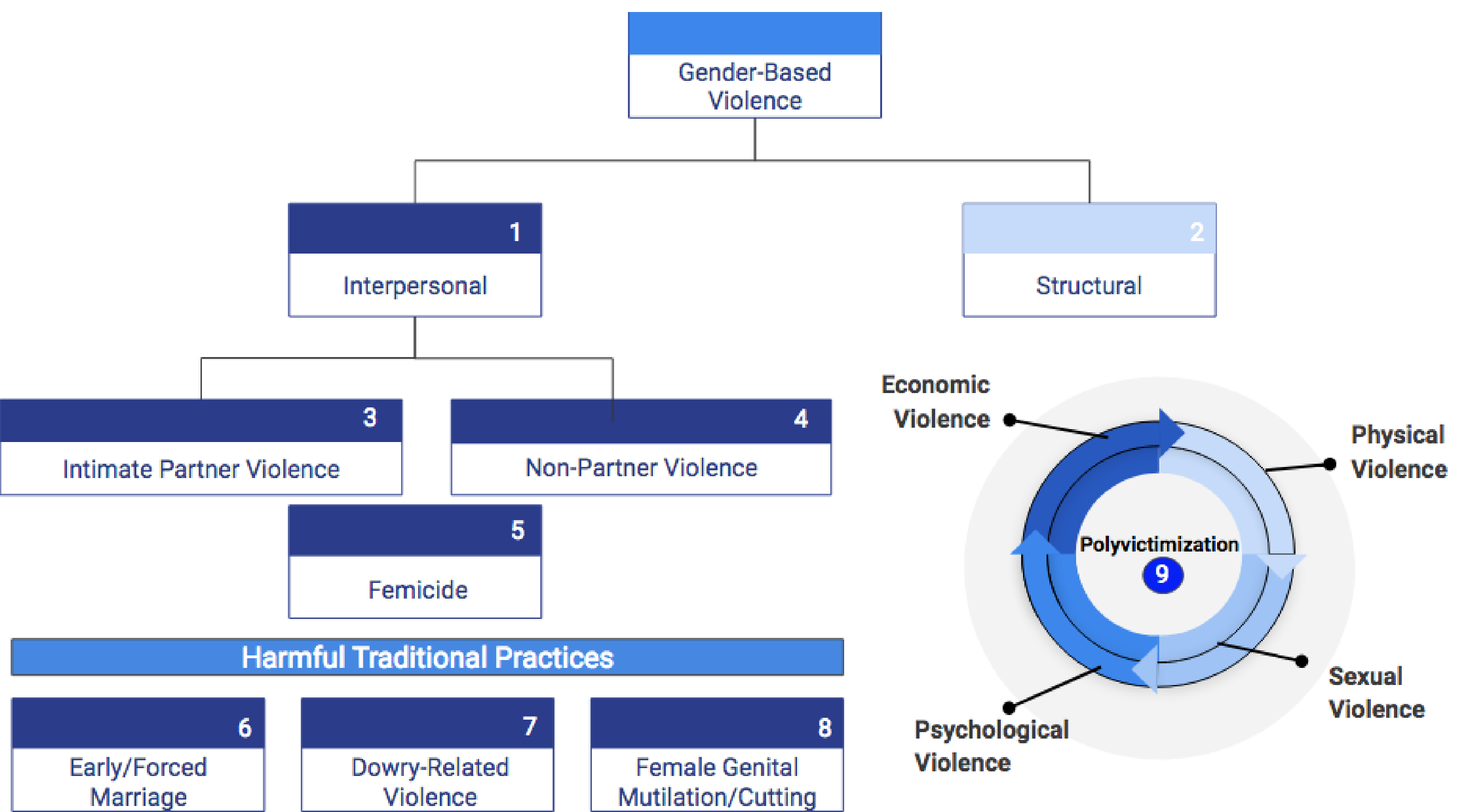
Introduction

With an estimated third of women and girls reporting an experience of physical and/or sexual violence, it is evident that gender-based violence poses an ongoing threat to the realization of the United Nations' (UN) Sustainable Development Goal #5: Achieve gender equality and empower all women and girls (UN Women 2017). Although the use of the term gender-based violence is relatively new, violence derived from socially constructed views of masculinity and femininity has been documented for centuries. According to the United Nations Declaration on the Elimination of Violence against Women in 1993, gender-based violence is defined as an act "that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life" (UN 1993). Although this commonly cited definition is largely interchangeable with the definition of 'violence against women', gender-based violence can also impact individuals with non-traditional gender identities that deviate from socially defined gender norms. In fact, the United States Agency for International Development (USAID) suggested that any form of violence "rooted in structural inequalities... and characterized by the use and abuse of physical, emotional, or financial power and control" qualifies as gender-based violence, regardless of the victim's biological sex (USAID 2012). However, women and girls tend to be the focus of anti-violence efforts as the vast majority of violent acts are perpetrated by men against intimate female partners, family members, or acquaintances (World Health Organization 2012; Fleming 2015).

Examples of gender-based violence include, but are not limited to:

- Intimate Partner Violence - an act of physical, sexual, psychological, or economic violence by an intimate partner
- Child Abuse - an act of physical, sexual, or psychological maltreatment against a child or the inaction of a parent or caregiver (i.e. neglect)
- Early or Forced Marriage - a practice where a child under the age of 18 enters a formal or informal union against his or her own will
- Female Genital Mutilation/Cutting - a practice that results in the total or partial removal of the external female genitalia for non-medical reasons
- Dowry-Related Violence - the continuous harassment of a physical, sexual, or psychological nature (typically by a woman's husband or in-laws) as a means to increase the dowry payment
- Female Infanticide - the intentional killing of newborn females or deliberate, fatal neglect of a female child
- Human Trafficking - the harboring and/or transport of an individual, often for the purpose of forced labor, organ sale, or sexual exploitation against his/her own will
- Femicide – the intentional murder of a woman or girl because of their gender

Although the list above is certainly not exhaustive, each act is an example of interpersonal gender-based violence, intended to cause harm or death to a specific individual.



<u>*The Global Scope of Gender-Based Violence*</u>

[1] *Interpersonal violence* has been defined as "the intentional use of physical force or power, threatened or actual, against another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (World Health Organization 2002). While interpersonal forms of gender-based violence often manifest in acts of intimate partner violence, community violence, such as non-partner violence, sexual exploitation, and human trafficking, has become increasingly common. Unfortunately, reported prevalence rates are not always accurate as "many deaths are concealed as accidents or attributed to natural or unknown causes" (WHO 2002).

[2] *Structural violence* is a form of gender-based violence that is "marked by unequal access to the determinants of health (e.g., housing, good quality health care, unemployment, education), which then creates conditions where interpersonal violence can occur and shape gendered forms of violence that place women in vulnerable positions" (Montesanti 2012). For example, structural violence is often prevalent in spheres that are rife with inequity, such as schools and the workplace. In these locales, gender-based violence often manifests itself in bullying, corporal punishment, discrimination, sexual harassment, and social exclusion, creating a hostile environment and widening pre-existing disparities. As a result, it is unsurprising that women are overrepresented in low-wage jobs with fewer opportunities to advance and have "less bargaining power over terms and conditions of their labor" (USAID 2012). However, the effects of structural violence often take root long before women enter the workforce. One study found that 90% of abandoned children in India were female, and there was a 10% increase in the mortality rate for girls as compared to boys (Vijay & Chary 2016). This "son preference", which has also been documented in sub-Saharan Africa and East Asia is a well-cited example of how gender-based violence (ex: female infanticide, child abuse/neglect) can create gendered disparities that place women at a disadvantage and increase one's risk of experiencing subsequent violence. In addition, other forms of structural violence include a failure to provide adequate and accessible services for survivors of violence, such as trauma-informed health facilities or trained law enforcement, or inadequate/non-inclusive policies and legal provisions.

[3] Approximately 35% of women worldwide are survivors of physical and/or sexual violence with the most commonly reported being *intimate partner violence*. According to a multi-country study conducted by the World Health Organization (WHO), which systematically reviewed 77 studies from 56 countries, "the global lifetime prevalence of physical and/or sexual

intimate partner violence among all ever-partnered women" over the age of 15 (n=347,605) is approximately 30% (WHO 2016). The highest prevalence rates of intimate partner violence were reported in the following WHO regions: Southeast Asia (37.7%), Eastern Mediterranean (37.0%), and Africa (36.6%), 10% higher compared to the prevalence rate in WHO's high-income region (23.2%) (WHO 2016). These findings were corroborated by the United Nations' review of national prevalence data, which found that physical and sexual intimate partner violence are most prevalent in Africa, however, for those countries with longitudinal data available, some rates appear to be declining over time (UN 2015).

[4] The lifetime prevalence of *non-partner violence* is estimated to be approximately 7% with the highest prevalence rate (12.6%) reported in the high-income region, which includes the United States. Studies have shown that female children are more likely to experience *sexual exploitation*, a form of non-partner sexual violence, as compared to male children, and "between ⅓ and ⅔ of known sexual assault victims are under the age of 16". Additionally, an estimated 20% have experienced sexual violence before age 8 (Finkelhor 1994; Heise 1994; Heise et al. 2002) with 15 million adolescent girls experiencing forced sex during their lifetime (UNICEF 2017). Of the 98% of women and girls experiencing forced sexual exploitation worldwide, approximately 20% are under the age of 17; however, female children represent over two thirds of all child human trafficking victims, which includes domestic servitude, removal of organs, and sex work (UN 2015; International Labor Organization 2012). As an industry, *human trafficking* disproportionately affects women and young girls, who represent an estimated 70% of all victims (International Labor Organization 2012).

Conversely, in the United States, a significant proportion of non-partner sexual violence is attributed to reports of *sexual assault* on college campuses, where "students are at an increased risk during the first few months of their first and second semesters" (Rape, Abuse and Incest National Network 2018). Amongst college-aged women, one in five experience sexual violence, and some studies found that these students are disproportionately at risk for sexual assault as compared to their peers, who are not in college (Krebs, et al. 2007; Krebs, et al. 2009). However, the stigmatization of sexual violence disclosure, fear of repercussions, means of measuring or defining acts of violence, and variability in sampling methodology across studies must be noted as limitations to measuring global, regional, national, and campus-wide prevalence rates of non-partner violence.

[5] As one of the most extreme forms of gender-based violence, *femicide* involves the intentional, gender-based killing of women, often at the hands of a former or current male partner, which is typically "motivated by hate, contempt, pleasure, or the assumption of ownership of women" (Russell 2008). While women can participate in acts of femicide (i.e. mothers-in-law), most femicide attempts involve male perpetrators and can be divided into four primary categories: intimate partner femicides, familial femicides, femicide by other known perpetrators, and stranger femicides (Russell 2008). Although there is limited data on the issue of femicide, current literature does suggest that intimate partner violence is a notable risk factor, and over 35% of female homicides are committed by intimate partners, compared to only 5% of male homicides (WHO 2012). While it is unclear whether these murders are gender-based or simply happenstance, there is clear evidence of gender-specific disparities in homicide rates. Regional differences are also apparent, with countries in Latin America and the Caribbean having the highest rates of female homicide in the world.

[6] In many countries, human rights violations targeting women and girls are rooted in culturally accepted familial practices that have persisted in communities for centuries; one of the most common harmful traditional practices is *early/forced marriage*, or *child marriage*. Over 700 million women alive today were married before the age of 18, with the highest rates of child marriage in low and middle income countries within South Asia and sub-Saharan Africa. Nearly a third of the global population of child brides reside in India, and over 25% of adolescents in West and Central Africa are currently married (UN 2015; UNICEF 2014). Early or forced marriage disproportionately affects young women living in poverty, particularly those in rural areas; "girls in the poorest 20% of the population (poorest quintile)" are twice as likely to marry before reaching adulthood as compared to those in the wealthiest quintile (UN 2015; International Center for Research on Women 2016). Child brides are also more likely to experience intimate partner violence and increased health complications than those that marry later. However, educational attainment has been found to be a protective factor against early/forced marriage; according to a study by the International Center for Research on Women, girls who completed secondary school are up to 6x less likely to become child brides (ICRW 2016).

[7] For young brides in South Asian countries, particularly India, Bangladesh, and Nepal, *dowry-related violence* has become a normalized practice, consisting of "any act of violence or harassment [perpetrated by a partner or family member] associated with the giving or receiving of dowry at any time before, during, or after the marriage" (UN 2009). Although there is a scarcity of data to determine the global prevalence of dowry-related violence, a 2011 study utilized data from public domains of governmental and related organizations to shed light on the incidence of dowry deaths and suicides in India during a 12 year period (1995-2007). The

authors found a 74% increase in the occurrence of dowry deaths and 31% increase in the occurrence of dowry-related suicides during the study period. Additionally, they estimated that there are 15,000 dowry-related deaths a year in India alone, which are "mostly in kitchen fires designed to look like accidents" (Babu & Babu 2011).

[8] The practice of *female genital mutilation/cutting* (FGM/C) is prevalent in 29 countries, predominantly in Africa and the Middle East, and has affected over 200 million women alive today. The highest rates have been reported in Somalia, Egypt, Guinea, and Djibouti with over 90% of women and girls undergoing FGM/C, however, global prevalence rates have been steadily decreasing, particularly among younger women. When asked about knowledge of FGM/C and attitudes toward the practice in national household surveys, the majority of women over the age of 15 in 22 out of 29 countries expressed support for discontinuation of the practice. In fact, "around 1 in 3 girls aged 15 to 19 today have undergone the practice versus 1 in 2 in the mid-1980s. However, not all countries have made progress, and the pace of decline has been uneven" (UNICEF 2017). Like many other forms of gender-based violence, prevalence rates tend to be lowest in families with higher levels of educational attainment and household income as well as in areas of increased urbanization (UN 2015).

[9] Although intimate partner violence among adult married, cohabiting women has historically been overrepresented in the literature, it is well documented that survivors of all ages often experience multiple forms of violence throughout the life course (Heise et al. 2002). This phenomenon of *poly-victimization* highlights the tendency for violence acts to co-occur, either concurrently (i.e. experiencing physical and psychological abuse by the same intimate partner) or sequentially (i.e. experiencing sexual abuse in childhood and sexual assault in adulthood)

(Finkelhor et al. 2007; Smith et al. 2002; Turner et al. 2010). In the aforementioned multi-country WHO study, many respondents reported experiencing multiple forms of violent behavior, such as controlling behavior and threats. In fact, over half of countries with available national data reported a lifetime prevalence rate of psychological violence over 40%, while others found that women who report experiences of physical abuse are more likely to be economically exploited and emotionally manipulated by that same partner (UN 2015). Given what we know about how poly-victimization is associated with gender-based violence, many researchers argue that experiences of violence in early childhood and adolescence demand greater attention, as they often increase one's risk for subsequent acts of violence in adulthood.

The Social Ecological Model of Gender-Based Violence

In 1998, Dr. Lori Heise, developed the first social ecological model of gender-based violence, which provided a theoretical framework to understand how violence is influenced by overlapping and interconnected factors within four social contexts (see Figure 1). By considering both the drivers and consequences of violence at the individual, interpersonal, community, and societal levels, Heise synthesized risk factors for both victimization and perpetration of gender-based violence and illustrated how interactions between factors across the life course can increase one's likelihood of experiencing violence. Below, Table 1 provides a comprehensive (but not exhaustive) list of risk-factors for gender-based violence that have been consistently documented in both primary peer-reviewed journals as well as grey literature from the World Health Organization and Centers for Disease Control and Prevention.

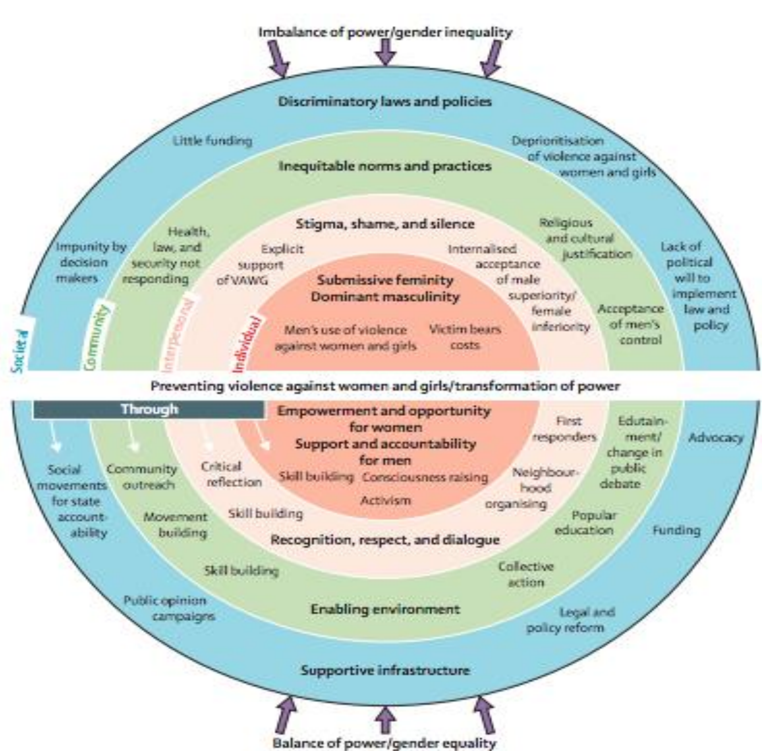


Figure 1: Using the Social Ecological Model to Address Violence Against Women and Girls
Source: Michau, L. et al 2015

Table 1: Risk Factors for Gender-Based Violence

Individual-Level Risk Factors	Relationship-Level Risk Factors	Community-Level Risk Factors	Societal-Level Risk Factors
Demographics ❖ Low level of educational attainment (P, V) ❖ Low level of household income (P, V) ❖ Younger age (P, V) ❖ Unemployment (P, V) ❖ Refugee status (V) ❖ Having a disability (V) ❖ Being female (V) ***Personality Traits*** ❖ Personality disorders (P) ❖ Sexual entitlement (P) ❖ Maintaining attitudes that condone violence or gender inequality (P, V) ❖ Low level of self-esteem/ depression (P, V) ***Personal Behaviors*** ❖ Absenteeism (P) ❖ Risky sexual behavior (P) ❖ Maintaining multiple sexual partners (P) ❖ Committing infidelity (P) ❖ Aggressive/hostile behavior (P) ❖ Hyper-masculinity (P) ❖ Substance use (P, V) ***History*** ❖ Early sexual initiation (P) ❖ Child abuse (P, V) ❖ Witnessing violence in childhood (P, V) ❖ Family history of violence (P, V)	❖ Delinquent peer associations (P) ❖ Predominately male decision-making in household (P, V) ❖ Predominately male control over finances (P, V) ❖ Belief in family honor (P, V) ❖ Belief in sexual purity (P, V) ❖ Unhealthy family relationships (P, V) ❖ Poor parenting practices (P, V) ❖ Past history of violent behavior (P, V) ❖ Lack of emotional support (P, V) ❖ Financial hardship within the household (P, V)	❖ Poverty ❖ High population density ❖ Lack of employment opportunities ❖ High rates of crime for other types of violence ❖ Social isolation of women ❖ Lack of social support for women ❖ Toxic masculinity ❖ Lack of institutional support (i.e law enforcement, judicial system) ❖ Poor legal sanctions for violent acts ❖ Tolerance of violence within communities ❖ Maintaining victim-blaming attitudes	❖ Rigid gender roles ❖ Toxic masculinity ❖ Maintaining cultural norms accepting of violence or gender inequality ❖ Inequitable policies and procedures ❖ Poor legal sanctions for violent acts ❖ Lack of representation of women in decision-making positions

Sources: *Heise 1998, Heise et al. 2002, Krug et al. 2002, WHO 2016, CDC 2017*	
P: Risk factor for perpetration	V: Risk factor for victimization

The Effects of Gender-Based Violence on Health Outcomes

Gender-based violence, whether that be forced sex or physical assault, is consistently associated with negative health outcomes, particularly sexual and reproductive health consequences, physical injury, and mental health concerns for women and girls. Those with a history of sexual violence are at a greater risk of sexually transmitted infections and unwanted pregnancies, particularly when they lack the autonomy to negotiate condom usage with intimate partners (Heise et al. 2002). Child brides often have higher risks of contracting HIV and other STIs (as much as 6x compared to boys of the same age) as a consequence of the inherent power imbalance in relationships between a young girl and older spouse. Similarly, adult women and unmarried children who have been victims of violence are 1.5x as likely to contract these diseases (WHO 2016). Those who have been sexually abused as children are more likely to become pregnant during adolescence, and the likelihood that a woman's first pregnancy is unintended increases with an increased frequency of abuse (Heise et al. 1999).

In addition to being more likely to report unintended pregnancies, survivors of violence also have an increased risk for fetal distress, miscarriages, abortion, and maternal mortality. Unintended, unwanted, or mistimed pregnancies have been consistently associated with not only delays in seeking prenatal care but also inadequate care; for example, "when compared with women who planned to conceive, women with an unwanted pregnancy are 1.8 to 2.9 times more likely to begin care after the first trimester" (Institute of Medicine 1995). These preterm disparities are suspected to contribute to the increased risk of poor health outcomes for the fetus,

such as preterm delivery, low birth weight, and fetal growth retardation (Alhusen et al 2015). However, risk is highly dependent on the mother's socioeconomic status and age. Stillbirths and newborn deaths are 50% higher among mothers under 20 than in women who get pregnant in their 20s (WHO 2013). Babies born from mothers younger than 18 have even worse outcomes as the risk for under-five stunting increases by over 6 percentage points and under-five mortality increases by 3.5 percentage points (ICRW 2016). Maternal mortality is also a concern for young mothers as childbirth and its complications are among the leading cause of death for girls ages 15-19 (United Nations Population Fund 2017). Nonfatal consequences associated with sexual violence include pelvic inflammatory disease, vaginal bleeding, discharge, painful menstruation, sexual dysfunction, and chronic pain (Heise et al. 2002; Coker 2007).

In addition to poor reproductive health outcomes, physical injury among survivors are often attributed to acts of violence, resulting in fractures, traumatic brain injury, gastrointestinal disorders, and chronic head, back, and abdominal pain. Two million partner rapes and assaults against women annually result in injury, and over a third of female homicides are committed by violent intimate partners (Tjaden & Thoennes 2000; WHO 2016). In fact, in 1994, rape and domestic violence were among the top ten causes and risk factors for disability and death among women aged 15 - 44, higher than cancer, motor vehicle accidents, war, and malaria (World Bank 1994). According to the National Center on Domestic Violence, Trauma, and Mental Health, survivors of violence are 2x as likely to report a disability, and in almost half of every violent altercation, the survivor, who is often a woman, sustains numerous injuries that often have long-lasting physical and mental health consequences (NCDVTMH 2014; WHO 2016).

A number of studies have also found an association between risk-taking behavior and

psychological distress, which is presumed to explain why those who experience sexual violence at a younger age have a greater predisposition for deviant behavior (Heise et al. 2002). Individuals can be indirectly affected by past history of physical and sexual abuse and attempt to self-medicate, turning to substance abuse, smoking, and unprotected sex, as coping mechanisms to respond to chronic anxiety or post-traumatic stress disorder. Survivors of violence are twice as likely to report “problem drinking” or depression, 3x as likely to turn to self-harm or experience suicidal ideation, and 4x as likely to attempt suicide (NCDVTMH 2014; WHO 2016). Eating disorders and sleep difficulties have also been documented as consequences of chronic stress that often accompanies physical and sexual violence.

Chapter 3: Methodology & Results

Needs Assessment

This special studies project originated from requests from faculty and students to expand upon content-specific course offerings in the Sexual and Reproductive Health and Population Studies concentration within the Hubert Department of Global Health. To supplement survey data that indicated that gender-based violence is a topic of interest for Global Health students, a thorough curriculum review was conducted to assess the need for the proposed course (Table 2). After reviewing the Rollins School of Public Health catalogs for the 2015-2016, 2016-2017, and 2017-2018 academic years, 24 relevant courses were initially identified; however, four courses were omitted for not meeting the inclusion criteria. The inclusion criteria for courses included in the curriculum review were the following: (1) currently active course offered between Fall 2015 and Spring 2018, (2) covers one topic that overlaps with the primary themes of the proposed course, and (3) has a former or current syllabus available for review. Three additional courses that met the above criteria were excluded from the curriculum review due to limitations on enrollment numbers (i.e. restricted to students in the Maternal & Child Health or Complex Humanitarian Emergencies certificates or international fellows). Sexual and reproductive health was the primary focus area of over half of the courses assessed (10); gender and violence were the primary focus in four and two courses, respectively. One course did not mention sexual and reproductive health, gender, or violence as an emphasis, however, it did cover four relevant topics that aligned with the themes of the proposed course. Given the clear need for more discussions of gender-based violence at RSPH, this course was approved by the Department of Global Health and will be taught in Spring 2019 (alternating with Gender and Global Health).

Table 2: Assessing the Need for a Gender-Based Violence Course at Rollins School of Public Health				
Course Assessed (Semester of Syllabus Reviewed)	Relevant Topics Covered	Primary Focus of Course		
		Violence	Gender	Sexual & Reproductive Health
Behavioral Sciences and Health Education				
BSHE 517: Adolescent Health (Fall 2017)	Child Maltreatment Sexual Assault STIs/HIV Unintended Pregnancy	◒	○	◒
BSHE 565: Violence as a Public Health Problem (Spring 2017)	Child Maltreatment Gender-Based Violence in Humanitarian Settings Intimate Partner Violence	●	◒	○
BSHE 567: LGBTQ Health (Spring 2017)	HIV Intimate Partner Violence	◒	●	◒
BSHE 568: Human Sexuality (Spring 2015)	Child Abuse Sexual Harassment Sexual Violence STIs/HIV	◒	◒	●
BSHE 591M/EH 580: Injury Prevention and Control (Fall 2015)	Interpersonal Violence	●	○	○

Epidemiology				
EPI 516: Issues in Women's Health* (Fall 2016)	Domestic Violence LGBT Health	◒	●	○
EPI 546: Methods in HIV Epidemiology (Spring 2015)	HIV	○	○	●
EPI 550/GH 550: Epidemiology and Dynamics of STD and HIV Transmission* (Fall 2016)	HIV/STDs	○	○	●
EPI 744: Pediatric and Perinatal Epidemiology (Fall 2017)	Pregnancy Outcomes	○	○	●
EPI 746: Reproductive Epidemiology* (Spring 2017)	Contraception Miscarriage Pregnancy Complications STDs	○	○	●
Global Health				
GH 530: The GEMMA Seminar - The Global Elimination of Maternal Mortality from Abortion* (Spring 2017)	Abortion	○	◒	●
GH 539: Reproductive Health Program Management* (Fall 2017)	Abortion Contraception Family Planning STIs Unintended Pregnancy	○	○	●
GH 541: Technology of Fertility Control* (Fall 2016)	Abortion Contraceptive Use Unintended Pregnancy	○	○	●

GH 559: Gender and Global Health* (Spring 2017)	Female Genital Cutting Sexual and Reproductive Health Sexual Violence Violence Against Women	◒	●	◒
GH 563: HIV/AIDS: Global Public Health Implications* (Fall 2017)	HIV/AIDS	○	○	●
GH 593: Religion and Reproductive Health* (Fall 2017)	Abortion Adolescent Sexual Health Contraception and Reproductive Technologies STIs/HIV	○	○	●
Health Policy and Management				
HPM 569: Women's Health Policy: A Lifecycle Approach (Spring 2017)	Abortion Family Planning STIs/HIV Unintended Pregnancy Violence Against Women	○	●	◒

Key

○ No mention of topic in course ⧫⧫ ◒ Partial mention of topic throughout course ⧫⧫ ● Course content is fully centered on topic

* Required or Elective Course for the Sexual, Reproductive, and Population Studies Concentration in Global Health

Note: The topic areas identified under "Relevant Topics Covered" reflect the wording used within each individual course syllabus; therefore, discrepancies in language (i.e. Intimate Partner Violence & Domestic Violence) must be recognized when making comparisons across courses.

Course Development

After conducting the curriculum review and reviewing the proposed syllabus, *Gender-Based Violence in Global Perspective* was developed in a multi-step process. Due to time constraints, three lessons were selected to focus on for this special studies project: Defining Gender-Based Violence, Effects of Gender-Based Violence on Health Outcomes (with a focus on Sexual and Reproductive Health), & Sexual Violence on College Campuses. Considering the goals of the course, lesson objectives were developed and used to craft a logic model for the course, outlining short, intermediate, and long-term goals (Table 3). An extensive literature review was conducted utilizing two primary online databases (PubMed & Google Scholar) and grey literature references, including reports from the World Health Organization, Centers for Disease Control and Prevention, UNICEF, and USAID. Required and supplemental course readings for each lesson were identified throughout this process. A thorough literature review outline was used to inform the content of each lesson plan, including a combination of didactic teaching and interactive activities (i.e. videos, case studies, group/pair exercises, and a panel discussion). Once developed, lesson plans were evaluated using a process called curriculum mapping to ensure that activities aligned with lesson objectives and reflected a diversity of learning styles (Table 4).

Pedagogy

This special studies project was developed with a foundational understanding of Adult Learning Theory, particularly the emphasis on active engagement in the classroom. It is well documented that "the human brain cannot focus for long when it is in a passive state", which is why educational psychologists have consistently advocated for student-centered models that produce the most favorable learning outcomes (Nilson 2010; Ganyaupfu 2013). Active learning models allow students to increase the retention of their working memories by allowing time to practice, apply, and store course material (Rosenshine 2012). Another important concept of learner-centered educational models is the ability to personalize course instruction to cater to student needs, which includes the use of multi-modal approaches, giving students the opportunity to engage with a particular subject matter in a number of different ways (Nilson 2010; Scott 2015). Lastly, evidence supports the use of team-based learning among adult learners as a means to encourage metacognitive development and supplement course content shared during a didactic lecture (Nilson 2010; Scott 2015). Not only do studies indicate that students who are expected to teach their peers are 'more prepared' than those expecting an exam, but "collaboration in the classroom embodies free thinking and even dissent. It prepares learners for real-life social and employment situations" (Scott 2015), which is of particular importance to students at the Rollins School of Public Health. With the use of student reaction journals, case studies, pair-and-share activities, mobile technology, student-led discussions, and an expert panel, this curriculum was designed with the principles of Adult Learning Theory in mind, ensuring active participation, self-reflection, and inquisition are a priority in each lesson plan.

Table 3 - 'Gender-Based Violence in Global Perspective' Logic Model

Session	Short Term Goals	Intermediate Goals	Long Term Goal
Defining GBV	Define gender-based violence Identify various forms of gender-based violence Describe multi-level and socio-contextual determinants of gender-based violence Understand the importance of utilizing clear terminology when studying gender-based violence and implications of inconsistent usage	Increased understanding of gender-based violence from a global perspective Increased advocacy for comprehensive, multilevel approaches to eliminate gender-based violence Increased interest in courses and workshops about gender-based violence at Rollins School of Public Health and comparable institutions	Additions to gender-based violence workforce, researchers, and subject-matter experts Elimination of gender-based violence
Effects of Gender-Based Violence on Health Outcomes	Understand implications of gender-based violence on physical and mental health outcomes across the life course Explain the neurobiology of trauma, including the short and long-term psychological effects of gender-based violence Describe the evidence linking gender-based violence to poor sexual and reproductive health outcomes		
Sexual Violence on College Campuses	Describe the scope and history of sexual violence on college campuses Understand the similarities and differences of sexual assault prevention and response efforts across college campuses (US in comparative perspective) Identify components of best practices in sexual violence prevention		

Table 4: Curriculum Mapping of Course Objectives				
Lesson Name	Lesson Objectives	Didactic Learning	Interactive Learning	Pair/Group Work
Defining Gender-Based Violence	Define gender-based violence	D		I
	Identify various forms of gender-based violence	D	I	A
	Describe multi-level and socio-contextual determinants of gender-based violence	I		
	Understand the importance of utilizing clear terminology when studying gender-based violence and implications of inconsistent usage	I		
Effects of Gender-Based Violence on Health Outcomes	Describe the evidence linking gender-based violence to poor sexual and reproductive health outcomes, including sexually transmitted infections, unwanted pregnancies, and gynecological disorders	I		D
	Explain the neurobiology of trauma, including the short and long-term psychological effects of gender-based violence	I	D	D
	Understand implications of gender-based violence on physical health outcomes across the life course	I		
Sexual Violence on College Campuses	Describe the scope and history of sexual violence on college campuses		I	D
	Understand the similarities and differences of sexual assault prevention and response efforts across college campuses (US in comparative perspective)	I	D	
	Identify best practices in sexual violence prevention		D	I

I = Introduced: Key ideas, concepts or skills related to the objectives of the course are introduced and demonstrated at an introductory level with activities intended to develop foundational knowledge and competencies.

D = Developing: Course objectives are reinforced with feedback to enhance and/or strengthen existing knowledge and skills with students demonstrate a higher level of proficiency.

A = Advanced: Learning objectives are demonstrated at the highest proficiency; activities integrate multiple course concepts and demand that the student has retained and is able to apply previously-taught material.

Adapted from California State University, Long Beach (n.d.) and Veltri, Webb, Matveev & Zapatero (2011).

Defining Gender-Based Violence

Objectives

1. Introductions – syllabus review – class expectations
2. Define gender-based violence
3. Identify various forms of gender-based violence
4. Describe multi-level and socio-contextual determinants of gender-based violence
5. Understand the importance of utilizing clear terminology when studying gender-based violence and implications of inconsistent usage

Learning Timeline

Prior to Class:

- Print and distribute copies of the syllabus
- Print definitions of gender-based violence and cut into strips
- Type icebreaker questions to project on a PowerPoint slide
- Print copies of case study

X:XX-X:XX: Icebreaker [Paired Exercise (15 min): 5 minutes – 10 minutes report back]

Instructions:
- Find someone in the room that you do not know personally.
- Introduce yourself by sharing your name, department, class year, and why you chose Rollins.
- After you and your partner have introduced yourselves, you must ask each other questions to determine at least one thing that you have in common. This commonality cannot be your name, department, class year, or why you chose Rollins.
- Below are some questions to get you started:
    - Where are you from?
    - Where did you complete your undergraduate degree?
    - Have you worked in another country? Which country?
    - What is your area of interest in public health?
    - Do you have pets?
    - What is your favorite type of food?
- Introduce your partner to the class and share what you have in common.

Equipment: Candy, Computer (PowerPoint)

X:XX-X:XX: Overview of the course, syllabus, and today's objectives [15 minutes]

X:XX-X:XX: How has gender-based violence been defined over time?

[Small Group Exercise (15 min): 5 minutes – 10 minutes report back]

Instructions:

- Break into groups of three or four.
- *Distribute one definition to each small group – note: there are four definitions total that should be labeled 1-4.*
- In your small group, read the following definition and consider the following questions:
  - What groups would be included in your definition?
  - What groups would be excluded in your definition?
  - What acts of violence would be covered under this definition?
- Choose one spokesperson to share your group's answers to the discussion questions about your assigned definition. After the first group has shared, other groups with that same definition may contribute other observations.
- *After all definitions have been discussed, project Slide 3 and ask the class:*
  - *What do you notice about these definitions?*
  - *Does the order of the definitions surprise you?*

Equipment: Printed Definitions, Computer (PowerPoint)

X:XX-X:XX: Social Ecological Model of Gender-Based Violence and Interpersonal Forms of Violence Lecture (Slides 4-22) [45 minutes]

Equipment: Computer (PowerPoint), Internet, Sound

X:XX-X:XX: Break [15 minutes]

X:XX-X:XX Structural Forms of Violence Mini Lecture (Slides 23-27) [15 minutes]

Equipment: Computer (PowerPoint)

X:XX-X:XX: Gender-Based Violence in Country X Case Study
[Small Group Exercise (40 min): 20 minutes – 20 minutes plenary]

Instructions:

- *Distribute a copy of the case study to each student.*
- Break into groups of three to four.
- In your small group, read the case study and consider the following questions:
  - What types of GBV are most prevalent in Country X? Consider both interpersonal and structural forms of violence.
  - What may be contributing to the perpetuation of GBV in Country X?
  - What may be some challenges for Country X when implementing its action plan?
  - Imagine you were tasked with developing an implementation strategy for Country X. How would you recommend Country X proceed with its national plan of action?
- The board has been divided into four categories: interpersonal violence, structural violence, perpetuation, and challenges. When your group is finished, please write one finding in each category. After all groups have contributed, all groups will have an opportunity to add additional notes.
- Be prepared to share highlights from your small group discussion and recommendations for Country X with the class.

Equipment: Printed Copies of Case Study, White Board, Markers

X:XX-X:XX: Wrap up, questions, instructions for next class [10 minutes]

Pre-Class Readings

None

Helpful Background Readings

Heise L (1998). Violence against women: an integrated, ecological framework. *Violence Against Women*; 4: 262 –290. Retrieved from http://gbvaor.net/wp-content/uploads/2012/10/Violence-Against-Women-An-Integrated-Ecological-Framework-Heise-1998.pdf.

United Nations Statistics Division (2015). Chapter 6: Violence against women. Retrieved from https://unstats.un.org/unsd/gender/downloads/WorldsWomen2015_chapter6_t.pdf.

USAID (2014). Part 2: GBV Definition, Prevalence, and Global Statistics: Toolkit for Integrating GBV Prevention and Response into Economic Growth Projects. Retrieved from https://www.usaid.gov/sites/default/files/documents/1865/USAID%20Toolkit%20GBV%20EG%20Final%20Section%202.pdf.

World Health Organization (2017). Violence against women. Retrieved from http://www.who.int/mediacentre/factsheets/fs239/en/.

Relevant Documents/Handouts

(1) Definitions of GBV
(2) GBV Case Study: Violence Against Women in Country X (Student)
(3) GBV Case Study Reference Sheet (Facilitator)

Assignments

Reaction Journal

(1) Definitions of Gender-Based Violence	
"Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life" *- UN Declaration on the Elimination of Violence Against Women*	"Any act of verbal or physical force, coercion or life-threatening deprivation, directed at an individual woman or girl that causes physical or psychological harm, humiliation or arbitrary deprivation of liberty and that perpetuates female subordination" *- Ending Violence Against Women (Heise, Ellsberg, Gottmoeller)*
"An umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females" *- Inter-Agency Standing Committee Guidelines on Gender-Based Violence Interventions in Humanitarian Settings*	"Violence that is directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity… gender-based violence is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control" *- United States Strategy to Prevent and Respond to Gender-Based Violence Globally (USAID)*

(2) Case Study: Violence against Women in Country X (Student)

Background

Violence against women and girls is a major public health and human rights problem in Country X. Women who are poorly educated and economically dependent on their male partners are the most vulnerable. Sexual violence is also a major problem, with men being the most common perpetrators of rape and women, the victims. Sexual violence is associated with a range of health risk-taking behaviors among men, including having more sexual partners, alcohol and drug use, and exchanging gifts or services for sex. These behaviors are rooted in cultural norms regarding masculinity, male honor, and male sexual entitlement, an ideology that encourages male aggressiveness, dominance, and control of women, and attitudes towards gender relations. Girls and women are considered to be subordinate to boys and men and wives are expected to obey their husbands. Addressing violence against women and girls (VAW/G) is part of the government's commitment to eliminating gender inequalities.

Nature and Incidence of Gender-Based Violence

- One in four women aged 15-49 have experienced physical intimate partner violence.
- Physical and psychological violence is most commonly reported. In 81% of reported cases, women report both of these forms of violence.
- Women report sexual violence in less than 15% of all reported cases. Researchers surmise that this is due to severe underreporting.
- Rape largely affects children and young women, with 40% of all survivors being under the age of 18 and 16% under 12.
- First sex is often coerced. A recent national study reports a prevalence of 24%. Those reporting forced first sex were twice as likely to report a subsequent sexual victimization.
- Friends, neighbors and acquaintances are the most common perpetrators of rape of adolescents.

Attitudes towards Gender-Based Violence

The problem of violence against women and girls is further exacerbated by its widespread cultural acceptance. Among young people, there is constant pressure on young boys to act in sexually aggressive ways towards women while young girls are expected to "accommodate men's sexual desires." In a national survey, close to three out of four women believed that intimate partner violence was justifiable punishment for a woman's failure to perform her normative roles in society. Furthermore, cultural norms allow husbands to "correct" their wives as long as such actions do not result in grievous harm. Focus group discussions revealed that intimate partner violence is considered a "normal" part of intimate and family relations and a private matter, and that those who witness such violence are discouraged from intervening.

As women are valued in many communities as wives and mothers, religious and community leaders who are approached by victims for help tend to stress the importance of commitment to marriage. Reporting incidents of violence to health workers and law enforcement officials can be viewed as a sign of disrespect for family members and elders, who are often responsible for intervening in cases of marital conflict. These attitudes and beliefs are grounded in social norms regarding gender and sexuality and are held more strongly by women who are poor, unemployed, lack access to information, and have little decision-making autonomy.

Legal Context

Country X has signed and ratified a number of international instruments on women's rights, including the Convention for the Elimination of All Forms of Discrimination against Women in 1981. The country has also ratified the United Nations Convention on the Rights of the Child, which calls on states to "take all appropriate legislative, administrative,

social, and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse." The provisions of these international treaties can be invoked in the country as the constitution grants the same status to international treaties ratified by the country and national legislation. However there is a wide gap between actual legislation and the experience of women and girls due to deep-rooted problems in the criminal justice system

Country X has not enacted specific legislation to protect women and girls from domestic violence and does not have specific legislation on sexual violence. Family violence falls under assault and battery, depending on the circumstances of the attack and the degree of injury of the victim. Although Country X's laws prohibit rape, the law does not explicitly address marital rape or incest, which is believed to account for the vast majority of domestic violence cases reported to women's organizations. Penalties for rape range from 10 to 15 years of forced labor if the victim is under 16 years of age, to life imprisonment with forced labor if the person committing the rape has some level of authority or power over the victim. The country does not otherwise prohibit violence against women within its criminal laws. Furthermore, some forms of violence, such as psychological violence, are not explicitly prohibited by law.

In general, existing legislation has been unsuccessful in curbing violence against women because most people are unaware of the law and the criminal justice system effectively discourages women from reporting violence, by systematically stigmatizing and discriminating against victims. For example, a recent report identifies inadequate legislation, and inappropriate or delayed response by the police as major factors preventing rape survivors' access to justice. The report notes that women's organizations have reported that police and social services are often reluctant to intervene in what are perceived as private and domestic matters, even in suspected cases of severe violence or abuse. The police are inadequately trained to respond to complaints from women and girls who allege that they have been the victims of rape and other forms of violence, which could potentially result in further victimization of violence survivors. There have been several reports that victims who have approached the police for help have been told "just move out…leave the relationship."

Health and Social Services

Health services are usually the first point of contact for women who are suffering from injuries related to VAW/G. However, a recent study showed health care providers have little means of protecting patients from violent partners and are often afraid to make an intervention other than treating the medical complaints. Health facilities vary in their record-keeping policies and often there is no medical evidence for use in legal action. Although there appears to be an increase in the proportion of women reporting sexual abuse and injuries during and after pregnancy, health care providers have limited access to information on women's options/ services available. Furthermore, there is a general lack of shelters and safe homes for abused women and children, especially in rural areas.

A study was conducted in 2007 to assess health care providers' perceptions of barriers to the identification of and referral to community and on-site services for women who are victims of intimate partner violence. The five barriers to identification of victims that health care providers most often agreed with were: (a) "patient denies battering as a cause of injury," (b) "patient fears repercussions of being identified as abused," (c) "patient does not mention abuse during history-taking," (d) "patient lacks privacy within the clinic," and (e) "what I view as abuse, my patient accepts as normal." The two barriers to referral to community services that health care providers most often agreed with were: (a) "fear of partner's reaction to referral" and (b) "battered patients do not want a referral." It was also found that there is a general lack of knowledge among medical personnel of procedures for identification, care and referral mechanisms in cases of violence against women, especially with respect to sexual violence from an intimate partner. Medical personnel also tended to perceive the legal responsibility involved in recording cases of violence as a problem, which prevented the cases from being recorded. Some health professionals were uncomfortable talking about violence with their patients while others tended to blame women for the violence perpetrated against them.

Opportunities

In 2007, the government created a national plan of action to prevent violence against women and girls, with the following objectives: (a) to reinforce and increase support services available to victims through different institutions; (b) to prevent violence against women and advocate for a coordinated national response; and (c) to strengthen the capacity of public institutions to prevent VAW/G by establishing strong partnerships with women's organizations and other nongovernmental organizations (NGOs). A gender-based violence prevention network, made up of government representatives, NGOs, women's groups, and international development agencies, has been created to step up the national response to violence against women, particularly in the area of sexual violence. However, more needs to be done and more resources need to be allocated to implement fully a national plan of action, guarantee access to justice and services for victims, and revoke laws that discriminate against women.

Source: Measure Evaluation. GBV Handouts. (2010, February 02). Retrieved from https://www.measureevaluation.org/resources/training/capacity-building-resources/gbv/GBV%20ME%20Handouts%20November%202009%20Final_nhDec09.doc/view

Discussion Questions:

1. **What types of GBV are most prevalent in Country X? Consider both interpersonal and structural forms of violence.**

2. **What may be contributing to the perpetuation of GBV in Country X?**

3. **What may be some challenges for Country X when implementing its action plan?**

4. **Imagine you were tasked with developing an implementation strategy for Country X. How would you recommend Country X proceed with its national plan of action?**

(3) Case Study: Violence against Women in Country X (Facilitator)

Background

Violence against women and girls is a major public health and human rights problem in Country X. Women who are poorly educated and economically dependent on their male partners are the most vulnerable. Sexual violence is also a major problem, with men being the most common perpetrators of rape and women, the victims. Sexual violence is associated with a range of health risk-taking behaviors among men, including having more sexual partners, alcohol and drug use, and exchanging gifts or services for sex. These behaviors are rooted in cultural norms regarding masculinity, male honor, and male sexual entitlement, an ideology that encourages male aggressiveness, dominance, and control of women, and attitudes towards gender relations. Girls and women are considered to be subordinate to boys and men and wives are expected to obey their husbands. Addressing violence against women and girls (VAW/G) is part of the government's commitment to eliminating gender inequalities.

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The problem of violence against women and girls is further exacerbated by its widespread cultural acceptance. Among young people, there is constant pressure on young boys to act in sexually aggressive ways towards women while young girls are expected to "accommodate men's sexual desires." In a national survey, close to three out of four women believed that intimate partner violence was justifiable punishment for a woman's failure to perform her normative roles in society. Furthermore, cultural norms allow husbands to "correct" their wives as long as such actions do not result in grievous harm. Focus group discussions revealed that intimate partner violence is considered a "normal" part of intimate and family relations and a private matter, and that those who witness such violence are discouraged from intervening.

As women are valued in many communities as wives and mothers, religious and community leaders who are approached by victims for help tend to stress the importance of commitment to marriage. Reporting incidents of violence to health workers and law enforcement officials can be viewed as a sign of disrespect for family members and elders, who are often responsible for intervening in cases of marital conflict. These attitudes and beliefs are grounded in social norms regarding gender and sexuality and are held more strongly by women who are poor, unemployed, lack access to information, and have little decision-making autonomy.

Legal Context

Country X has signed and ratified a number of international instruments on women's rights, including the Convention for the Elimination of All Forms of Discrimination against Women in 1981. The country has also ratified the United Nations Convention on the Rights of the Child, which calls on states to "take all appropriate legislative, administrative,

social, and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse." The provisions of these international treaties can be invoked in the country as the constitution grants the same status to international treaties ratified by the country and national legislation. However there is a wide gap between actual legislation and the experience of women and girls due to deep-rooted problems in the criminal justice system

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In general, existing legislation has been unsuccessful in curbing violence against women because most people are unaware of the law and the criminal justice system effectively discourages women from reporting violence, by systematically stigmatizing and discriminating against victims. For example, a recent report identifies inadequate legislation, and inappropriate or delayed response by the police as major factors preventing rape survivors' access to justice. The report notes that women's organizations have reported that police and social services are often reluctant to intervene in what are perceived as private and domestic matters, even in suspected cases of severe violence or abuse. The police are inadequately trained to respond to complaints from women and girls who allege that they have been the victims of rape and other forms of violence, which could potentially result in further victimization of violence survivors. There have been several reports that victims who have approached the police for help have been told "just move out…leave the relationship."

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Health services are usually the first point of contact for women who are suffering from injuries related to VAW/G. However, a recent study showed health care providers have little means of protecting patients from violent partners and are often afraid to make an intervention other than treating the medical complaints. Health facilities vary in their record-keeping policies and often there is no medical evidence for use in legal action. Although there appears to be an increase in the proportion of women reporting sexual abuse and injuries during and after pregnancy, health care providers have limited access to information on women's options/ services available. Furthermore, there is a general lack of shelters and safe homes for abused women and children, especially in rural areas.

A study was conducted in 2007 to assess health care providers' perceptions of barriers to the identification of and referral to community and on-site services for women who are victims of intimate partner violence. The five barriers to identification of victims that health care providers most often agreed with were: (a) "patient denies battering as a cause of injury," (b) "patient fears repercussions of being identified as abused," (c) "patient does not mention abuse during history-taking," (d) "patient lacks privacy within the clinic," and (e) "what I view as abuse, my patient accepts as normal." The two barriers to referral to community services that health care providers most often agreed with were: (a) "fear of partner's reaction to referral" and (b) "battered patients do not want a referral." It was also found that there is a general lack of knowledge among medical personnel of procedures for identification, care and referral mechanisms in cases of violence against women, especially with respect to sexual violence from an intimate partner. Medical personnel also tended to perceive the legal responsibility involved in recording cases of violence as a problem, which prevented the cases from being recorded. Some health professionals were uncomfortable talking about violence with their patients while others tended to blame women for the violence perpetrated against them.

Opportunities

In 2007, the government created a national plan of action to prevent violence against women and girls, with the following objectives: (a) to reinforce and increase support services available to victims through different institutions; (b) to prevent violence against women and advocate for a coordinated national response; and (c) to strengthen the capacity of public institutions to prevent VAW/G by establishing strong partnerships with women's organizations and other nongovernmental organizations (NGOs). A gender-based violence prevention network, made up of government representatives, NGOs, women's groups, and international development agencies, has been created to step up the national response to violence against women, particularly in the area of sexual violence. However, more needs to be done and more resources need to be allocated to implement fully a national plan of action, guarantee access to justice and services for victims, and revoke laws that discriminate against women.

1. **What types of GBV are most prevalent in Country X? Consider both interpersonal and structural forms of violence.** ***[See highlighted passages]***

Interpersonal: Sexual violence (rape, coerced Sex, incest), intimate partner violence (physical, psychological), child sexual abuse

Structural: Systematic stigmatization/discrimination by law enforcement, inadequate legal provisions & legislation, lack of access to knowledgeable, trauma-informed medical professionals

2. **What may be contributing to the perpetuation of GBV in Country X? [*See highlighted passages*]**
    - Toxic masculinity
    - Male honor
    - Male sexual entitlement
    - Strict gender roles
    - Cultural acceptance/normalization ("private matter")
    - Consequences of intervening or reporting (i.e. victim blaming)
    - Lack of legislative protections
    - "No place to go" - lack of safe houses and shelters for abused women and children

Note to Facilitator: For questions #3 and #4, allow students the opportunity to describe their national plan of action to the class and ask them to speak to the challenges that they may face during implementation. Use the answers to question #2 as a starting point for potential barriers to implementation.

Effects of Gender-Based Violence on Health Outcomes

Objectives

1. Describe the evidence linking gender-based violence to poor sexual and reproductive health outcomes, including sexually transmitted infections, unwanted pregnancies, and gynecological disorders
2. Explain the neurobiology of trauma, including the short and long-term psychological effects of gender-based violence
3. Understand implications of gender-based violence on physical health outcomes across the life course

Learning Timeline

Prior to Class:

- Assign one empirical article to each student and post group assignments on Canvas

X:XX-X:XX: Effects of GBV on Sexual/Reproductive Health Outcomes Mini Lecture (Slides 1-8) [20 minutes]

Equipment: Computer (PowerPoint)

X:XX-X:XX: How does gender-based violence affect sexual and/or reproductive health? [Small Group Exercise (30 mins): 10 minutes - 20 minutes report back]

Instructions:

- Break into six groups as assigned on Canvas *[Project Slide 9*]:
  - Group 1: Speizer et al. (South Africa)
  - Group 2: Silverman et al. (Bangladesh)
  - Group 3: Decker et al. (Thailand)
  - Group 4: Champion et al. (USA)
  - Group 5: Davis et al. (China)
  - Group 6: Waszak Geary et al. (Jamaica)
- In your small group, discuss the article and consider the following [*Project Slide 10*]:
  - What was the purpose of the research study?
  - Who are the participants, and which population(s) do they represent?
  - Briefly explain the recruitment and data collection methodology.
  - Describe the findings and any implications for sexual and reproductive health.
  - What are some limitations of the study?

- Write group findings on the whiteboard. Then, choose one or two spokespeople to share your answers to the discussion questions.
- *After all articles have been discussed, ask the class to take a look at the similarities/differences across the articles. Use appropriate probes to have students discover what topic areas are missing from the selected articles and methodological/ethical challenges faced by the authors. Takeaways should include:*
    - *Studies in LGBTQ communities, migrant/conflict-affected/hard-to-reach populations, and early adolescents are needed. Studies on violence are "easiest" among married couples and sexually experienced adolescents and adults.*
    - *Other forms of violence could be considered. Physical and sexual violence are "easiest" to measure and study; however, there may be associations between other forms of violence (psychological, economic, FGM/C) and SRH that could be explored.*
    - *STDs/HIV and unintended pregnancy are consistently examined. This may be because of funding opportunities, large-scale research priorities, and ease of study. However, other SRH outcomes of interest should be considered.*
    - *Other research methodologies could be employed. This sample consisted of six quantitative methodologies - qualitative approaches could be used in future research.*
    - *Methodological/ethical challenges include: different definitions/interpretations of violence (lack of generalizability), safety/confidentiality of participant after data collection, cultural norms (ex: need to be accompanied by a partner), mandatory reporting*

Equipment: Computer (PowerPoint), Article Group Assignments

X:XX-X:XX: Effects of GBV on Physical/Mental Health Outcomes Mini Lecture (Slides 9-13) [35 minutes]

- How might an understanding of trauma be useful for GBV researchers? For practitioners?

Equipment: Computer (PowerPoint), Internet, Sound

X:XX-X:XX: Wrap up, questions, instructions for next class (Slide 14) [5 minutes]

Pre-Class Readings

Greenhalgh, Trisha (2014). How to Read a Paper: The Basics of Evidence-Based Medicine, John Wiley & Sons, Incorporated. ProQuest Ebook Central, http://ebookcentral.proquest.com/lib/umn/detail.action?docID=1642418.

Maxwell L. et al. (2015) Estimating the Effect of Intimate Partner Violence on Women's Use of Contraception: A Systematic Review and Meta-Analysis. PLOS ONE 10(2): e0118234. Retrieved from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0118234.

One of the following empirical articles as assigned on Canvas:

Champion, J. D. et al. (2005). Relationship of abuse and pelvic inflammatory disease risk behavior in minority adolescents. *Journal of the American Association of Nurse Practitioners*, 17(6), 234-241. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.920.800&rep=rep1&type=pdf.

Davis, A. et al. (2015). Intimate Partner Violence and Correlates with Risk Behaviors and HIV/STI Diagnoses Among Men Who Have Sex With Men and Men Who Have Sex with Men and Women in China: A Hidden Epidemic. *Sexually Transmitted Diseases*, 42(7), 387–392. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4520252/pdf/nihms688054.pdf.

Decker, M. et al. (2011). Sex trafficking, sexual risk, STI and reproductive health among a national sample of FSWs in Thailand. *Journal of Epidemiology and Community Health*, 65(4), 334–339. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3521618/pdf/nihms422918.pdf.

Silverman, J. et al (2007). Intimate partner violence and unwanted pregnancy, miscarriage, induced abortion, and stillbirth among a national sample of Bangladeshi women. *BJOG*, 114: 1246–1252. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2007.01481.x/epdf.

Speizer, I. S.et al. (2009). Sexual Violence and Reproductive Health Outcomes Among South African Female Youths: A Contextual Analysis. *American Journal of Public Health*, 99(Suppl 2), S425–S431. Retreived from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3515795/pdf/AJPH.2008.136606.pdf.

Waszak Geary, C et al. (2006). Sexual violence and reproductive health among young people in three communities in Jamaica. *Journal of Interpersonal Violence*, 21(11), 1512-1533. Retrieved from https://www.researchgate.net/profile/Cynthia_Geary/publication/6739153_Sexual_Violence_and_Reproductive_Health_Among_Young_People_in_Three_Communities_in_Jamaica/links/5474dc230cf245eb436e2122.pdf.

Helpful Background Readings

Sharps, P., Laughon, K., & Giangrande, S. (2007). Intimate Partner Violence and the Childbearing Year. *Trauma, Violence, & Abuse*, *8*(2), 105-116. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.825.4386&rep=rep1&type=pdf.

NCTVDMH (2014). Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness. Retrieved from http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/FactSheet_IPVTraumaMHChronicIllness_2014_Final.pdf.

Relevant Documents/Handouts

None

Assignments

Reaction Journal

Sexual Violence on College Campuses

Objectives

1. Describe the scope of sexual violence on college campuses globally
2. Understand the similarities and differences of sexual assault prevention and response efforts across college campuses (US in comparative perspective)
3. Identify components of best practices in sexual violence prevention

Learning Timeline

Prior to Class:

- Assign student leadership groups and topic areas to each student and post group assignments on Canvas
- Send guest speaker invitations to panel members and secure parking validation
- Print speaker biographies for distribution to class

X:XX-X:XX: Student Leadership Groups 1-6 [60 minutes - 7-10 minutes per group]

Instructions:

Students in groups of 4–5 will provide a 7-10 minute overview on an assigned topic as outlined by Allison Tombros Korman in her article 'Shifting Culture to End Campus Assault'. In this article, Korman provides a framework for holistic culture change that is defined by the following areas:

1. Positive survivor support with options for reporting
2. Clear policies on campus investigations, adjudications, and sanctions
3. Robust, multi-tiered prevention education at all levels of the institution
4. Public disclosure of sexual assault statistics and related information
5. School-wide mobilization in partnership with campus organizations and student leaders
6. Ongoing self-assessment

Tombros Korman, A. (2015). Shifting Culture to End Campus Sexual Assault. Association of American Colleges and Universities. Retrieved from https://www.aacu.org/diversitydemocracy/2015/spring/korman

Each student group will be assigned one of the above focus areas to present to the class. A detailed rubric for peer teaching will be provided; however, at a minimum, student leadership should include the following elements:

(a) describe components of the assigned focus area,
(b) discuss how Emory University is addressing the assigned focus area and provide a 'grade',
(c) provide recommendations for future directions to address identified gaps, and
(d) complete overview within 7-10 minutes.

Otherwise, the format is flexible and will be left to the student group.

Consider using the following websites when researching Emory-specific offerings:
http://sexualmisconductresources.emory.edu/
http://equityandinclusion.emory.edu/compliance/sexual-misconduct/index.html
http://policies.emory.edu/8.2
http://sapa.emorylife.org/
http://clery.emory.edu/

Equipment: As determined by student groups

X:XX-X:XX: Break [10 minutes]

X:XX-X:XX: Review 'A History of Sexual Assault on College Campuses' Reference Sheet
[Small Group Exercise (15 mins): 10 minutes pair & share - 5 minutes report back]

- *Ask student groups to share their impressions of the data provided. Briefly discuss shocking statistics or things that were unsurprising. Have students note information that they would like additional information on to ask panelists during Q&A.*

X:XX-X:XX: Sexual Assault Prevention & Response Panel [45 min discussion - 30 min Q&A]

Equipment: Panel Biographies, Panel Facilitation Guide, Microphones, Rectangular Table and Chairs, Poll Everywhere Online Software

X:XX-X:XX: Additional Q&A time, one-on-one questions with panelists, wrap up [20 minutes]

Pre-Class Readings

Dills J., Fowler D., & Payne G. (2016). Sexual Violence on Campus: Strategies for Prevention. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/campussvprevention.pdf.

Kahn, S. (2017). Sexual Violence on Campus: What Numbers Can and Can't Tell Us. Retrieved from http://www.center4research.org/sexual-violence-campus-numbers-can-cant-tell-us/

Tombros Korman, A. (2015). Shifting Culture to End Campus Sexual Assault. Association of American Colleges and Universities. Retrieved from https://www.aacu.org/diversitydemocracy/2015/spring/korman

Helpful Background Readings

None

Relevant Documents/Handouts

(1) Student Leadership Rubric
(2) An Overview of Sexual Assault on College Campuses' Reference Document
(3) Sexual Violence on Campus Panel Preparation/Facilitation Guide
(4) Panel Biographies and Contact Information

Assignments

Student Leadership
Reaction Journal

(1) Student Leadership Rubric				
Criteria	*Needs Improvement* ***0-1***	*Meets Expectations* ***2-3***	*Excellent* ***4-5***	Total Points
Preparation	Student leaders demonstrate little to no mastery of the topic area. The information presented is generally inaccurate or non-specific and fails to produce a substantive discussion that supports the primary themes of the course.	Student leaders demonstrate some mastery of the topic area. The information presented is at times inaccurate and/or does not align with the primary themes of the course.	Student leaders demonstrate depth and breadth of the topic area. The information presented is relevant, accurate, and connects to the primary themes of the course.	10
Content	More than three of the required elements are missing.	One or two of the required elements are missing.	The components of the assigned focus area are discussed. Student leaders share how Emory University is addressing the assigned focus area. A 'grade' is provided with sound reasoning. Recommendations are provided. Student leaders stay within the allotted time limit.	5
Organization	There is no apparent organization of topics; student leaders occasionally veer off topic, which makes the discussion difficult to follow.	Student-led lesson has a clear direction and reasonable evidence is presented with minimal digressions.	Topics are thoughtfully organized with a coherent message, convincing supporting evidence, and logical flow.	5
Delivery	Student leaders do not maintain eye contact with the class and/or read speaker notes verbatim/in a distracting manner.	Student leaders are generally relaxed and comfortable presenting material with limited reliance on speaker notes.	Student leaders are professional, conversational, and at ease in front of the class with minimal use of speaker notes.	5
Group Member Evaluation	Grading provided by group members on the following Likert scale: 1-Poor 2-Fair 3-Average 4-Good 5-Excellent			5
Comments:				

(2) An Overview of Sexual Assault on College Campuses

I. Timeline of Monumental Legislation/Events for Sexual Violence Prevention (Weis 2015)

A. Title IX - 1972
1. Mandate: "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving federal financial assistance…"
2. One of many educational amendments that aimed to protect post-secondary students from sex discrimination and promote equal opportunity to education
3. Any institution that accepts federal funding must abide by Title IX and is required "to respond and remedy hostile educational environments"

B. Clery Act - 1990
1. Mandate: On-campus crime statistics must be reported and be publicly available to students, faculty, and staff
2. Named in memory of Jeanne Clery, a student at Lehigh University, who was raped and murdered in her dorm room
3. Universities are also encouraged to be transparent, regarding safety and security concerns; one example is the issuing of "timely warnings" - campus-wide messages that inform the campus community of an occurrence of campus crime

C. Violence Against Women Act (VAWA) - 1994
1. Mandate: Amendment of Clery Act, which provided first legal definitions for dating violence, domestic violence, stalking, and sexual assault and required university officials to report on them
2. Provided funding for investigations of rape and other violent crimes and hardened penalties for perpetrators
3. Universities are also required to implement prevention-based programming for incoming students and new employees, such as awareness campaigns, bystander interventions, and primary prevention, which are all defined in the amendment

D. "Dear Colleague" Letter - 2001 & 2011
1. Provides universities "guidance" on how to appropriately respond to allegations of campus sexual harassment and violence
2. Lowered the evidential standard from "clear and convincing" (there is a large probability that the accused student is responsible) to a "preponderance of evidence" (the accused student is more likely than not responsible)

E. Campus SaVE Act - 2013
1. Mandate: Reauthorizes VAWA by adding additional legal definitions for violence experienced by college students (i.e. acquaintance rape) and requires university officials to report on them
2. Requires universities to implement ongoing educational programs for all students, faculty, and staff

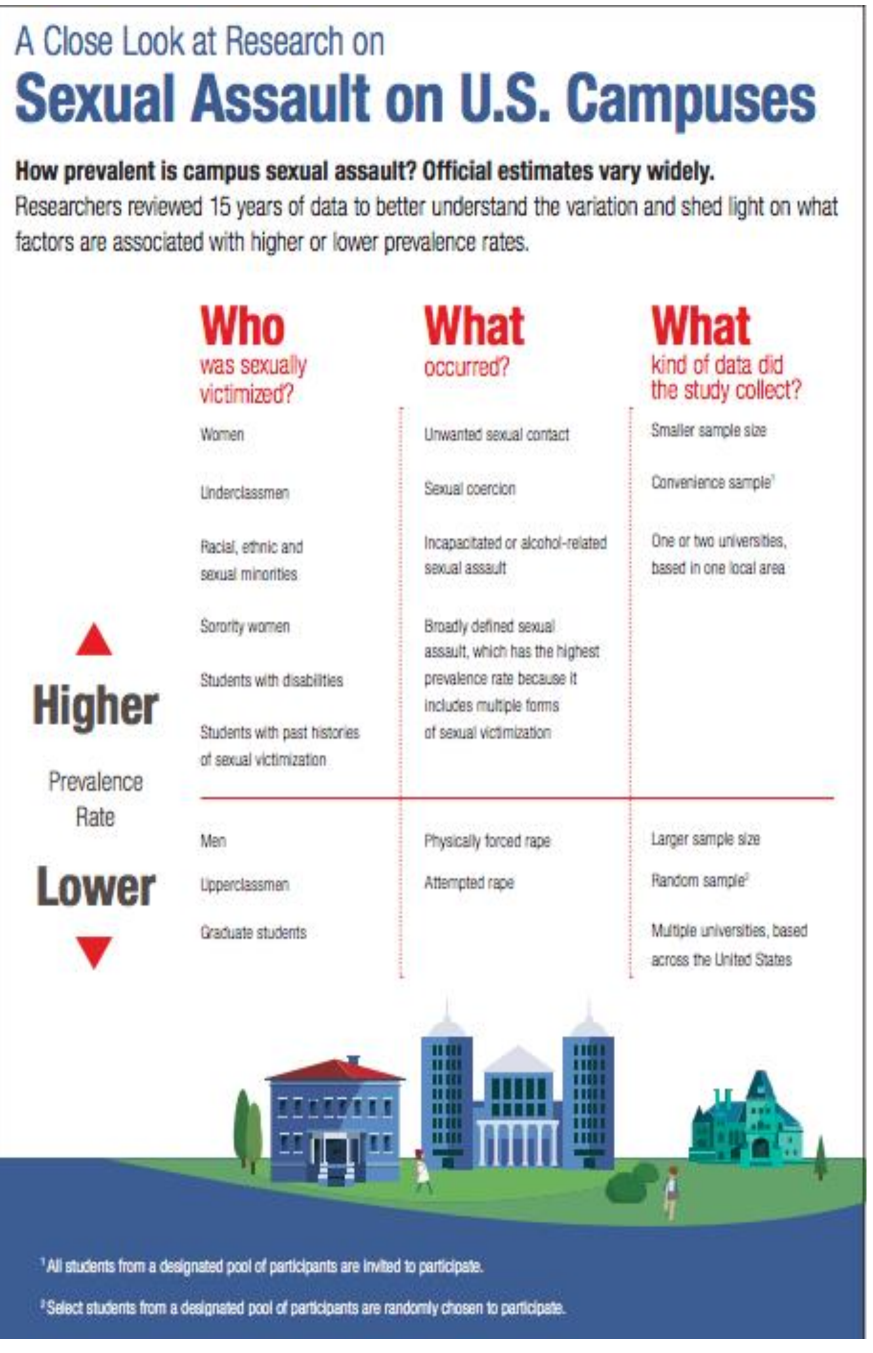
F. White House Task Force to Protect Students from Sexual Assault - 2014
    1. Under Vice President Joe Biden's leadership, this task force developed toolkits and a list of recommendations for universities to use when implementing on-campus sexual violence prevention plans
    2. The guide focused on six components:
        a) Coordinated Campus and Community Response
        b) Prevention and Education
        c) Policy Development and Implementation
        d) Reporting Options, Advocacy, and Support Services
        e) Climate Surveys, Performance Measurement, and Evaluation
        f) Transparency

II. II. Determining the Prevalence of Violence on Campus

A. Studies have found that estimates of sexual violence, including unwanted sexual contact, sexual coercion, incapacitated rape, attempted rape, and completed forcible rape, on college campuses vary considerably
    1. Differences in measurement
    2. Inconsistent definitions of sexual assault
    3. Research limited to white, heterosexual, cisgender female students attending four-year colleges with little consideration of the experiences of racial/ethnic minorities or other students who may be at risk for assault, such as LGBTQ students, students with disabilities, and students who have experienced victimization prior to college
    4. Variations in campus size, demographics of survey respondents, classification (i.e. public vs private institution) and campus culture

B. Approximately 20-25% of undergraduate women and 5-6% of undergraduate men will experience sexual assault while in college (Krebs et al. 2007; Anderson & Clement 2015)
    1. More than 50% of sexual assaults on college campuses occur from August - November (known as the "red zone"), and are at increased risk during their first and second semesters in college (Kimble et al. 2008)
    2. Undergraduate women (18-24) are 20% less likely than non-students of the same age to be a victim of rape or sexual assault. Undergraduate men (18-24) are more likely than non-students of the same age to experience sexual assault (Langton & Sinozich 2014)
    3. In 2016, a cross-sectional survey (Ford & Marquez 2016) of 21,000 students found:
        a) 1 in 4 (24.7%) self-reported heterosexual women report experiencing sexual assault by their senior year of college. In contrast, 12.7% of heterosexual men reported sexual assault
        b) Bisexual women were more likely to report sexual assault (37.8%), while lesbian women had the lowest reports (11.4%)
        c) 24.3% of gay men and 17.7% of bisexual men experienced sexual assault by their senior year, higher than their heterosexual peers

C. Only 20% of sexual assaults of college students are reported to law enforcement authorities, compared to 32% reported among non-student peers (Langton & Sinozich 2014). Even fewer students report experiences of sexual violence to campus officials (less than 5%) or decide to pursue legal action against the perpetrator (Karjane et al. 2005; Rubenfeld, 2014; Langton & Sinozich 2014)



Source: Fedina, Holmes, and Backes 2016

III. III. Criminal Sexual Assault Statutes (DeMatteo et al. 2015)

A. Only 7 states (14%) explicitly define "consent" in state statutes
   1. 14 states (28%) outlined the requirements of acting without consent of the victim
   2. 12 states (24%) described the requirements of mental capacity to provide consent
      a) "Temporary incapacity" to consent to sexual acts, as a result of alcohol or drug use, is defined in 24 states (48%). However, only 11 states (22%) include intoxication in this definition of incapacity, and 7 states (14%) include voluntary intoxication within this definition
      b) 23 states (46%) "explicitly require the defendant to have known about the victim's incapacity", but only two states (4%) explicitly assume that a defendant knows the victim is incapacitated, unless he or she can prove otherwise

B. Definitions of sexual violence vary widely and are even excluded from some state statutes
   1. 18 states (36%) provide a definition of "sexual assault"
   2. 17 states (34%) provide a definition of "rape"
   3. 28 states (56%) describe the term "sexual conduct"
   4. 14 states (28%) thoroughly outline what constitutes an illegal sex act
   5. 17 states (34%) define what constitutes "force" in cases of rape

C. While 47 states (94%) have gender-neutral language describing the perpetrator and victim of sexual violence, three states (6%) explicitly indicate that the victim must be female while two states (4%) suggest that the perpetrator is male
   1. Georgia Code Annotated § 16 – 6 –1[a], 2011: "[a] person commits the offense of rape when **he** has carnal knowledge of . . . a female forcibly against her will...[c]arnal knowledge in rape occurs when there is penetration of the female sex organ by the male sex organ"
   2. Maryland Code Annotated Criminal Law § 3–303[a], 2009: rape is defined as "vaginal intercourse with another by force, or threat of force, without consent of the other"

For additional information, see the following articles:

DeMatteo, D., Galloway, M., Arnold, S., & Patel, U. (2015). Sexual assault on college campuses: A 50-state survey of criminal sexual assault statutes and their relevance to campus sexual assault. *Psychology, Public Policy, and Law*, *21*(3), 227.

Fedina, L., Holmes, J. L., & Backes, B. (2016). How Prevalent Is Campus Sexual Assault in the United States?. *National Institute of Justice*, *277*, 26-30.

Ford, J., & Soto-Marquez, J. G. (2016). Sexual assault victimization among straight, gay/lesbian, and bisexual college students. Violence and gender, 3(2), 107-115.

Weis, J. R. (2015). Title IX and the state of campus sexual violence in the United States: Power, policy, and local bodies. Human Organization, 74(3), 276-286.

(3) Sexual Violence on Campus Panel Preparation/Facilitation Guide

Panel Preparation Guide

Composition: Invite one representative from each university category for a panel size of 4.

Title IX/Compliance

- ❖ Title IX Investigators
- ❖ Title IX Coordinators
- ❖ Title IX Hearing Board Members
- ❖ Office of Diversity & Inclusion/Equal Opportunity

Student Health & Counseling Services

- ❖ Clinical Staff
- ❖ Counseling and Psychological Services (CAPS) Staff
- ❖ Office of Health Promotion
- ❖ Respect Program

Student/Campus Services

- ❖ Residence Life
- ❖ Office of Accessibility Services
- ❖ Office of Student Conduct
- ❖ Office of Sorority and Fraternity Life
- ❖ Department of Public Safety (EMS/University Police)

Student Advocates

- ❖ Resident Assistants
- ❖ Sexual Assault Peer Advocates (SAPA)
- ❖ Peer Leaders

Sample Email Invitation:

Dear Panelist,

My name is ____, and I am contacting you as a _____ for a course on Gender-Based Violence in Global Perspective to be taught this spring at the Rollins School of Public Health at Emory University.

I would like to extend a warm invitation for you to share your expertise on a 45 min panel discussion and 30 min Q&A for a session entitled “Sexual Violence on College Campuses". The course meets at _____ in the Grace Crum Rollins/Claudia Nance Rollins Building room _____, and the date of the panel is slated for ______. The purpose of the panel discussion is to provide students with the opportunity to hear real life experiences of experts working in this field. We will ask you to discuss what has shaped your thinking, challenges you have faced, and how you anticipate violence prevention efforts on college campuses will change in the coming years. If you accept, I will be happy to provide you the full list of questions in advance.

Your participation as a guest speaker would be a tremendous addition to the course, and we enthusiastically welcome you to share your experience. I look forward to hearing from you.

Best Regards,

____

Panel Facilitation Guide

Now that we have some foundational knowledge of strategies used to address sexual violence on college campuses, we will have our panel of experts share real life experiences working in this field and discuss what has shaped their current thinking, challenges they have faced, and how they anticipate violence prevention efforts will change in the coming years. There will be a 30-minute question and answer period after the panel discussion using PollEverywhere. If you have any questions for the panelists during the session, please send them to _______, and we will ask them at the end.

Notes to Facilitator:

- ❖ Feel free to skip questions and modify as needed. The following are to be used as a guide.
- ❖ Invite two panelists to contribute to each question, but do not feel obligated to request a response from each panelist for every question.
- ❖ Ensure there is adequate time for student questions (at least 20 minutes).

Sample Questions:

- **What role do you (or your office) play in addressing sexual assault, and how do each of you (or your offices) work together?**
  - Rationale: This question clarifies the responsibilities of each panelist/office represented and highlights the interdisciplinary nature of the topic area.
- **What do you think are the most effective ways to address sexual violence on college campuses/ what strategies do you see as key for holistic culture change?**
  - Rationale: This question provides the panelists the opportunity to discuss best practices for prevention efforts.
- **In your opinion, what institutional barriers or benefits are present in this field?**
  - Rationale: This question allows students to begin thinking about the challenges faced by on-campus staff and advantages of campus-based prevention.
- **What are common misconceptions people have about sexual assault?**
  - Rationale: This question sheds light on challenges faced by sexual assault trainers, educators, and advocates.
- **How has sexual violence on college campuses changed in the past 5 years?**
  - Rationale: This question provides panelists the opportunity to discuss successes and evolution of the field.
- **What are some trends you are seeing arise in this field, and how would you recommend they be addressed?**
  - Rationale: This question allows panelists to speak on contemporary issues and provide predictions for future directions while offering solutions.
- **What are the best resources for students who want to learn more about this subject?**
  - Rationale: This question allows panelists to provide additional information for interested students.

Chapter 5: Conclusions

As the Rollins School of Public Health (RSPH) continues to emerge as a top-tier institution and international leader in graduate education, critical assessment of departmental course offerings and ongoing curriculum reviews are becoming even more important. After examining the institution's course catalogs from 2015-2018 and assessing gaps in course content, I identified several areas of further exploration. Grounded in Adult Learning Theory and best practices in educational instruction, *Gender-Based Violence in Global Perspective* addresses one of these areas, the omission of violence from the current curriculum, and is pedagogically designed to engage students in an intentional manner. After reviewing the approved syllabus, three lessons were developed for use by first and second year students within the Sexual and Reproductive Health and Population Studies concentration within the Hubert Department of Global Health: (1) Defining Gender-Based Violence, (2) Effects of Gender-Based Violence on Health Outcomes, and (3) Sexual Violence on College Campuses. Similar to those of its sister course, *Gender and Global Health,* the topics discussed throughout this special studies project appeal to a wide range of students, both within and beyond the School of Public Health. Moving forward, the instructors intend to offer *Gender-Based Violence in Global Perspective* as a cross-listed course that will be available to undergraduate, graduate, and professional students across Emory University. In addition, because all three lessons have been designed in a manner that allows them to be delivered independently, as well as taught sequentially, it is our hope that the institution will consider offering an abbreviated version for use in one-day workshops or trainings; in that same vein, an online format is also being considered. In the creation of this special studies project, RSPH not only reinforces the importance of academic diversity, but also renews its commitment to addressing widening disparities in global health.

Chapter 6: Annotated Bibliography

Alhusen, Jeanne L. et al. (2015). Intimate partner violence during pregnancy: maternal and neonatal outcomes. *Journal of Women's Health*, *24*(1), 100-106. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4361157/.

This article discusses the impact intimate partner violence has on pregnancy-related outcomes for both the mother and fetus, particularly delayed prenatal care, overall poor health, increased depressive symptoms, fetal growth retardation, and maternal/fetal death. The authors recommend screening all pregnant women for intimate partner violence prior to providing care and training providers to address intimate partner violence when treating their patients.

Champion, J. D. et al. (2005). Relationship of abuse and pelvic inflammatory disease risk behavior in minority adolescents. *Journal of the American Association of Nurse Practitioners*, 17(6), 234-241. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.920.800&rep=rep1&type=pdf.

This article describes a research study that aimed to determine the association between physical or sexual abuse and gynecological symptoms amongst African American and Mexican American adolescents aged 14-18 with a current STD. Adolescents completed an in-person verbal questionnaire, regarding physical and sexual abuse, gynecological symptoms, and risk factors associated with pelvic inflammatory disease. Among 373 adolescents, 62% reported physical or sexual abuse and 74% reported psychological abuse. Overall, adolescents who reported one form of abuse had an increased risk for pelvic inflammatory disease and were more likely to initiate sex at a younger age, have more sexual partners, more sexually transmitted infections, and delays seeking medical treatment as compared to non-abused adolescents.

Coker, A. L. (2007). Does physical intimate partner violence affect sexual health? A systematic review. *Trauma, Violence, & Abuse*, *8*(2), 149-177. Retrieved from http://journals.sagepub.com/doi/10.1177/1524838007301162.

This systematic review outlines the relationship between intimate partner violence and sexual/reproductive health, as documented in 51 articles from 1966-2006. According to the abstract, intimate partner violence “was consistently associated with sexual risk taking, inconsistent condom use, or partner non-monogamy (23 of 27 studies), having an unplanned pregnancy or induced abortion (13 of 16 studies), have a sexually transmitted infection (17 of 24 studies), and sexual dysfunction (17 of 18 studies)”.

Davis, A. et al. (2015). Intimate Partner Violence and Correlates with Risk Behaviors and HIV/STI Diagnoses Among Men Who Have Sex With Men and Men Who Have Sex with Men and Women in China: A Hidden Epidemic. *Sexually Transmitted Diseases*, 42(7), 387–392. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4520252/pdf/nihms688054.pdf.

This article describes a research study that was designed to estimate the prevalence of intimate partner violence among men over the age of 16 who have sex with men (MSM) and men over the age of 16 who have sex with men and women (MSMW) in China. Eligible participants completed an online questionnaire discussing risk behaviors, intimate partner violence victimization, and previous STI diagnoses. Among 610 respondents, 30% reported at least one type of intimate partner violence and were more likely to have HIV, participate in sex in exchange for monetary items, and/or participate in group sex. Additionally, MSMW were at greater risk for IPV as compared to MSM.

Decker, M. et al. (2011). Sex trafficking, sexual risk, STI and reproductive health among a national sample of FSWs in Thailand. *Journal of Epidemiology and Community Health*, 65(4), 334–339. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3521618/pdf/nihms422918.pdf.

This article describes a research study that explored differences in risk-taking behaviors and sexual/reproductive health outcomes among female sex workers (FSWs) in Thailand who were victims of sex trafficking and those who were not. After mapping known establishments for sex work, the study team recruited 1,025 FSWs from these venues and asked them to complete an in-person survey discussing previous experiences with sex trafficking, entry into sex work, sexual risk behaviors (i.e. condom usage), and sexual/reproductive health outcomes (i.e. STI symptoms). Among 815 FSWs, 10% experienced trafficking as an "entry mechanism to sex work" and were more likely to experience workplace-related violence, forgo condom use, and report having an abortion.

Dills J., Fowler D., & Payne G. (2016). Sexual Violence on Campus: Strategies for Prevention. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/campussvprevention.pdf.

This technical assistance document was drafted by experts at the CDC to provide universities and practitioners in the sexual violence prevention field a starting point from which to develop and implement prevention strategies on college campuses. To begin, the authors outline the five components framework, including the following elements: comprehensive prevention, infrastructure, audience, partnerships and sustainability, and evaluation. The report also provides

an overview of an evidence-based technical package entitled, STOP SV, that outlines approaches that can be considered utilizing the "current best available evidence".

Dyjur, Patti & Kalu, Frances (2016). Curriculum Review: Curriculum Mapping. University of Calgary: Taylor Institute for Teaching and Learning Educational Development Unit. Retrieved from https://curriculummapping.weebly.com/uploads/1/4/9/0/14908434/handout_cr_3_curriculum_mapping_2016_11_16.pdf.

This report defines curriculum mapping, provides a description of the process, and gives a comprehensive overview of the benefits of curriculum mapping. The authors emphasize the importance of alignment in course outcomes and program-level outcomes and provide a chart to be used when determining whether alignment is met. The report also discusses constructive alignment, "a term used to describe the fidelity between course outcomes, student assessment, and teaching and learning activities (Biggs 2014)" and provides an example of how interactive activities can supplement didactic teaching to achieve constructive alignment.

Finkelhor David, Ormrod Richard K., & Turner Heather A (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse and Neglect*. 31: 7–26. Retrieved from http://www.unh.edu/ccrc/pdf/CV91.pdf.

This article discusses findings from a study that aims to understand how poly-victimization among children is associated with trauma. As a follow-up to a previous study utilizing telephone-administered surveys, data from a nationally representative sample of children and their guardians yielded responses from 2,030 children aged 2-17. Among this sample, 22% of children experienced greater than three types of victimization in a one-year period. Poly-victimization "was highly predictive of trauma symptoms" and resulted in more symptoms as compared to repeated experiences of one kind of victimization.

Fleming et al. (2015). Men's violence against women and men are inter-related: Recommendations for simultaneous intervention. *Social Science & Medicine*. 146: 249–256. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4643362/pdf/nihms731447.pdf.

This article argues that the current model of "isolating each type of violence and constructing separate interventions for each type is insufficient and less effective" and advocates for the development of joint interventions that address both the perpetrators and victims of interpersonal violence. It is well-documented that men are the primary perpetrators of violence worldwide and are also likely to be victims of interpersonal violence. The authors suggest that the root causes of

violence (persisting gender norms and social constructions of masculinity) must be addressed to spur societal change.

Ganyaupfu, Elvis M. (2013). Teaching Methods and Students' Academic Performance. *International Journal of Humanities and Social Science Intervention*; 2, 9: 2319-7714. Retrieved from http://www.ijhssi.org/papers/v2(9)/Version-2/E0292029035.pdf.

This article shares findings from a study that assessed three unique teaching methods (teacher-centered method, student-centered method, and teacher-student interactive method) on the academic performance of 109 undergraduate students. After comparing pre-post test results, the method that involved interaction between students and instructors yielded the highest mean score, followed by the student-centered method ('discovery learning') and the teacher-centered method (didactic learning).

Greenhalgh, Trisha (2014). How to Read a Paper: The Basics of Evidence-Based Medicine, John Wiley & Sons, Incorporated. ProQuest Ebook Central, http://ebookcentral.proquest.com/lib/umn/detail.action?docID=1642418.

This book serves as a tool for students to use to evaluate and critique research articles. The selection used in this paper discusses survey methodology and provides ten questions to ask when assessing the validity of study findings using questionnaires, starting with the research question and ending with conclusions.

Heise L (1998). Violence against women: an integrated, ecological framework. *Violence Against Women*; 4: 262 –290. Retrieved from http://gbvaor.net/wp-content/uploads/2012/10/Violence-Against-Women-An-Integrated-Ecological-Framework-Heise-1998.pdf.

This article proposes an ecological framework to better understand the etiology of violence against women. According to this integrated, ecological model, gender-based violence is perpetuated as a result of a number of interconnected factors at the individual, micro, and macro levels. The paper also associates risk factors for abuse at each of the aforementioned levels, including child abuse, marital violence/male-dominated households, substance abuse, unemployment, and strict gender norms.

Heise, L., Ellsberg, M. & Gottmoeller, M (2002). A global overview of gender-based violence. *International Journal of Gynecology and Obstetrics*, *78*, 1. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.456.7203&rep=rep1&type=pdf

This paper provides readers a foundational understanding of gender-based violence, addressing the scope of the problem, forms of violence, risk factors of violence perpetration, and the impact of violence on women's sexual and reproductive health, including reduced sexual autonomy, unwanted pregnancies and sexually transmitted infections, gynecological concerns, and adverse pregnancy outcomes. A diagram is included in the paper highlighting the direct and indirect effects of physical abuse/coerced sex.

Institute of Medicine (1995). *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. Washington, DC: The National Academies Press. Retrieved from https://www.nap.edu/read/4903/chapter/5#51

This book provides an overview of the sexual and reproductive health consequences of unintended pregnancies among adult and adolescent women as well as their infants. Using a myriad of data sources, the book offers statistical evidence that suggests that unintended, unwanted, and mistimed pregnancies are associated with adverse outcomes for mother and baby. It also discusses the increased risk of childbearing for parents under the age of 20.

Kahn, S. (2017). Sexual Violence on Campus: What Numbers Can and Can't Tell Us. Retrieved from http://www.center4research.org/sexual-violence-campus-numbers-can-cant-tell-us/

This article discusses the challenge collecting data and adequately measuring the true scope of sexual violence on college campuses. The author suggests that prevalence rates fluctuate so vastly across studies due to a number of variable factors: length of study, age of study participants, definition of sexual violence, wording of study instrument, and demographics of the university (i.e. public vs private). The article further argues that determining exact prevalence rates is less important than evaluating the efficacy of existing and new prevention programs.

Michau, L. et al. *(2015). Prevention of violence against women and girls: lessons from practice.* The Lancet, 385(9978), 1672-1684. Retrieved from http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61797-9/abstract.

This paper is one of a series that discusses best practices in reducing the global prevalence of violence against women and girls. In describing the most promising prevention programs, the authors identify five required elements: (1) addressing violence across all levels of the social-ecological model, (2) utilizing an "intersectional gender-power analysis" in the intervention design, (3) using theoretically sound, evidence-based approaches, (4) investing in holistic, multi-sectoral and multi-dimensional approaches to addressing violence, and (5) empowering women and girls to individually and collectively advocate for themselves and the right to a "violence-free lives".

Montesanti, S. R. (2015). The role of structural and interpersonal violence in the lives of women: a conceptual shift in prevention of gender-based violence. *BMC Women's Health*, *15*, 93. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4623903/.

This article discusses the importance of considering both interpersonal and structural factors in the study of gender-based violence. The author discusses how certain conditions create spaces where violence can occur and explains how "gender is inescapably embedded in social systems and institutions".

National Center on Domestic Violence, Trauma, and Mental Health (2014). Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness. Retrieved from http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/FactSheet_IPVTraumaMHChronicIllness_2014_Final.pdf.

This report from the National Center on Domestic Violence, Trauma, & Mental Health discusses the known associations between intimate partner violence, mental health, and chronic health conditions. The authors provide statistics on the increased risk of depression, PTSD, self-harm/suicidality, HIV/AIDS, and a range of other conditions among abused individuals as compared to those who have not experienced violence.

Nilson, L. B. (2010). *Teaching at its best: a research-based resource for college instructors*. San Francisco, CA: Jossey-Bass.

This book serves as an evidence-based resource for college and graduate-level instructors with a focus on adult learners. The authors outline an array of learning styles and provide examples of teaching formats and activities that cater to this diversity within a typical student population. Similarly, the book offers suggestions for classroom management as well as how to integrate technology into the learning environment.

Rosenshine, B. (2012). Principles of Instruction: Research Based Strategies That All Teachers Should Know. Retrieved from https://www.aft.org/sites/default/files/periodicals/Rosenshine.pdf.

This article presents ten research-based strategies that instructors should utilize when establishing a learning environment to ensure retention of class material and ability to apply course concepts outside the classroom. Some of the primary takeaways include the teacher's role as a facilitator, importance of independent practice, and understanding the limitations of human memory by presenting small amounts of information at one time.

Russell, D. (2008). Femicide: Politicizing the Killing of Females. Meeting of Strengthening Understanding of Femicide, Washington, DC.

This transcript of a speech given at the Meeting of Strengthening Understanding of Femicide provides concrete definitions of femicide as well as in what ways it may manifest. The author describes femicide as "the killing of women because they are women" and argues that both men and women can participate in this type of violence. Femicide is divided into four primary categories: intimate partner femicides, familial femicides, femicide by other known perpetrators, and stranger femicides. Lastly, the author suggests future directions and priorities for femicide research.

Scott, C. L. (2015). THE FUTURES OF LEARNING 3: WHAT KIND OF PEDAGOGIES FOR THE 21st CENTURY? UNESCO Education Research and Foresight, Paris. [ERF Working Papers Series, No. 15]. Retrieved from http://unesdoc.unesco.org/images/0024/002431/243126e.pdf.

This paper discusses a pedagogical approach to engage millennial learners in the classroom and prepare them for the skills needed in the 21st century workforce. While the authors discuss a number of strategies, the theme of the paper is the importance of institutionalizing participatory-based, problem-based learning where classroom instruction is primarily learner-driven. Students should have the ability to be creative, and instructors should strive to develop learning plans that are personalized to the needs of their students.

Sharps, P., Laughon, K., & Giangrande, S. (2007). Intimate Partner Violence and the Childbearing Year. *Trauma, Violence, & Abuse*, *8*(2), 105-116. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.825.4386&rep=rep1&type=pdf

This paper provides a comprehensive overview of research from the early 2000s, regarding the effects of intimate partner violence on pregnant women and their children, both before and during delivery. The authors note that experiences of intimate partner violence have been associated with an "increased risk for preterm delivery, low-birth-weight infants, and neonatal deaths", regardless of the socioeconomic status of the mother and access to medical care. The prevalence rate of intimate partner violence during pregnancy is inconsistent in the literature (ranging from 3% - 19%), however, it is well documented that experiences of violence widens maternal health disparities.

Silverman, J. et al. (2007). Intimate partner violence and unwanted pregnancy, miscarriage, induced abortion, and stillbirth among a national sample of Bangladeshi women. *BJOG*, 114: 1246–1252. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2007.01481.x/epdf.

This article describes a study that aimed to determine the prevalence of physical and sexual intimate partner violence as well as the experiences of unwanted pregnancy, miscarriage, induced abortion, and fetal death/stillbirth among married, cohabiting Bangladeshi women aged 13-44. 2,677 women were included in the study after completing the 2004 MEASURE Bangladesh Demographic Health Survey. Over 75% of married Bangladeshi women self-reported experiences of physical or sexual violence by their husbands and were more likely to experience pregnancy, miscarriage, abortion, or stillbirth.

Smith, P.H. et al. (2002). Prevalence and distinctiveness of battering, physical assault and sexual assault in a population-based sample. *Violence Against Women*, 8 (10), 1209-1232. Retrieved from https://pdfs.semanticscholar.org/aba8/e515c65f68bef83d6a6cd1ba034ac1d2a3e6.pdf

This article shares results from a research study examining prevalence rates of intimate partner violence by type (specifically battering, physical assaults, and sexual assaults) among registered female voters in North Carolina aged 15-45. Among 268 eligible surveys, 18.4% of women reported an experience of intimate partner violence in their most recent relationship. Intimate partner violence was associated with adverse health, including delays seeking medical care, increased stress, and poor sexual and reproductive health outcomes (i.e. sexually transmitted and urinary tract infections).

Speizer, I. S. et al. (2009). Sexual Violence and Reproductive Health Outcomes Among South African Female Youths: A Contextual Analysis. *American Journal of Public Health*, 99(Suppl 2), S425–S431. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3515795/pdf/AJPH.2008.136606.pdf.

This article outlines a study that examined sexual behaviors of females aged 15-24 and associations with unintended pregnancy and sexually transmitted infections. Data was collected from 6,217 respondents via a 2003 nationally representative household survey. The authors found that "youths from communities with greater sexual violence were significantly more likely to have experienced an adolescent pregnancy or to be HIV-position than were youths from communities experiencing lower sexual violence". Similarly, respondents from communities with higher levels of violence were more likely to report condom non-use in their last sexual encounter.

Tjaden, Patricia & Thoennes, Nancy (2000). Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey. National Institute of Justice. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/183781.pdf.

This report presents data from the National Violence Against Women Survey, conducted from November 1995 to May 1996. 16,005 total respondents were interviewed (8,000 women and 8,005 men) using computer-assisted telephone interviewing and asked about experiences of physical assault, emotional abuse, child abuse, sexual assault, and stalking. The authors provide a comprehensive presentation of survey findings, including the prevalence and incidence of violent experiences, stratified by gender and race/ethnicity, and utilization of medical services within the sample. The report concludes with a summary of how the survey findings can inform policy and future interventions.

Tombros, Korman, A. (2015). Shifting Culture to End Campus Sexual Assault. Association of American Colleges and Universities. Retrieved from https://www.aacu.org/diversitydemocracy/2015/spring/korman.

This article outlines a multi-pronged framework to address campus sexual assault that spurs "holistic cultural change" within the university system. This approach is adaptable to different university contexts and emphasizes the importance of accountability and collaboration. The six components include the following: (1) positive survivor support with options for reporting, (2) clear policies on campus investigations, adjudications, and sanctions, (3) robust, multi-tiered prevention education at all levels of the institutions, (4) public disclosure of sexual assault statistics and related information, (5) school-wide mobilization in partnership with campus organizations and student leaders, and (6) ongoing self-assessment.

Turner, Heather A., Finkelhor, David, & Ormrod, Richard (2010). Poly-Victimization in a National Sample of Children and Youth. *American Journal of Preventive Medicine*. 38: 323–330. Retrieved from https://s3.amazonaws.com/academia.edu.documents/35807140/CV195.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1519791299&Signature=ayFJs%2FfcLuWXFL2xrWRohL%2BJcA4%3D&response-content-disposition=inline%3B%20filename%3DPoly-victimization_in_a_national_sample.pdf.

This article discusses findings from a study that aims to understand how children's exposure to violence across the lifespan is associated with trauma. Phone interviews were conducted with a nationally representative sample of children and their guardians and yielded responses from 4,053 children aged 2-17. Among this sample, ⅔ reported at least one type of victimization. However, those children who experienced multiple forms of victimization were more likely to describe trauma symptoms.

University of Connecticut: Office of Institutional Research and Effectiveness (n.d.). Assessment Primer. UCONN. Retrieved from https://assessment.uconn.edu/assessment-primer/assessment-primer-curriculum-mapping/

This primer from the University of Connecticut describes the process of curriculum mapping to ensure that learning outcomes are clearly defined throughout the development of a course. It provides detailed steps that outline ways to align curriculum activities to course objectives. Program-level examples of curriculum mapping are also provided.

United Nations (2015). The World's Women 2015: Trends and Statistics: Chapter 6: Violence against women. United Nations, Department of Economic and Social Affairs. Retrieved from https://unstats.un.org/unsd/gender/downloads/worldswomen2015_report.pdf.

This chapter provides an overview of the scope of violence against women globally, including prevalence rates of various types of physical and sexual violence, using compiled survey data collected in 89 countries from 2005-2014. While the report is fairly comprehensive, the authors note challenges comparing data across countries, due to differences in definitions of violence and study methodologies.

UN Women (2017). Spotlight on Sustainable Development Goal 5: Achieve gender equality and empower all women and girls. United Nations. Retrieved from http://www.unwomen.org/en/digital-library/multimedia/2017/7/infographic-spotlight-on-sdg-5.

This "thematic spotlight" highlights six content areas within the field of gender equality and women's empowerment (Intimate Partner Violence, Harmful Practices, Unpaid Care & Domestic Work, Women in Leadership, Sexual and Reproductive Health, & Gender Data Gap) and data for Sustainable Development Goal (SDG) targets within each category. It provides an infographic outlining key statistics and data gaps within each set of indicators.

USAID (2014). Toolkit for Integrating GBV Prevention and Response into Economic Growth Projects. United States Agency for International Development. Retrieved from https://www.usaid.gov/sites/default/files/documents/1865/USAID%20Toolkit%20GBV%20EG%20Final%209-22-14.pdf.

This report serves as a practical guide to prepare practitioners to address gender-based violence in projects related to economic empowerment. The report provides an overview of the types of gender-based violence both within and outside of the workplace as well as prevalence statistics globally and nationally. High-risk groups and gaps in the literature are also identified. The most

dense portion of the report outlines how to integrate gender-based violence prevention and response into existing and new USAID projects.

Waszak Geary, C et al. (2006). Sexual violence and reproductive health among young people in three communities in Jamaica. *Journal of Interpersonal Violence*, 21(11), 1512-1533. Retrieved from https://www.researchgate.net/profile/Cynthia_Geary/publication/6739153_Sexual_Violence_and_Reproductive_Health_Among_Young_People_in_Three_Communities_in_Jamaica/links/5474dc230cf245eb436e2122.pdf.

This article outlines a study conducted in Jamaica that aimed to identify associations between sexual violence, sexual risk-taking, and reproductive health outcomes, such as genital discharge and pregnancy. Among 1,130 surveyed adolescents aged 15-24, over 75% of females and 14% of males had experienced forced sex during their first sexual experience (~80% vs 20%), reported being touched in an inappropriate manner (~86% vs 14%), and had been victims of violence in the home (~79% vs 21%). Youth who reported first forced sex were more likely to experience genital discharge and pregnancy.

World Health Organization (2002). *World Report on Violence and Health: Summary.* Geneva: World Health Organization. Retrieved from http://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf.

This report discusses the types of violence - interpersonal, self-directed, and collective - and their impacts on individuals and communities. The authors provide statistics on the prevalence of violence as well as risk factors for perpetration and victimization. Lastly, examples of each form of violence are discussed at length, including child abuse, elder abuse, suicide, and violence in conflicts.

World Health Organization (2012). *Understanding and addressing violence against women.* Geneva: World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf.

This report provides readers foundational understanding of intimate partner violence by sharing clear examples, a summary of recent data on the prevalence among adolescent girls and women, multi-level risk factors, and associated health consequences with experiences of intimate partner violence. The authors also discuss barriers that women face when attempting to flee an abusive relationship as well as how practitioners can assist in prevention and response efforts.

World Health Organization (2017). Violence against women. Retrieved from http://www.who.int/mediacentre/factsheets/fs239/en/.

This fact sheet provides a brief overview of the scope of intimate partner violence and sexual violence, including definitions of both types of violence, prevalence rates, risk factors of perpetration and victimization, health consequences on survivors and their children, and existing literature discussing the effectiveness of prevention efforts.

Appendix

Defining Gender-Based Violence (GBV)

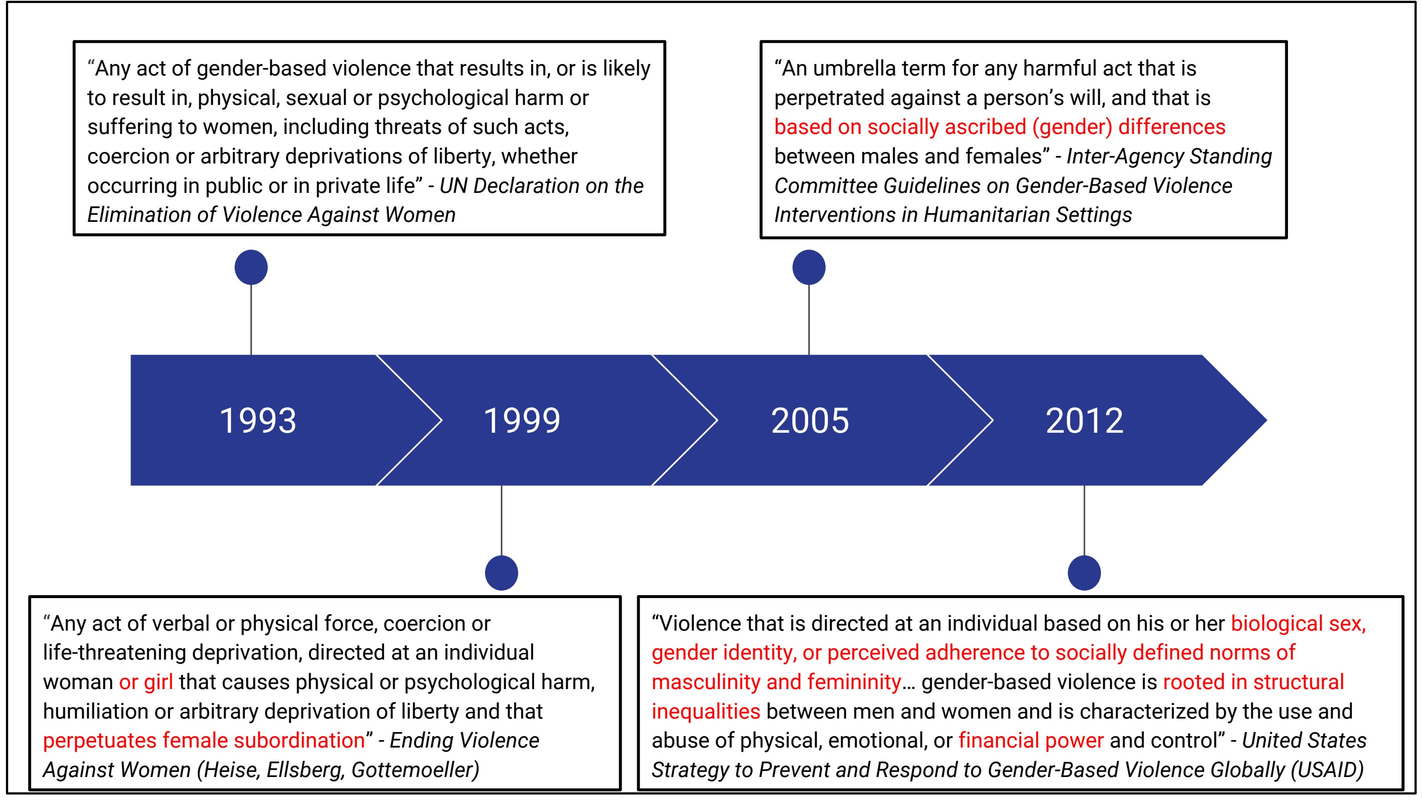
Cari Clark, Sc.D., MPH
Kathryn Yount, PhD

Spring 2018

By the end of the day, you should be able to...

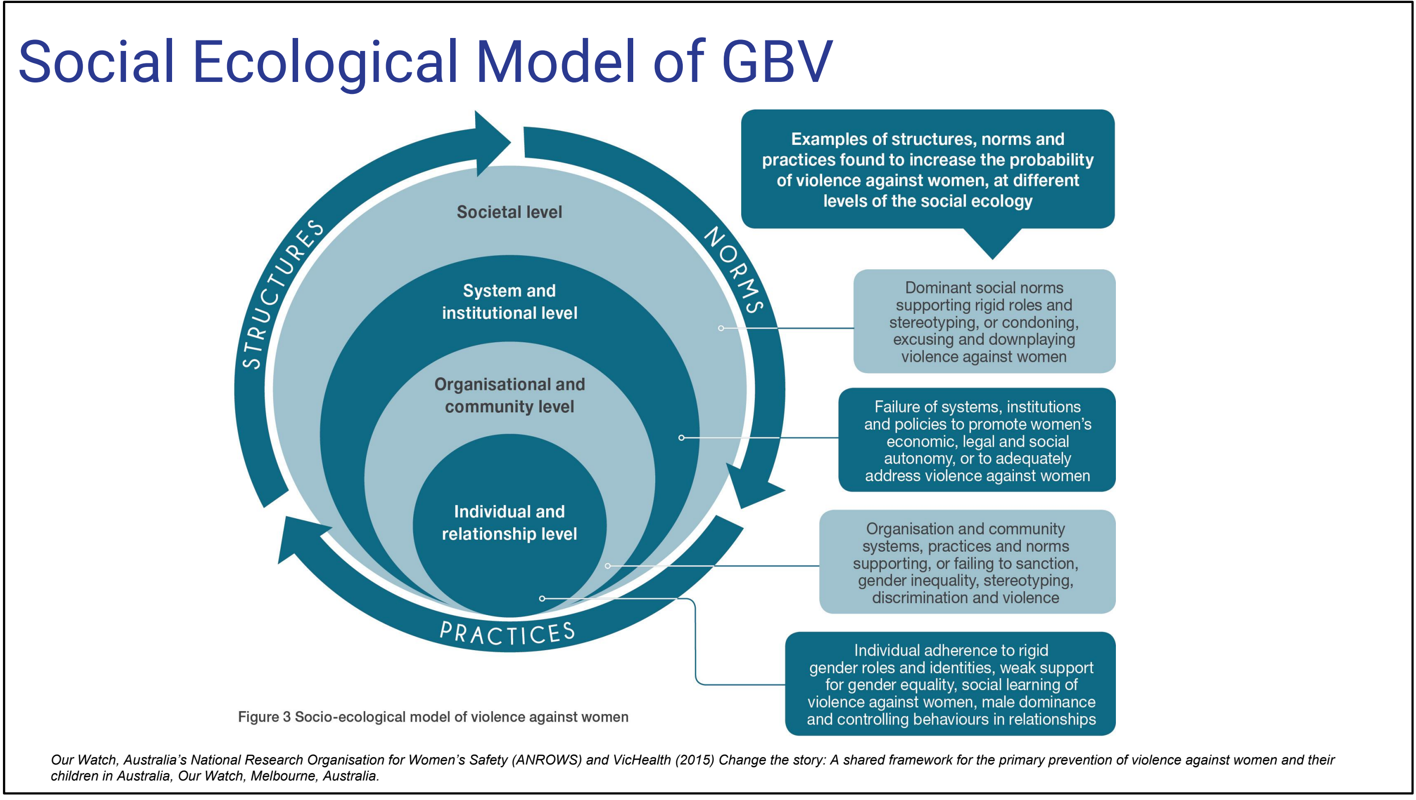
Definitions	Types of GBV	The Social Ecological Model of GBV
Define gender-based violence Understand the importance of utilizing clear terminology when studying gender-based violence and implications of inconsistent usage	Identify various forms of gender-based violence ❖ Interpersonal Violence ❖ Structural Violence	Describe multi-level and socio-contextual determinants of gender-based violence Identify risk factors at the: ❖ Individual Level ❖ Interpersonal Level ❖ Community Level ❖ Societal Level

This slide includes the lesson objectives and overview of today's class.



Notes for Presenter: Briefly discuss each definition and the changes over time. Ask students after the 2012 definition what they think about the changes and if they think that the current definition is adequate/any recommendations for things to add or clarify.

As you can see, GBV has been both defined and redefined over time. The definition has been expanded over the years to distinguish GBV from violence against women and include the importance of social norms and structural inequalities in perpetuating violence. GBV does not solely affect women and girls - sexual minorities, such as LGBTQ populations and young boys, can also be affected, given the 2012 definition.



For those of you in BSHE, this model should look familiar. The social ecological model highlights the interaction of multiple levels on the continued perpetration of a health behavior, in this case GBV. The surrounding arrows indicate that these multilevel factors assist in the reinforcement of norms, practices, and structures that underpin GBV. While there are a number of risk factors at each level, some of the strongest correlates that researchers have associated with GBV have been history of child abuse/family violence, male-decision making and financial control, and rigid gender roles and norms. Many of the formative findings for the development of this model and others like it were spearheaded by Lori Heise, who popularized the use of the ecological model framework to better understand violence against women in the early 1990s.

Background for Presenter - Comprehensive List of Associations with GBV at Each Level:

1. Individual Risk Factors - “Personal Risk Factors that Influence Individual Behavior”
    a) Gender, age, and education, family history of violence, witnessing GBV, victim of child abuse and neglect, lack of sufficient livelihood and personal income, unemployment, mental health/behavioral problems, alcohol and substance abuse,

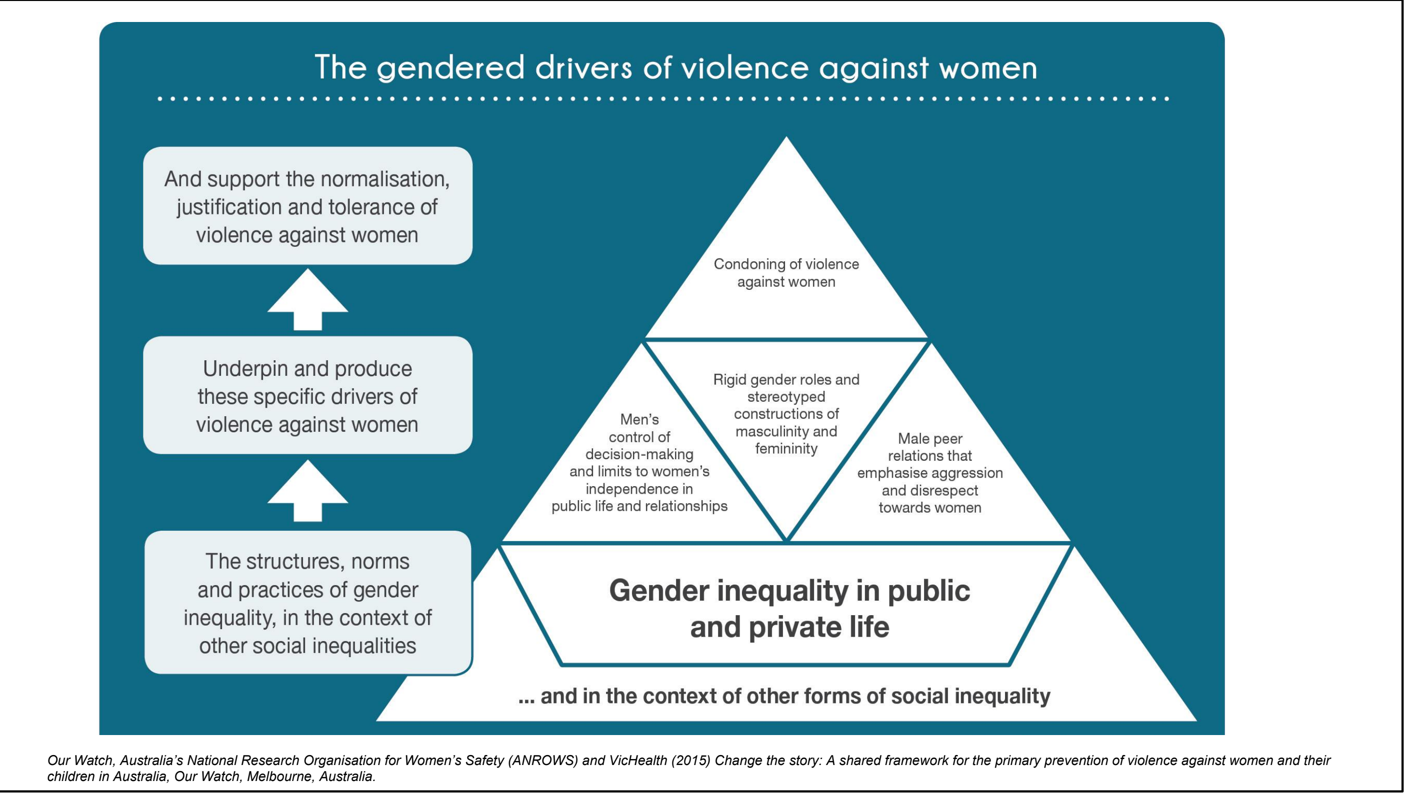
a) prostitution, refugee or internally displaced person, disabilities, small firearms ownership
    (1) Perpetration: **child abuse**, **witness of violence**, absenteeism, alcohol use (Heise et al 2002), antisocial personality disorder, multiple partners/infidelity, male sexual entitlement (WHO 2016)
    (2) Both: lower level of education, low SES, child abuse, **witness of violence**, alcohol use, attitudes accepting of violence/gender inequality (WHO 2016)

2. Interpersonal/Family Risk Factors - “Relationship with Family, Intimate Partners, and Friends”
    a) Family dysfunction, inter-generational violence and poor parenting practices, parental conflict involving violence, association with friends who engage in violent of delinquent behavior, low-socioeconomic status or socioeconomic stress, friction over women’s empowerment, family honor more important than female health and safety
        (1) Predominantly **male decision-making/financial control,** marital conflict (Heise et al 2002)
        (2) Family honor, sexual purity (WHO 2016)
        (3) Delinquent peer associations (Heise 1998)

3. Community Risk Factors - “Neighborhood, schools, and workplace”
    a) High unemployment, high population density, social isolation of females and family, lack of information, inadequate victim care, schools and workplaces that don’t address GBV, weak community sanctions against GBV, poor safety in public spaces, challenging traditional gender roles, victim blaming, violations of victim confidentiality
        (1) Female isolation (both cause and consequence of violence), lack of social support, toxic masculinity (Heise et al 2002)
        (2) Weak legal sanctions for violence (WHO 2016)

4. Societal Risk Factors - “Broad factors that reduce inhibitions against violence”
    a) Poverty, economic/social/gender inequalities, poor

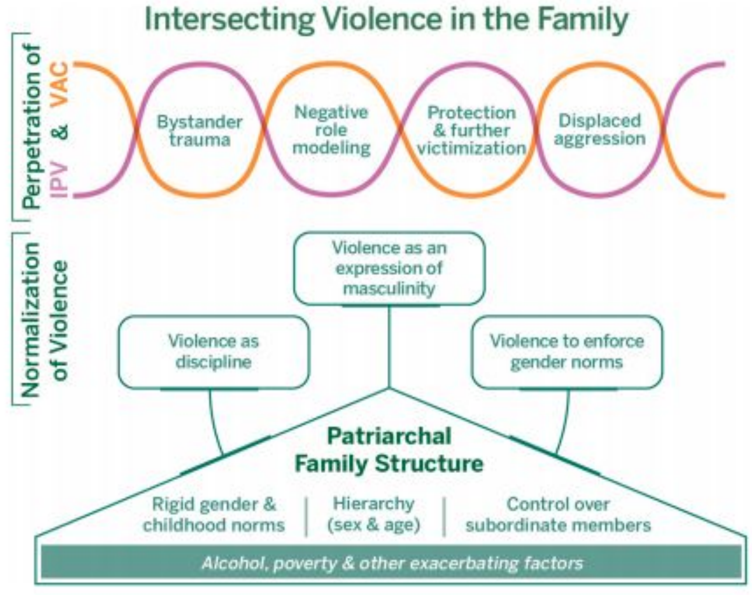
a) social security, masculinity linked to aggression and dominance, weak legal and criminal justice system, lack of prosecution of perpetrators, no legal rights for victims, social and cultural norms that support violence, small fire arms, conflict or post-conflict, internal displacement and refugee camps
    (1) Rigid gender roles, toxic masculinity, cultural norms, (Heise et al 2002)



Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth (2015) Change the story: A shared framework for the primary prevention of violence against women and their children in Australia, Our Watch, Melbourne, Australia.

This graphic further reinforces what we just discussed by illustrating the multiple drivers that result in the justification and tolerance of violence against women. Although this graphic focuses on violence against women, the concepts apply to gender based violence generally. From the base of the pyramid, you can see how individual behaviors, norms, and practices are maintained by inequitable social structures, and create additional drivers of violence that are highlighted in the second tier of the pyramid. As each factor overlaps, it becomes increasingly normalized to condone violence against women.

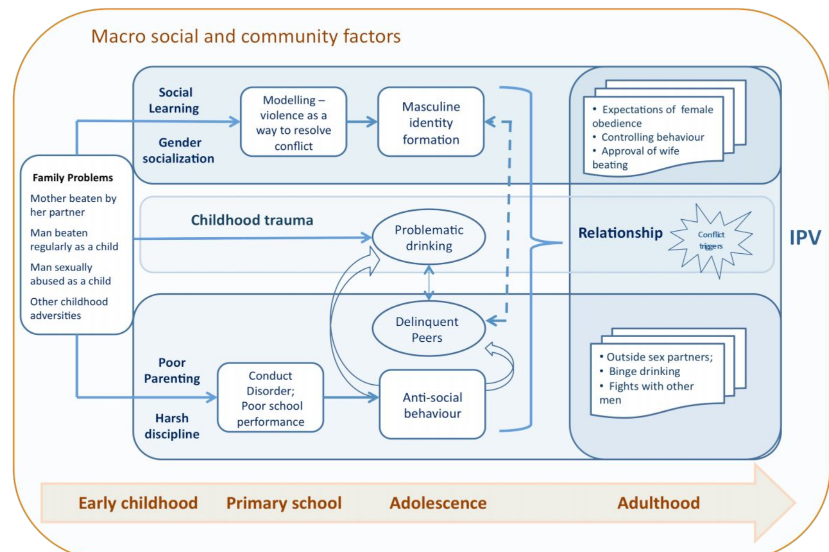
Patriarchal Norms Perpetuate Intergenerational Violence



- Maintenance of a "patriarchal family structure that celebrates hegemonic masculinities"
- Interconnectedness of intimate partner violence and violence against children

Namy, S. et al. (2017). Towards a feminist understanding of intersecting violence against women and children in the family. Social Science & Medicine, 184, 40-48.

The Intergenerational Transmission of Violence in Families

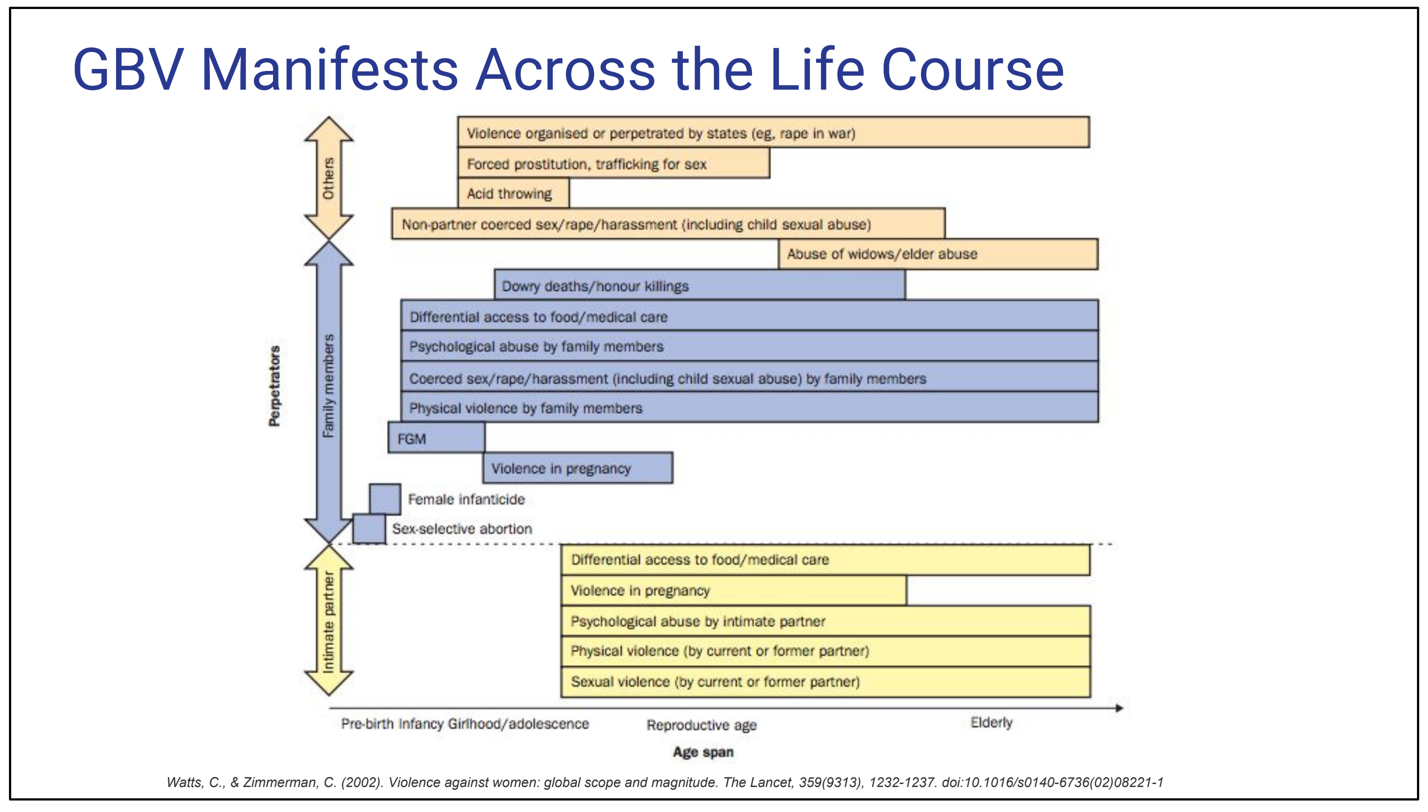


- **Child maltreatment is a known predictor** of adolescent and adult violence perpetration
  - Associated with psychological problems, behavioral delinquency, substance abuse
  - Child witnesses of IPV were over 3.5 times more likely to experience maltreatment in the home

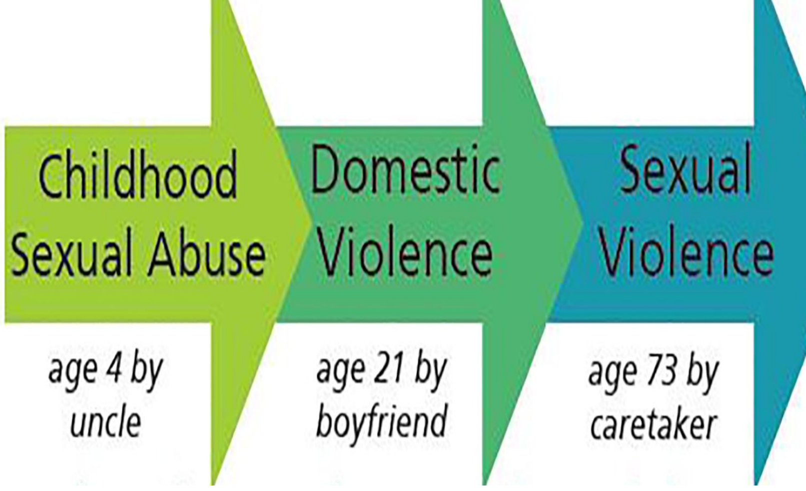
Hamby, S.,et al. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. Child abuse & neglect, 34(10), 734-741.

Millett, L. S. et al. (2013). Child Maltreatment Victimization and Subsequent Perpetration of Young Adult Intimate Partner Violence: An Exploration of Mediating Factors. Child Maltreatment, 18(2), 71–84.

Widom, C. S. et al. (2014). Child Abuse and Neglect and Intimate Partner Violence Victimization and Perpetration: A Prospective Investigation. Child Abuse & Neglect, 38(4), 650–663.

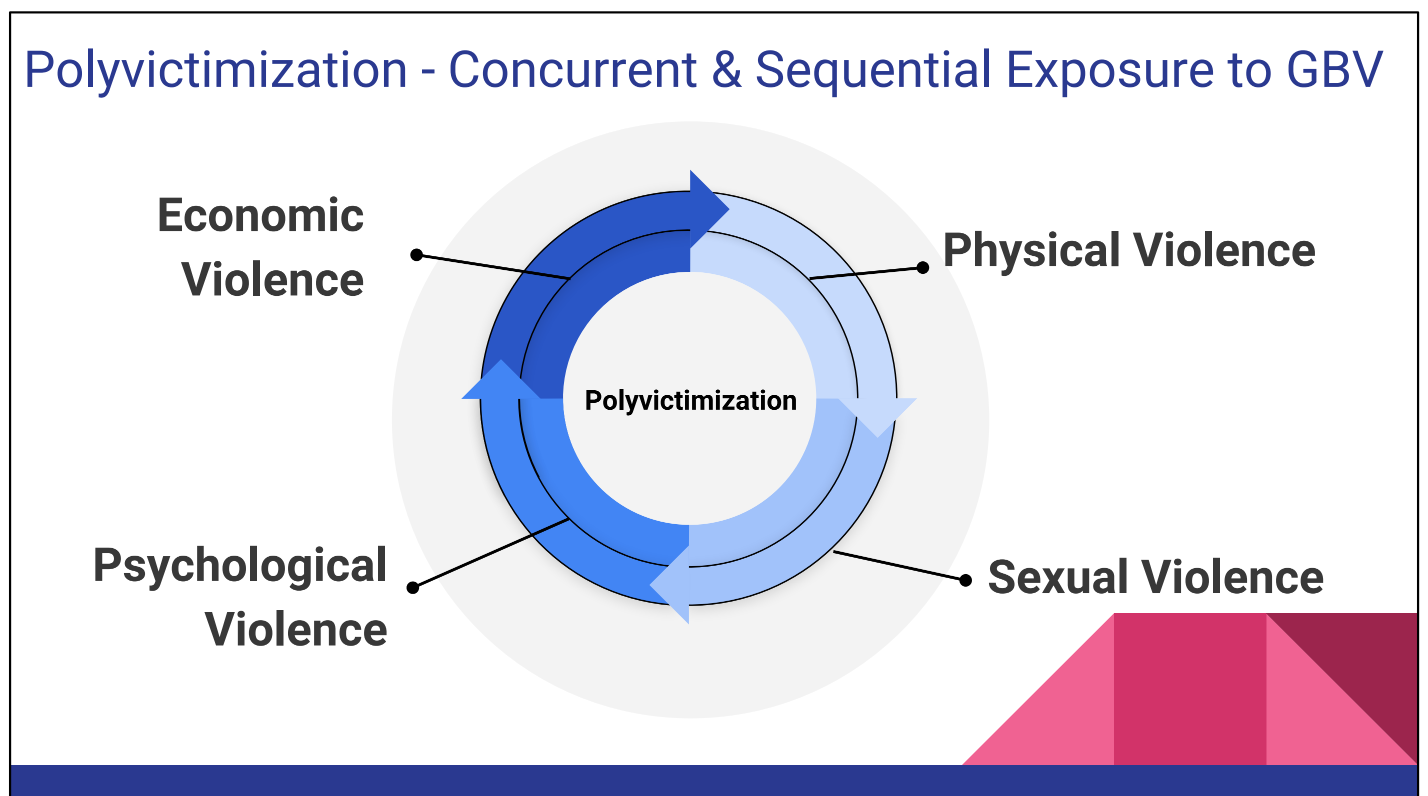


Now that we have a better understanding of the risk factors and drivers of GBV, let's look at GBV across the lifecourse. This graphic from Charlotte Watts and Cathy Zimmerman illustrates how GBV disproportionately affects young girls and women at various stages of life as well as by whom. As you can see there are a number of forms of violence highlighted in this graphic (we will spend more time discussing select forms of GBV in a few slides), but a key takeaway is that many of these experiences tend to be overlapping and can happen concurrently by one or more partners OR they occur sequentially, as seen in this image.



CENTRE FOR RESEARCH & EDUCATION ON VIOLENCE AGAINST WOMEN & CHILDREN (2017). Learning Network Infographics. Retrieved from http://www.vawlearningnetwork.ca/learning-network-resources/learning-network-infographics.

- Adults with a **history of abuse/neglect** are more likely to report injuries by an intimate partner - **increased vulnerability to IPV** and other forms of violence, including psychological violence
  - Evidence of an association between **child maltreatment** and experiencing **relationship violence** in adulthood

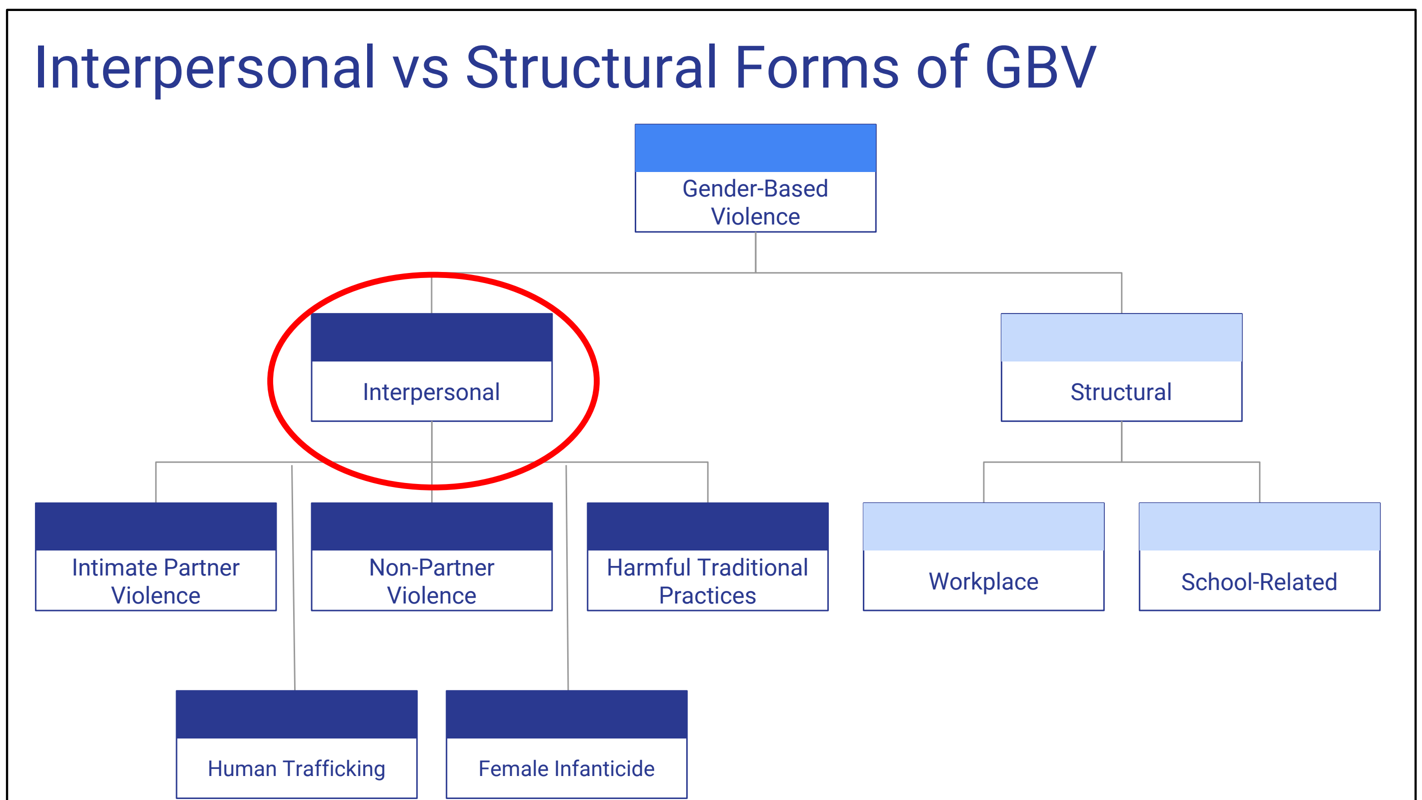


To further expand upon what was discussed on the previous slide, polyvictimization is frequently defined as experiences of multiple forms of victimization, however, it is not specified whether these forms are experienced sequentially (as exhibited on the previous slide) or simultaneously. Regardless, it is important for practitioners to avoid focusing on the prevention of one type of GBV and ensure that polyvictimization is being considered when developing interventions and policies.

Four overarching types of interpersonal GBV are physical, sexual, psychological, and economic violence - generally, many women experience multiple types of violence over time. In many countries, women that experience physical or sexual violence by an intimate partner are more likely to experience economic exploitation and psychological violence. According to the United Nation's World's Women Report in 2015, economic violence "can involve denying access to property, durable goods or the labour market; deliberately

not complying with economic responsibilities, thereby exposing a woman to poverty and hardship; or denying participation in economic decision-making" , whereas psychological violence "includes a range of behaviours that encompass acts of emotional abuse and controlling behaviour" (UN World's Women 2015). While all forms of GBV are underreported due to the nature of the topic, there is greater knowledge on the prevalence of physical and sexual violence as there are inconsistent measures used for the other two categories.

https://www.youtube.com/watch?v=3AF9Rjki0DE



Before we discuss the specific forms of GBV, we have broken down GBV into two overarching categories: interpersonal violence and structural violence. To be clear, this diagram does not provide an exhaustive list of GBV - further, some boxes are broad categories that can include several forms of violence. Interpersonal violence refers to everyday experiences of violence, whereas structural violence is characterized by "unequal access to the determinants of health (e.g., housing, good quality health care, unemployment, education), which then creates conditions where interpersonal violence can occur and shape gendered forms of violence that place women in vulnerable positions" (Montessori 2015). We will begin by discussing five common types of interpersonal violence.

Global Prevalence of IPV

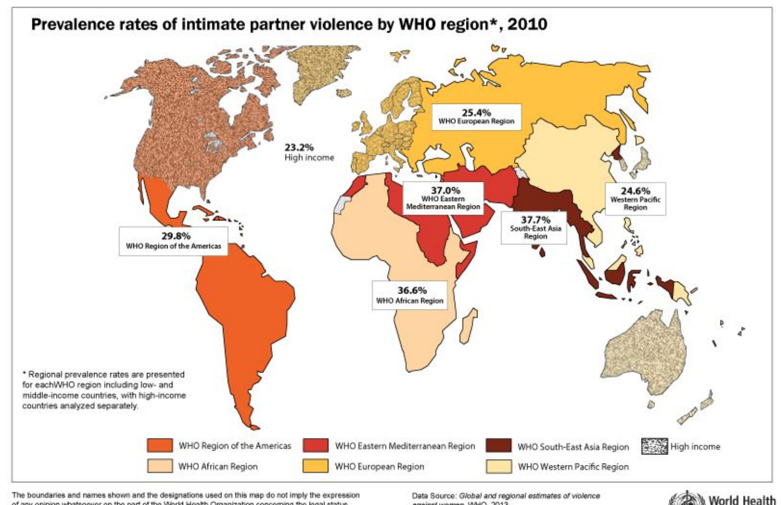


Table 3. Lifetime prevalence of intimate partner violence by age group among ever-partnered women

Age group, years	Prevalence, %	95% CI, %
15–19	29.4	26.8 to 32.1
20–24	31.6	29.2 to 33.9
25–29	32.3	30.0 to 34.6
30–34	31.1	28.9 to 33.4
35–39	36.6	30.0 to 43.2
40–44	37.8	30.7 to 44.9
45–49	29.2	26.9 to 31.5
50–54	25.5	18.6 to 32.4
55–59	15.1	6.1 to 24.1
60–64	19.6	9.6 to 29.5
65–69	22.2	12.8 to 31.6

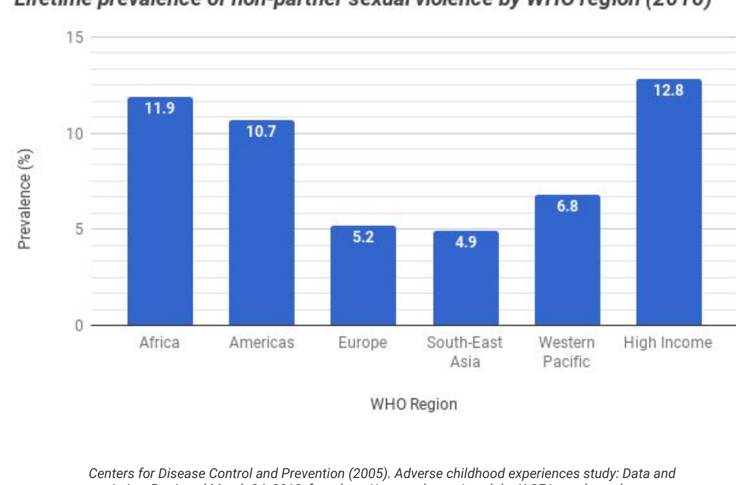
CI = confidence interval.

World Health Organization (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Retrieved from http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf

According to the CDC, intimate partner violence, or IPV, describes physical, sexual, or psychological harm by a current or former partner or a spouse. Approximately, 30% of women worldwide have experienced physical and/or sexual IPV according to multiple reports, but as you can see this percentage tends to vary depending on the region and age group sampled. High income countries have slightly lower rates of IPV than LMICs, and young adults and middle age women (late 20s-late 40s) are more likely to report experiences of IPV. As mentioned previously, in many countries, women that experience physical or sexual violence by an intimate partner are more likely to experience economic exploitation and psychological violence by that same partner so polyvictimization must always be considered. Globally, over a third of murders of women are committed by male intimate partners, and the “vast majority of partner abuse is perpetrated by men against female partners” (Heise 2002). However, IPV also persists in same-sex relationships; interestingly, “women living with female intimate partners experience less intimate partner violence than women living with male intimate partners, and men living with male intimate partners experience more intimate partner violence than do men who live with female intimate partners” (Tjaden and Thoeness 2000).

Non-Partner Sexual Exploitation and Abuse

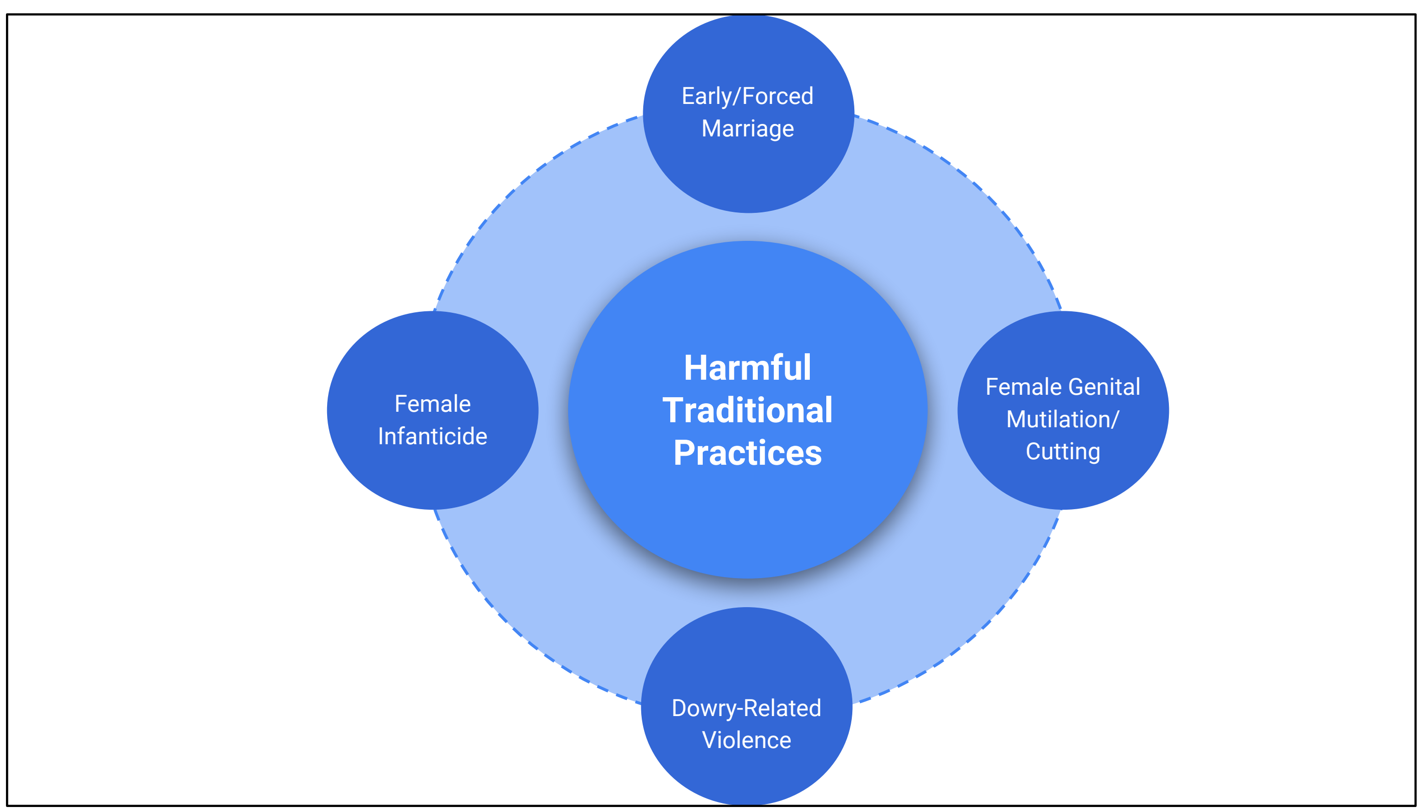
- Sexual Exploitation: “any actual or attempted **abuse of a position of vulnerability, differential power, or trust, for sexual purposes**, including, but not limited to, threatening or profiting monetarily, socially or politically from the sexual exploitation of another”
- Sexual Abuse: “the actual or threatened **physical intrusion of a sexual nature**, whether by force or under unequal or coercive conditions”



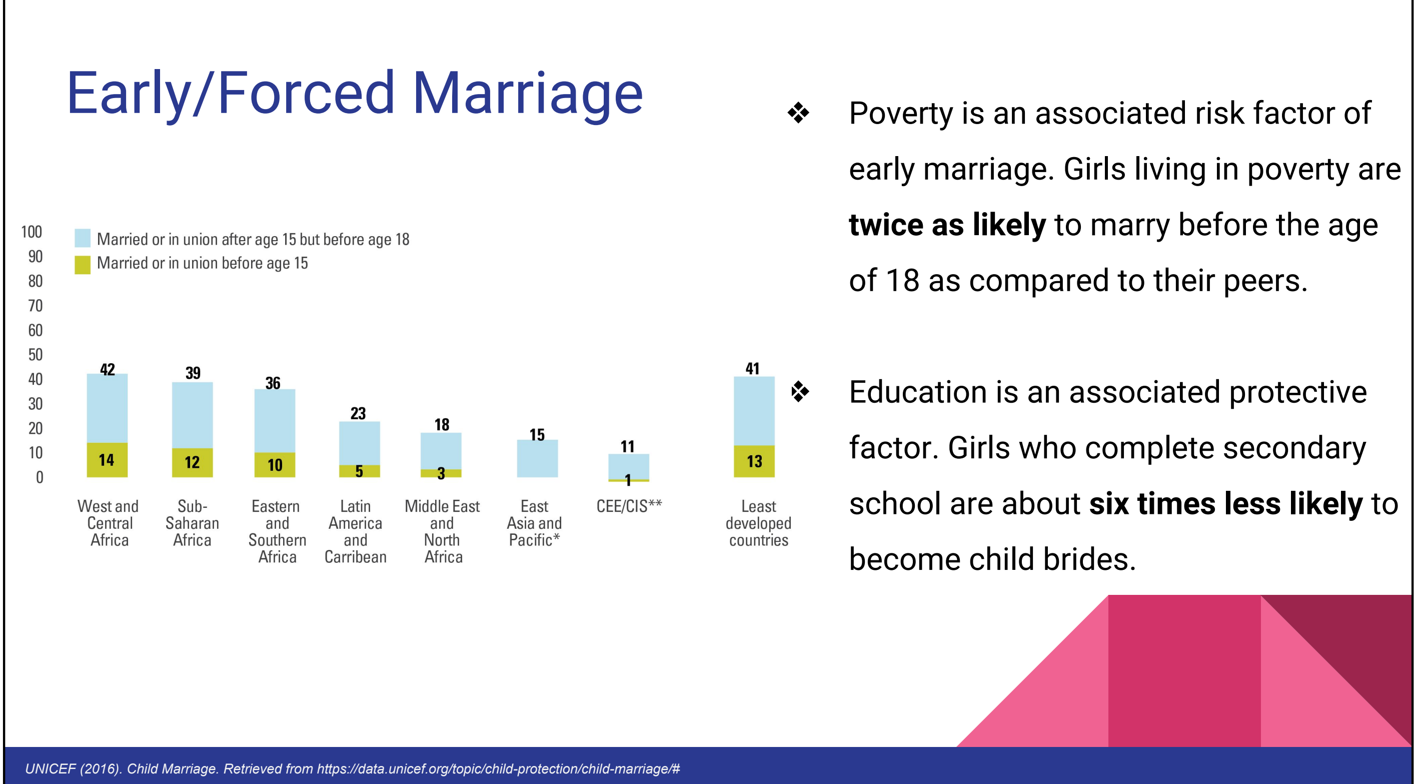
Centers for Disease Control and Prevention (2005). Adverse childhood experiences study: Data and statistics. Retrieved March 24, 2010, from http://www.cdc.gov/nccdphp/ACE/prevalence.htm

World Health Organization (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Retrieved from http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf

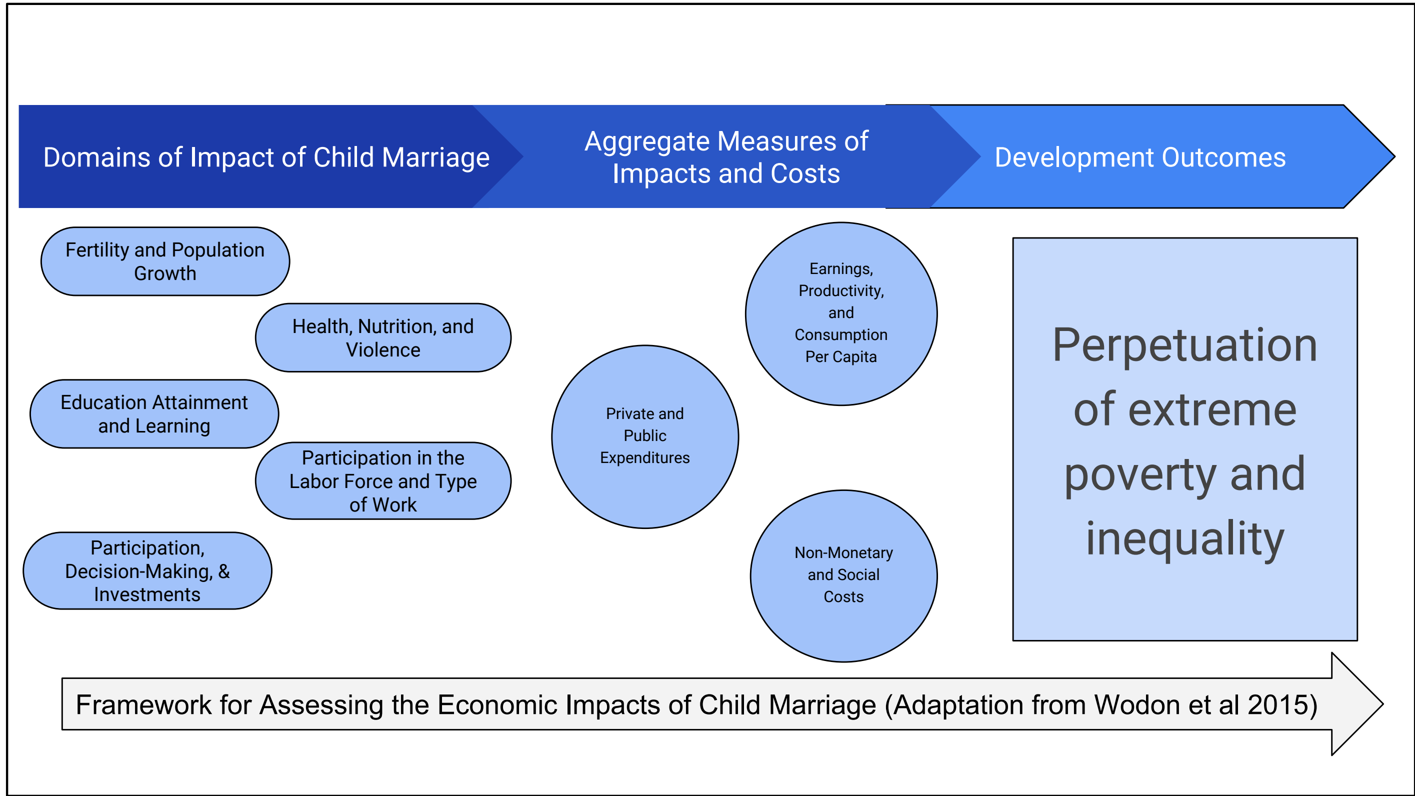
Although the majority of acts of GBV are committed by intimate partners, non-partner sexual violence is also fairly common, particularly sexual exploitation and sexual abuse of children. The global lifetime prevalence of non-partner sexual violence is approximately with the highest rates being in the WHO high-income region and Africa. 4.5 million people are victims of forced sexual exploitation worldwide, and most acts are between individuals who know each other. Over a third of victims of sexual violence are under the age of 16, and 20% have been abused before age 8 (Heise et al 1994). Worldwide, over 95% of victims of sexual violence are women and girls, but it is important to note that sexual violence may be underreported among men and boys (Finkelhor 1994). Generally, the prevalence of sexual violence is lower than that of physical violence, but it tends to be underreported globally.



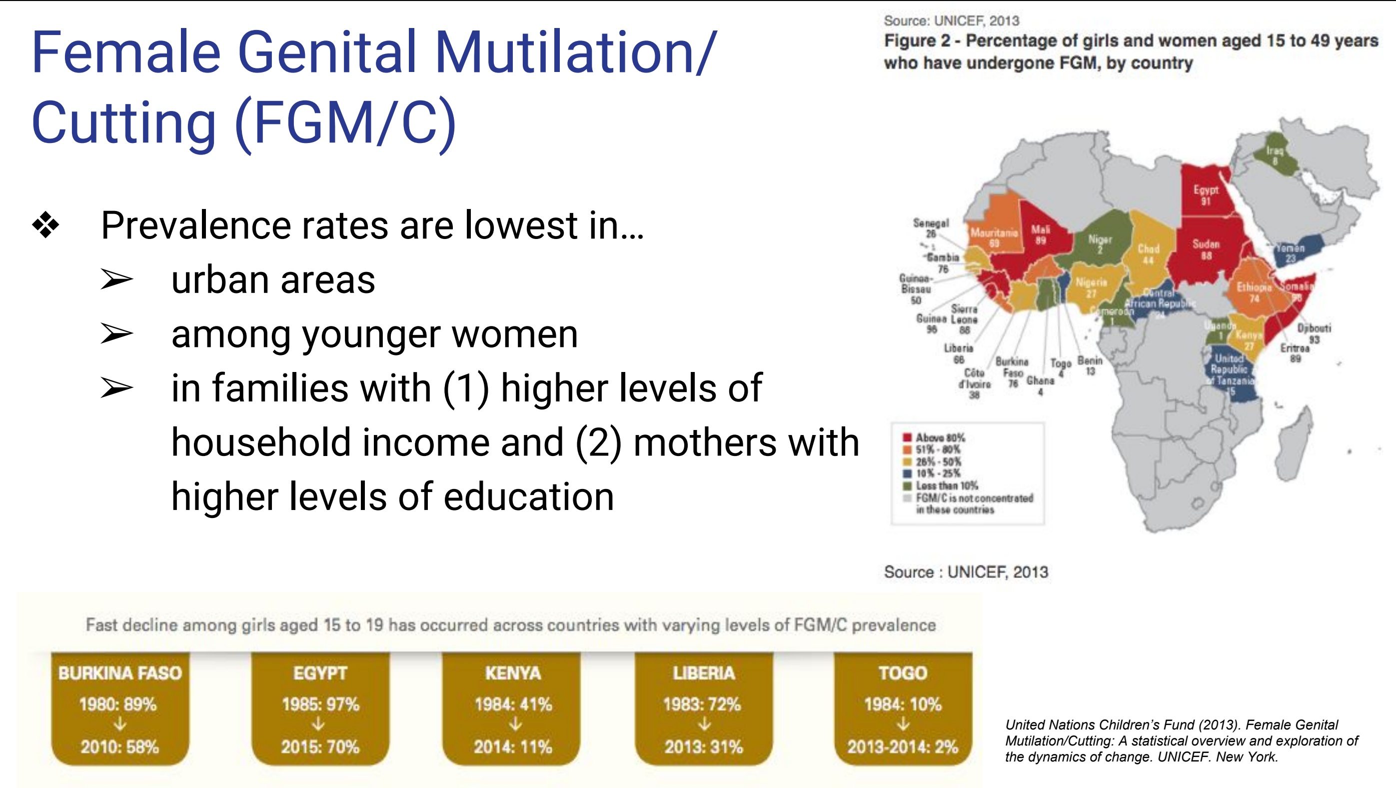
Moving into harmful traditional practices, an overarching category that highlights forms of violence that have persisted in communities for enough time to become culturally accepted, I want to reiterate that this diagram is not exhaustive. For the purposes of this course, we will focus on some of the most prevalent practices, including early or forced marriage, female genital mutilation/cutting, dowry-related violence, and female infanticide.



Early or forced marriage predominantly affects LMICs with 1 in 3 of married women reporting being married before the age of 18 and 1 in 9 by age 15. The highest rates of child marriage are in sub-saharan Africa, and more than 1 in 4 adolescents in West and Central Africa are currently married. Child brides are more likely to experience IPV and health complications than those that marry later, and those in poverty are most at risk. However, education has been found to be a protective factor against child marriage and its health impacts.



Child marriage also has economic consequences in a number of domains of impact that are often perpetuated across generations. These five domains presented on the slide are often affected by early marriage of young girls and typically have a negative relationship on their lives. For example, increased rates of child marriage often result in decreased educational attainment, limited participation in the workforce, and less decision-making power. However, population growth and intimate partner violence tend to increase significantly amongst child brides. As a result of these changes in domains of impact, women often have lower wages and decreased productivity in the workforce, which limits economic growth and perpetuates extreme poverty.



FGM/C is defined as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons." The practice is most common on the African continent, however, rates of the practice have been dropping as support for discontinuation increases among younger women. Like many other forms of GBV, prevalence rates tend to be lowest in families with high SES and educational attainment, as well as in areas of increased urbanization.

Dowry-Related Violence

Dowry deaths: a neglected public health issue in India

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ARTICLE INFO

Article history:
Received 3 February 2010
Received in revised form 2 October 2010
Accepted 15 December 2010
Available online 12 February 2011

Keywords:
Dowry
homicides
suicides
domestic violence
public health
India

ABSTRACT

This paper appraises the public health burden of mortality in India caused by the practice of dowry and examines the association of some demographic and socio-economic factors with dowry deaths and dowry-related suicides. The paper is based on the data available on the public domains of the National Crime Records Bureau (NCRB), third National Family Health and Survey-2005-06, Planning Commission of India and Census of India 2001. In 2007, the total number of dowry deaths and dowry-related suicides reported in India were 8093 and 3148, respectively. There was a 74% increase in dowry-related deaths from1995 to 2007, while there was a 31% increase in the reporting of dowry-related suicides. Occurrence of dowry deaths has significant association with some demographic and socio-economic variables. The data reveal that the status of women is undesirable, and the burden of mortality and related morbidity is enormous. There should be a national injury surveillance system and reliable estimates of dowry-related homicides. However, available information can be used to design and implement some counter-measures to prevent dowry-related violence and deaths. The study warrants the undertaking of research to give insights into circumstances and triggers of such violence, the healthcare seeking of these victims, bottlenecks in seeking health care and reporting to the police.

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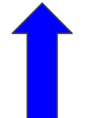


74% increase in dowry-related deaths

31% increase in dowry-related suicides

Babu, G., & Babu, B. (2011). Dowry deaths: a neglected public health issue in India.
Retrieved from https://academic.oup.com/inthealth/article/3/1/35/665774/Dowry-deaths-a-neglected-public-health-issue-in

Dowry-related violence is a common traditional practice in Asian countries, particularly India, Bangladesh, and Nepal. It is defined as “any act of violence or harassment associated with the giving or receiving of dowry at any time before, during or after the marriage” and can be perpetrated by a partner or family member. To illustrate the impact of dowry-related violence, we have highlighted an article published in 2011 by Babu and Babu that utilized data from public domains of governmental and related organizations to track dowry deaths and suicides in India. It is estimated that there are 15,000 dowry-related deaths a year in India alone, which are “mostly in kitchen fires designed to look like accidents”. Lower educational attainment and household income are positively associated with the occurrence of family violence.

Female Infanticide/Sex-Selective Abortion

- ❖ The natural sex ratio is ~105 M / 100 F
  - ➢ Deviations due to sex-selective abortion, female infanticide, and fatal neglect of girls

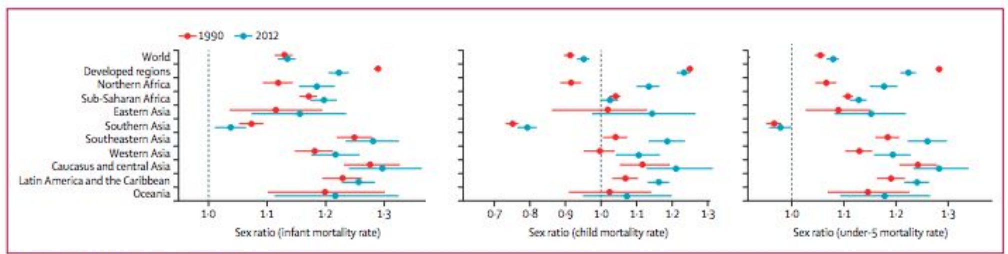
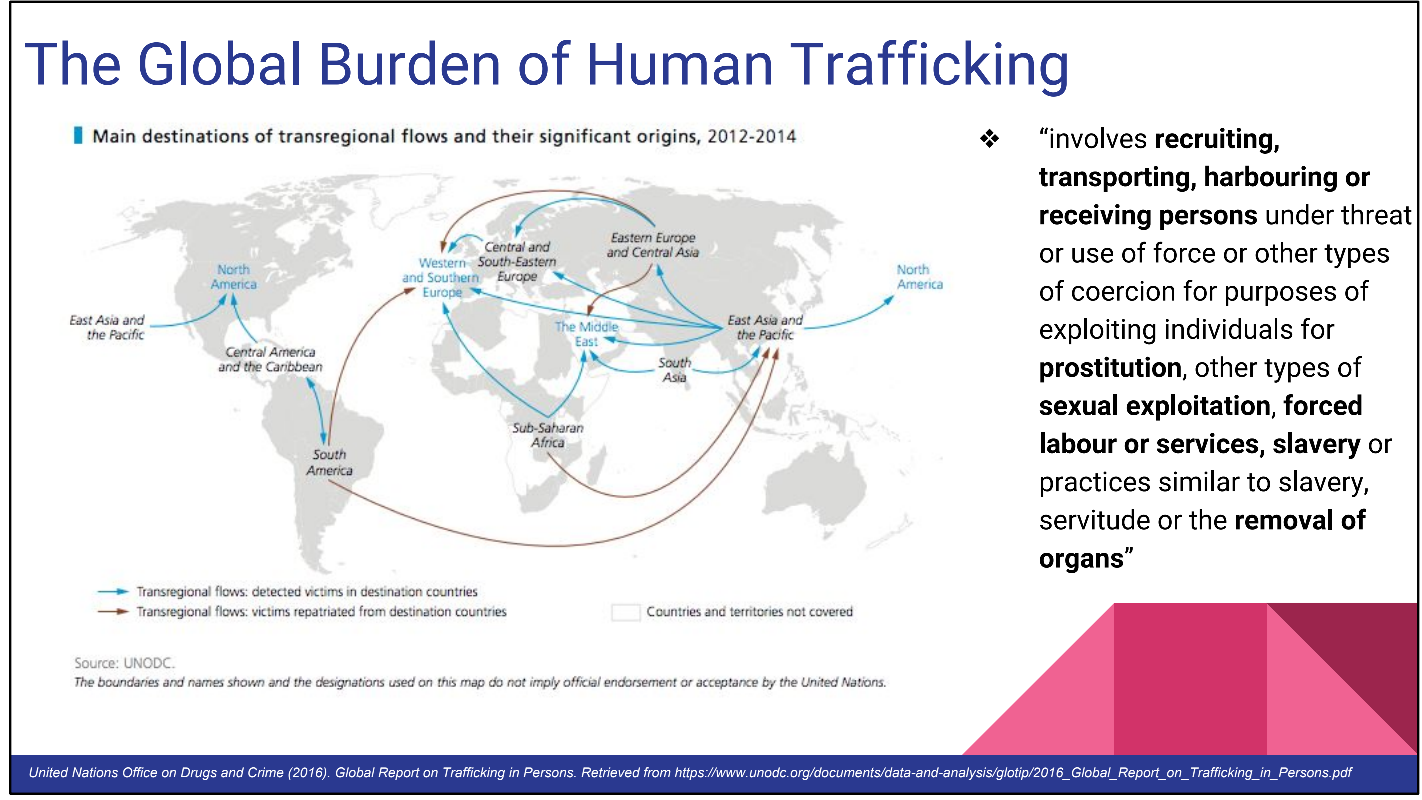


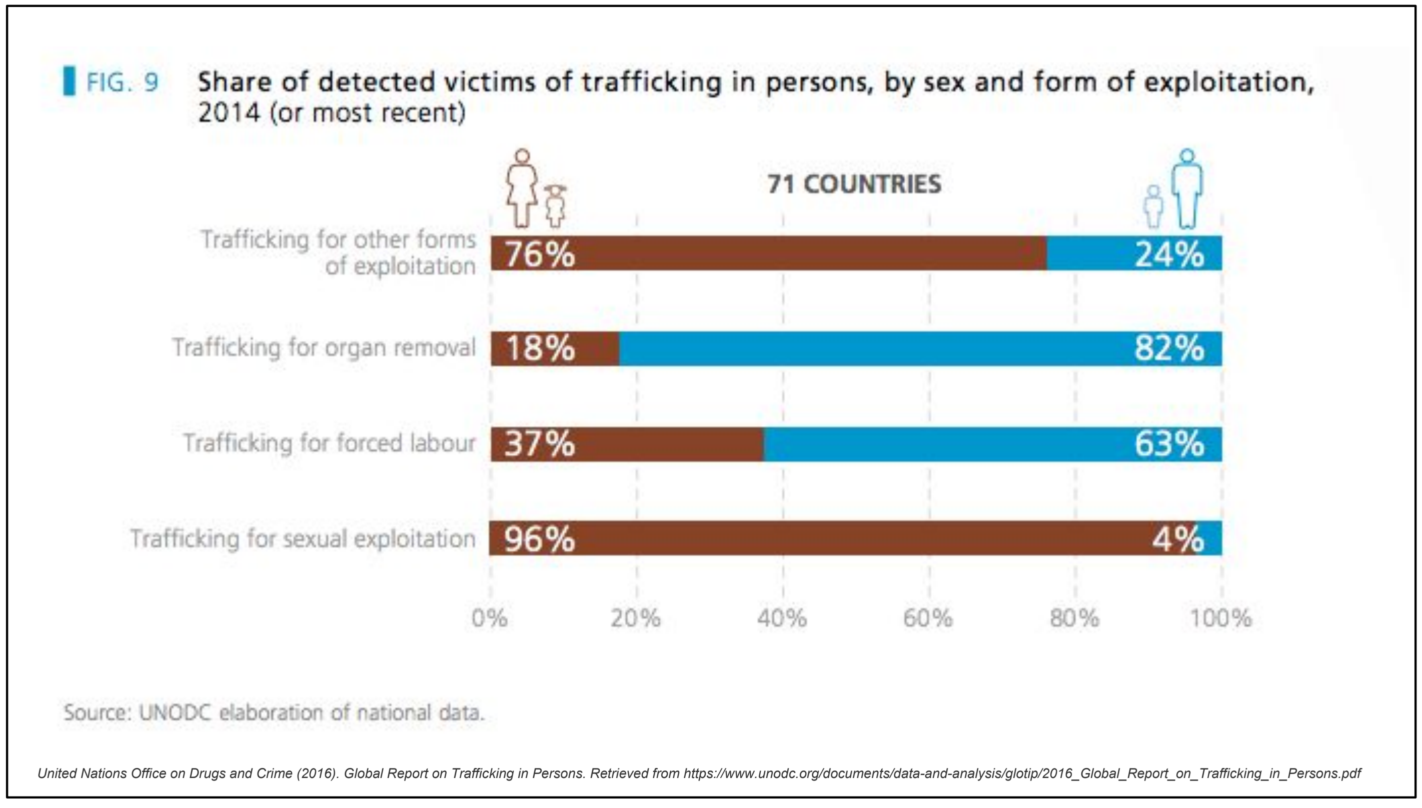
Figure 1: Sex ratios by age group, year, and regions
Error bars are 90% uncertainty intervals.

Alkema, L et al. (2014). National, regional, and global sex ratios of infant, child, and under-5 mortality and identification of countries with outlying ratios: a systematic assessment. Retrieved from http://www.sciencedirect.com/science/article/pii/S2214109X14702803

The last harmful traditional practice we will discuss today is a form of GBV that occurs at the earliest stage of life. While the sex distribution of the global population is about 50/50 with males slightly outnumbering women, certain countries report much higher sex ratios than would be reasonably expected, as a result of sex-selective abortion of female fetuses, female infanticide, and the fatal neglect of girls. For example, in India, out of all abandoned children, 90% of them are girls, and there is a 10% higher mortality rate for girls than boys (Vijay and Chary 2016). If you observe the figure presented, most regions of the world report higher ratios than is “typical” (1.05/1.06).

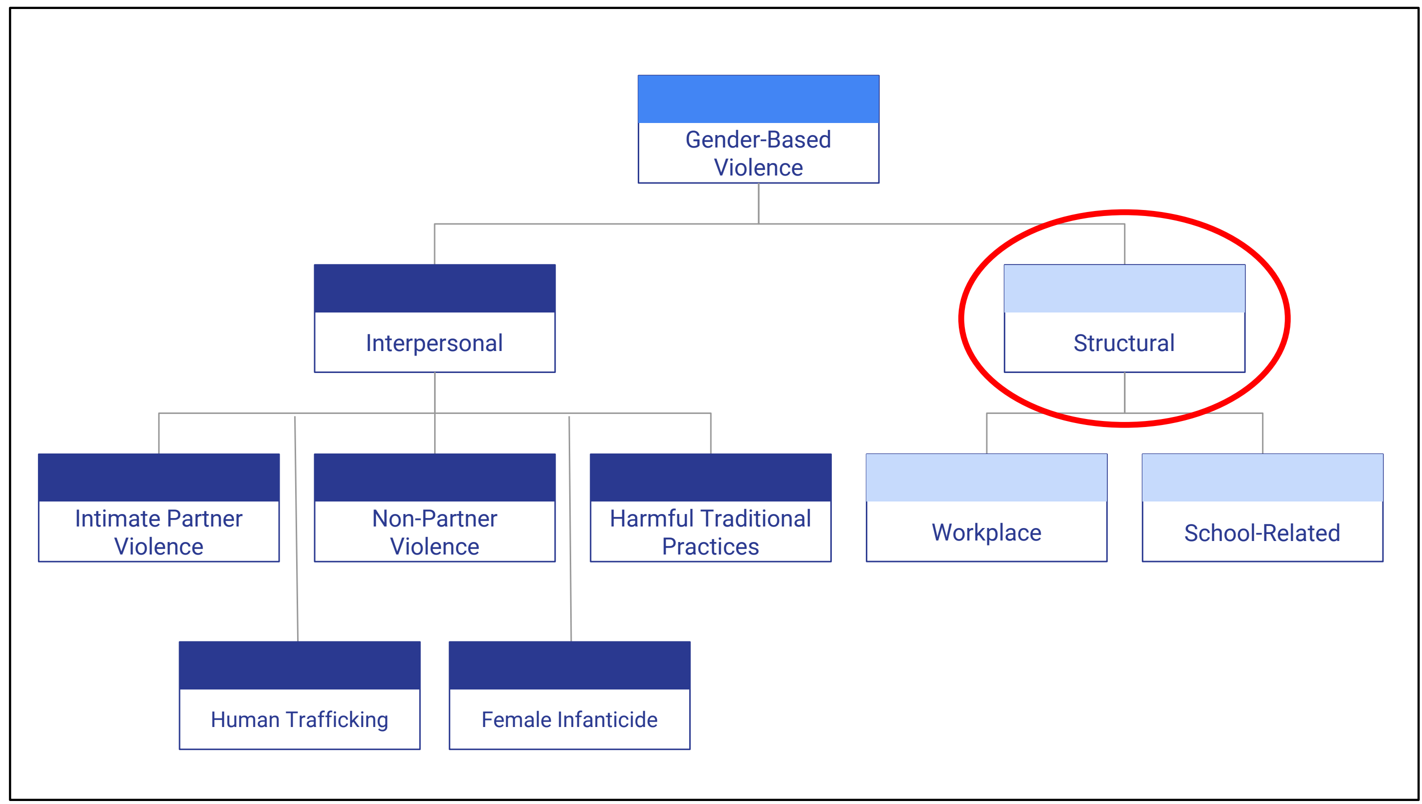


Lastly, human trafficking is an industry that disproportionately affects women and girls, who represent approximately 70% of all victims. In regards to the trafficking of minors, underage girls represent about ⅔ of child victims. The most common form of trafficking is sexual exploitation (72%), whereas labor trafficking is identified approximately 20% of the time. As seen in the figure, victims of human trafficking tend to be transported from countries with low economic opportunity to those with high economic opportunity, such as the United States and Western/Southern Europe. However, data shows that intra-regional and domestic trafficking are the most common forms of human trafficking globally.



United Nations Office on Drugs and Crime (2016). Global Report on Trafficking in Persons. Retrieved from https://www.unodc.org/documents/data-and-analysis/glotip/2016_Global_Report_on_Trafficking_in_Persons.pdf

This figure illustrates the gendered nature of human trafficking. Although women and girls make up over 95% of trafficking victims, they are most commonly trafficked for acts of a sexual nature, whereas men are trafficked for manual labor and body parts. However, these rates specifically indicate those victims that have been detected by law enforcement officials and may not be a useful proxy for actual demographic data of victims. Another important thing to note is the increased involvement of women on the criminal side of human trafficking. Between 2010-2012, approximately ¾ of detected perpetrators were men, however, the most recent data indicates a decrease to under ⅔.



Now that we've discussed some types of interpersonal violence, let's dive into the structural forms of GBV.

Structural Factors that Impact GBV

School-Based Violence

- Bullying
- Sexual Harassment
- Corporal Punishment
- Inadequate Facilities and Services

Workplace-Related Violence

- Discrimination
- Stigmatization
- Sexual Harassment
- Social Exclusion
- Non-Inclusive Policies

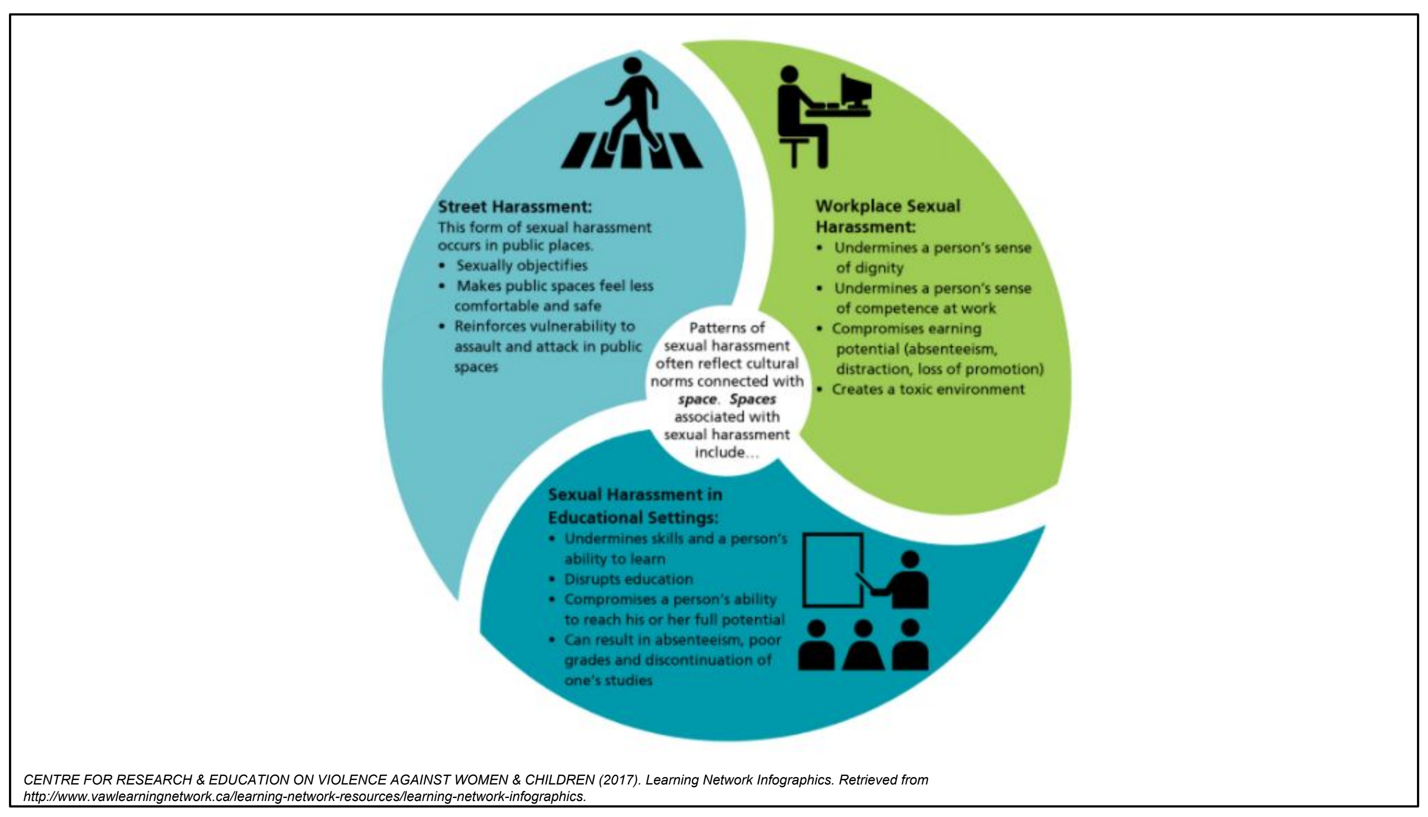
Community-Based Violence

- Women are overrepresented in low-wage jobs - of the world's poor, 70% are women
- Women are given fewer opportunities to advance to "decision-making" positions
- Women often hold "less bargaining power over the terms and conditions of their labor"

Like other types of GBV, structural violence impacts women and girls throughout the lifecourse. For girls, the first experiences of GBV often begin within the educational system in a multitude of ways, but unfortunately, limited data exists on the prevalence of school-based violence. Most research focuses on sexual violence in schools, particularly in sub-saharan Africa, and have noted the following findings:

- 70% of girls in Botswana reported sexual harassment at school
- 50% of teachers reported having sexual relations with students in Côte d'Ivoire
- 16% of schoolchildren in Lebanon reported sexual abuse, with the majority being girls

It is also important to note that lack of access to education is another way young girls are deprived of opportunity and placed at greater risk for interpersonal violence in the future. Social structures in the workplace continue to perpetuate the status quo with women tackling issues, such as sexual harassment, stigmatization, and exclusion, that many have faced previously. Overall, these "invisible factors" that reinforce inequitable systems perpetuate community-based violence, which, ultimately, leaves women and girls with less economic opportunity, political voice, and autonomy as compared to their male peers.



CENTRE FOR RESEARCH & EDUCATION ON VIOLENCE AGAINST WOMEN & CHILDREN (2017). Learning Network Infographics. Retrieved from http://www.vawlearningnetwork.ca/learning-network-resources/learning-network-infographics.

As an example, this diagram considers the case of sexual harassment. A negative experience in one or all of these spaces contributes to the creation of toxic living and working conditions, increasing the risk for other types of victimization and reinforcing a culture that condones "gendered forms of violence that place women in vulnerable positions". Does this resonate with you? How else is violence structurally reinforced in public spaces?

Why are clear definitions important?

Research & Information-Sharing

- Uniformly measure scope and prevalence in order to “compare information across studies and generate a knowledge base”
- Identify high-risk populations
- Monitor changes over time

Prosecution & Punishment

- Allow effective prosecution of perpetrators
- Avoid legal loopholes and ambiguities

Prevention & Protection

- Provide evidence that GBV is widespread to increase allocation of resources
- Ensure adequate support for potential victims and survivors and prevent incidental exclusion
- Effective screening in healthcare settings

Before we close, it’s important that we discuss why all of this terminology is critical to the practice of public health.

How might clear definitions be important for:
... research and information sharing?
... prosecution and punishment of perpetrators?
... ensuring the prevention of GBV and protection of survivors?

Next Steps

- Break into small groups for the case study: *Violence Against Women in Country X*
- Be prepared to report back to the large group and share what you and your group discussed

Add discussion questions for group/pair work or assignments/readings for the next class

Effects of GBV on Health Outcomes

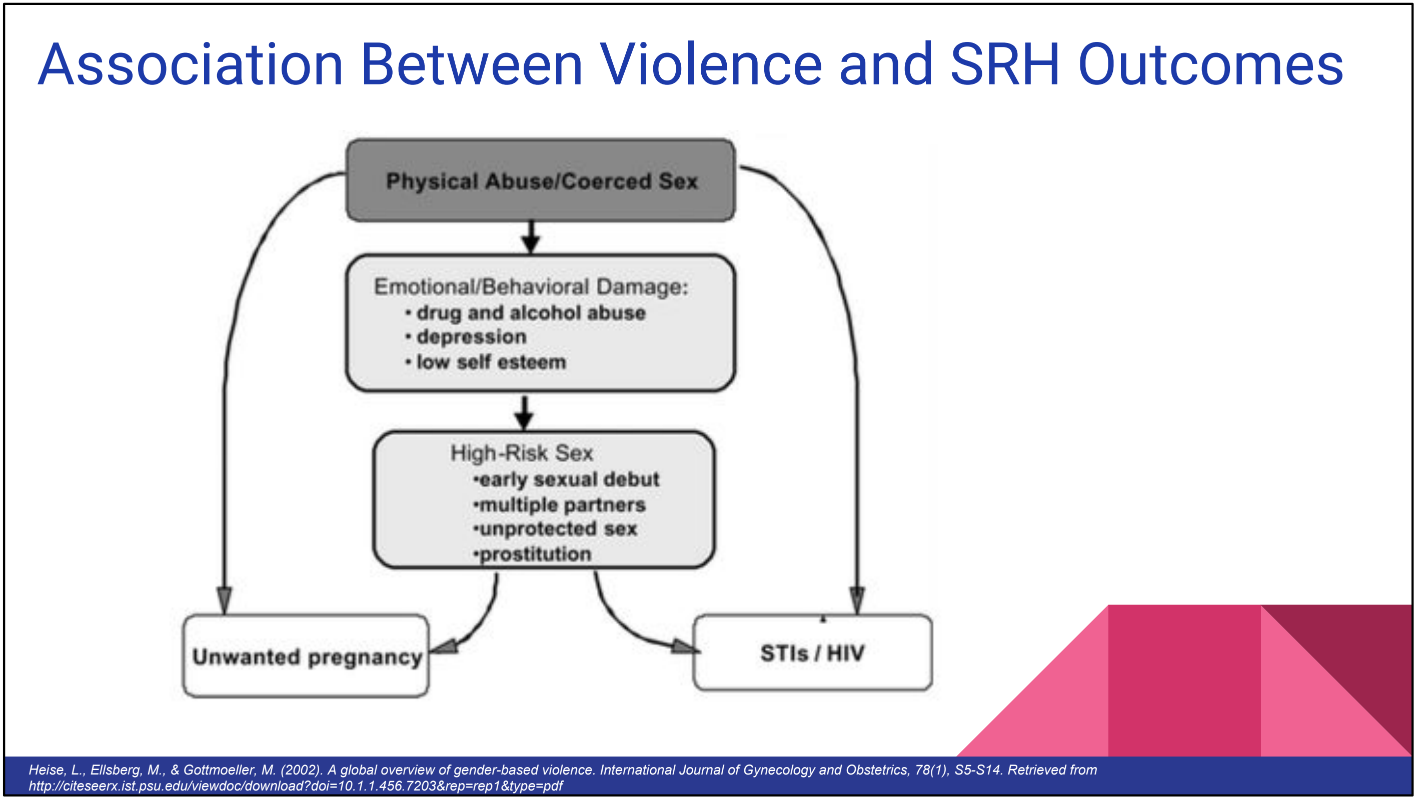
Cari Clark, Sc.D., MPH
Kathryn Yount, PhD

Spring 2018

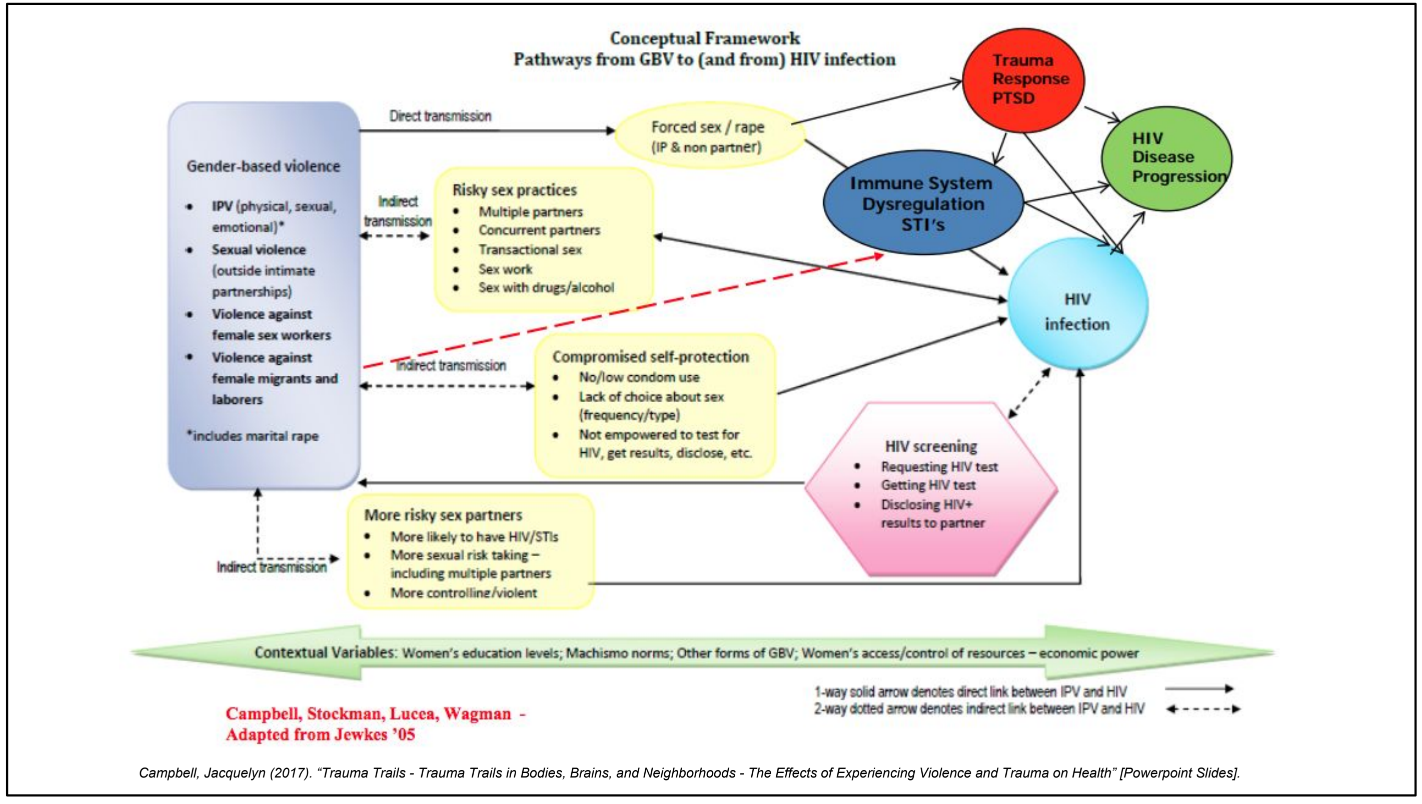
By the end of the day, you should be able to...

Sexual and Reproductive Health	Mental Health and Coping	Physical Injury and Chronic Pain
Describe the evidence linking gender-based violence to sexually transmitted infections, gynecological disorders, and other poor health outcomes	Explain the neurobiology of trauma, including the short and long-term psychological effects of gender-based violence	Understand implications of gender-based violence on physical health outcomes across the life course

This slide includes the lesson objectives and overview of today's class.

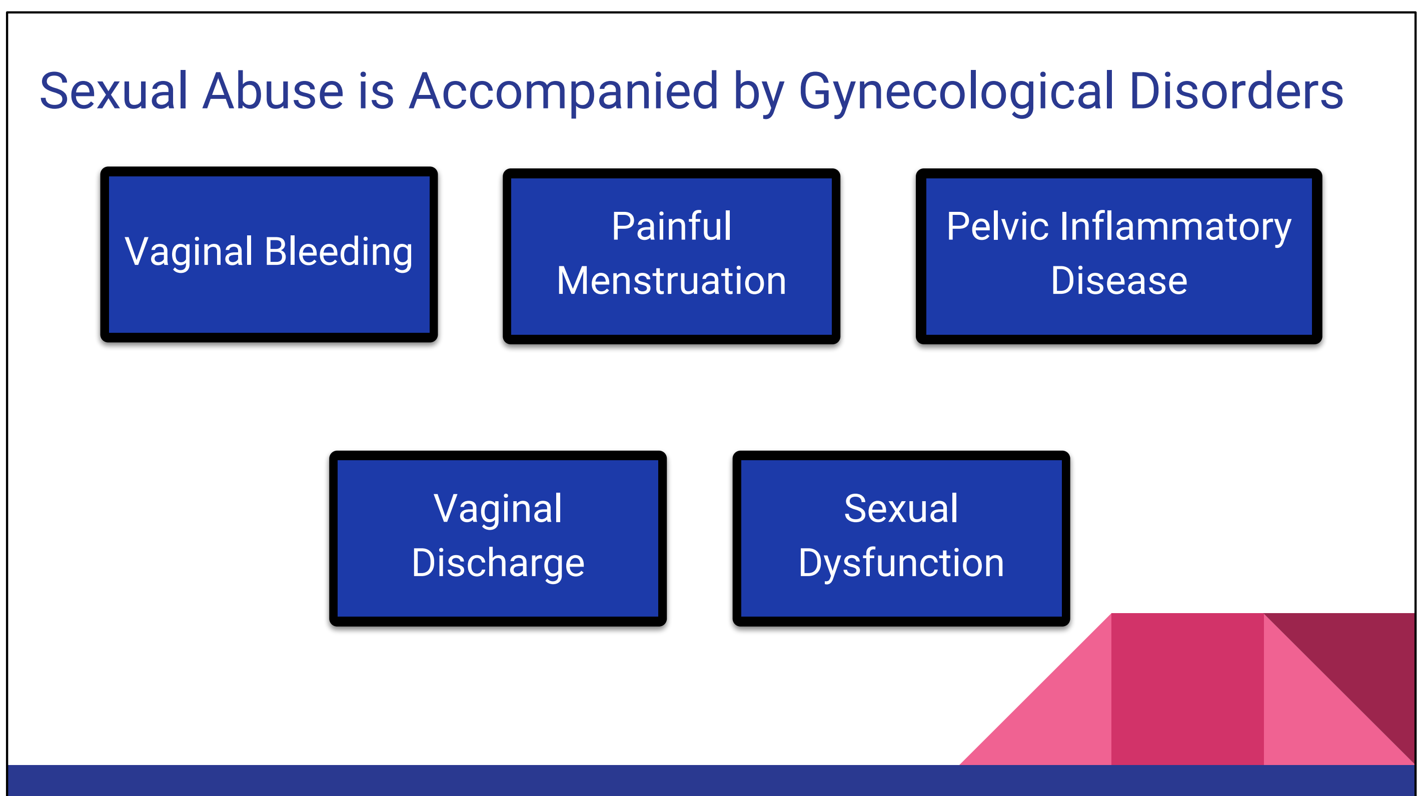


As you read in the global overview of gender-based violence that was assigned, there are both direct and indirect relationships between violence and adverse health consequences, particularly those related to sexual and reproductive health. Gender-based violence, whether that be forced sex or physical assault, places women and girls directly at risk of sexually transmitted infections and unwanted pregnancies, particularly when they lack the autonomy to negotiate condom usage with intimate partners. For example, those who have been sexually abused as children are more likely to become pregnant during adolescence (Heise 1999). Similarly, child brides often have higher risks of contracting HIV and other STIs (as much as 6x compared to boys of the same age) as a result of this power imbalance (WHO 2016). This is illustrated in the diagram by the outermost arrows. In addition, survivors of violence are also indirectly affected by past history of physical and sexual abuse by increasing risk-taking behaviors, including substance abuse and unprotected sex while decreasing the likelihood of seeking testing or counseling for sexually-transmitted infections. In fact, those who have experienced violence are 1.5x more likely to have an STI or HIV. Today, we will discuss some additional statistics that illustrate the prevalence of poor sexual and reproductive health outcomes among victims of physical and sexual violence.



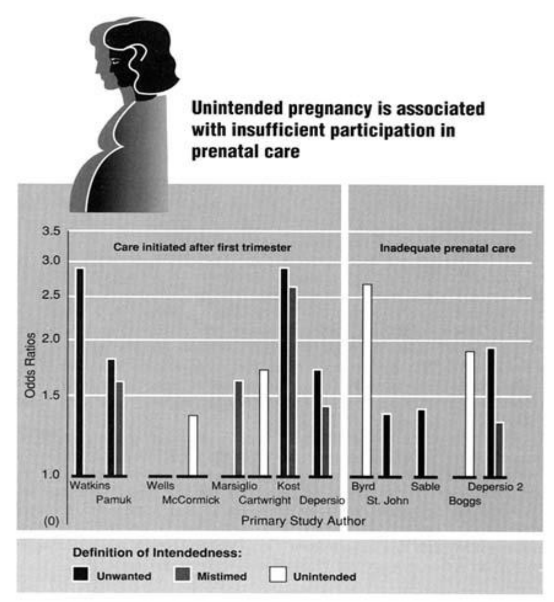
Campbell, Jacquelyn (2017). "Trauma Trails - Trauma Trails in Bodies, Brains, and Neighborhoods - The Effects of Experiencing Violence and Trauma on Health" [Powerpoint Slides].

This is an updated conceptual framework that was adapted from Rachel Jewkes, illustrating both direct and indirect pathways connecting GBV to HIV.



When an individual experiences sexual violence, they tend to report additional gynecological symptoms, such as vaginal bleeding, discharge, painful menstruation, sexual dysfunction, and chronic pain. Those who suffer from these symptoms are more likely to have a history of sexual assault or child abuse.

Unintended Pregnancy in Violent Relationships Worsens MCH Outcomes with Increased Risk for Young Mothers



Additional risks include:

- ❖ Preterm Delivery (41% more likely)
- ❖ Abortion (2x as likely)
- ❖ Low Birth Weight (16% more likely)
- ❖ Antenatal Hospitalization (2x as likely)
- ❖ Fetal Growth Retardation*
- ❖ Fetal Death*
- ❖ Maternal Mortality*
- ❖ Postpartum Depression
- ❖ Infant and Under-Five Child Mortality

* An increased risk is documented in the literature for mothers under the age of 20.

Brown, S. S., & Eisenberg, L. (1995). The best intentions: unintended pregnancy and the well-being of children and families. Retrieved from https://www.nap.edu/read/4903/chapter/5

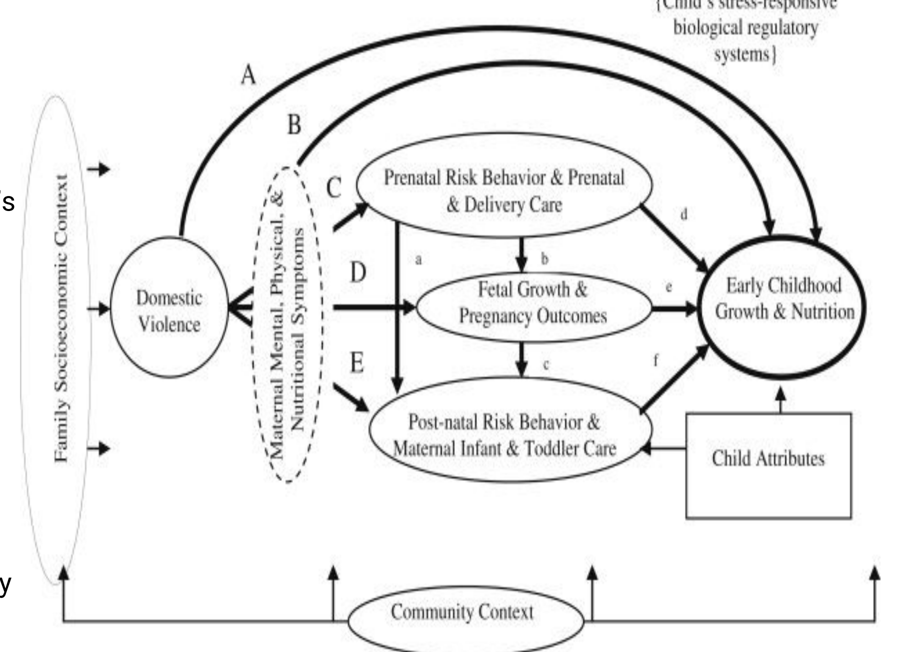
Clark, Cari. "Intimate Partner Violence and Health Care" [Powerpoint Slides].

In addition to being more likely to report unintended or unwanted pregnancies, survivors of violence have an increased risk for fetal distress, miscarriages, abortion, and maternal mortality. As illustrated in the chart, unintended pregnancy has been consistently associated with not only delays in seeking prenatal care but also inadequate care. These preterm disparities are suspected to contribute to the increased risk of poor health outcomes for the fetus, such as preterm delivery, low birth weight, and fetal growth retardation. However, risk is highly dependent on the mother's socioeconomic status and age; for example, stillbirths and newborn deaths are 50% higher among mothers under 20 than in women who get pregnant in their 20s (WHO 2013). Babies born from mothers younger than 18 have even worse outcomes as the risk for under-five stunting increases by over 6 percentage points and under-five mortality increases by 3.5 percentage points (ICRW 2016). Maternal mortality is also a concern for young mothers - pregnancy is among the leading cause of death for girls ages 15-19.

- ***"Risky Family Environment Model"*** impacts a child's stress-responsive biological regulatory system

- ***"Family Disruption Model"*** - mother's experience of violence initiates behavioral risks (i.e. substance abuse) and other symptoms that mediate effects on child's stress-responsive system

- These pathways can contribute to ***maternal impairments*** (i.e. lack of prenatal care or poor feeding practices) and adversely affect early growth and nutritional status



*** The strength of these pathways may vary or be confounded by "Community Context", which can include community/household poverty, co-occurring family violence, maternal autonomy, obstetric history, and the child's age, gender, and genetic predispositions.

Pathways Linking Childhood Exposure to Violence to Growth in Utero and Early Childhood

1. Domestic violence > child's stress-responsive biological regulatory systems
2. Domestic violence > maternal mental, physical, and nutritional health
3. Domestic violence > maternal mental health > fetal/young child growth
4. Domestic violence > maternal physical health/nutrition > fetal/young child growth
5. Domestic violence > maternal risk behavior > fetal/young child growth
6. Domestic violence > prenatal and delivery care > fetal/young child growth
7. Domestic violence > fetal growth/pregnancy outcome > child growth
8. Domestic violence > maternal infant/toddler care > young child growth

Yount, K. M., DiGirolamo, A. M., & Ramakrishnan, U. (2011). Impacts of domestic violence on child growth and nutrition: a conceptual review of the pathways of influence. Social Science & Medicine, 72(9), 1534-1554.

How did gender-based violence impact sexual and/or reproductive health in this particular population?

Group 1: Speizer et al. (South Africa)

Group 2: Silverman et al. (Bangladesh)

Group 3: Decker et al. (Thailand)

Group 4: Champion et al. (USA)

Group 5: Davis et al. (China)

Group 6: Waszak Geary et al. (Jamaica)

Articles:

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3515795/
2. https://www.ncbi.nlm.nih.gov/pubmed/17877676
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3521618/
4. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.908.5797&rep=rep1&type=pdf
5. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4520252/
6. https://www.researchgate.net/profile/Cynthia_Geary/publication/6739153_Sexual_Violence_and_Reproductive_Health_Among_Young_People_in_Three_Communities_in_Jamaica/links/5474dc230cf245eb436e2122.pdf

Discussion Questions

1. What was the purpose of the research study?
2. Who are the participants, and which population(s) do they represent?
3. Briefly explain the recruitment and data collection methodology.
4. Describe the findings and any implications for sexual and reproductive health.
5. What are some limitations of the study?

Once each group has shared, the facilitator can ask the following questions:

- In what ways, are these findings similar across studies? In what ways, are they different?
- What other variables could have been considered?
- What are some potential future directions for research examining the relationship between GBV and SRH?

Chronic Pain Persists Long After Violent Acts

Death and Injury

42%

of women who have experienced physical or sexual violence at the hands of a partner have experienced injuries as a result

38%

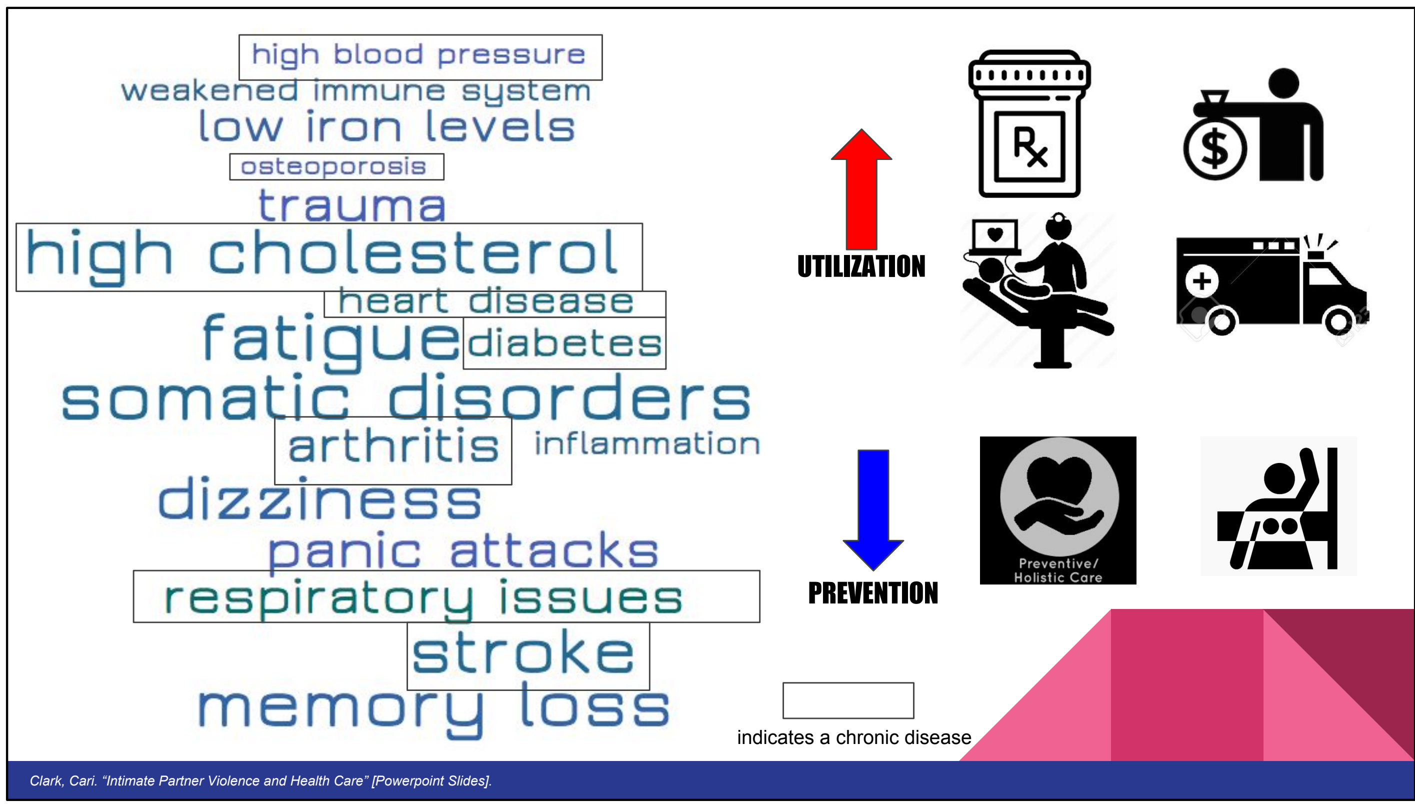
of all murders of women globally were reported as being committed by their intimate partners

Physical injury among survivors are often attributed to acts of violence, resulting in:

- Headaches
- Back Pain
- Abdominal Pain
- Fractures/Hemorrhaging
- Traumatic Brain Injury
- Fibromyalgia
- GI Disorders
- Limited Mobility

World Health Organization. Violence against women. (2017). World Health Organization. Retrieved from http://www.who.int/mediacentre/factsheets/fs239/en/

In almost half of every violent altercation, the survivor (often a woman) sustains numerous injuries that often have long-lasting consequences. Chronic pain is frequently reported by survivors of violence.



Although the majority of post-violence symptoms are common and treatable, survivors of violence rarely seek medical treatment to manage these chronic conditions. In fact, compared to other patients, IPV survivors utilize emergency services at an alarming rate and also have more prescriptions, hospitalizations, and provider visits. Unfortunately, preventative care is relatively low - for example, female survivors undergo fewer mammograms than non-survivors.

Individuals with disabilities are at increased risk for IPV, are four times as likely to experience sexual assault, and report prolonged exposure to violence (Brownridge 2006; Martin et al. 2006; Plummer & Findley 2012).

Compared to those who have not experienced IPV, survivors of violence:

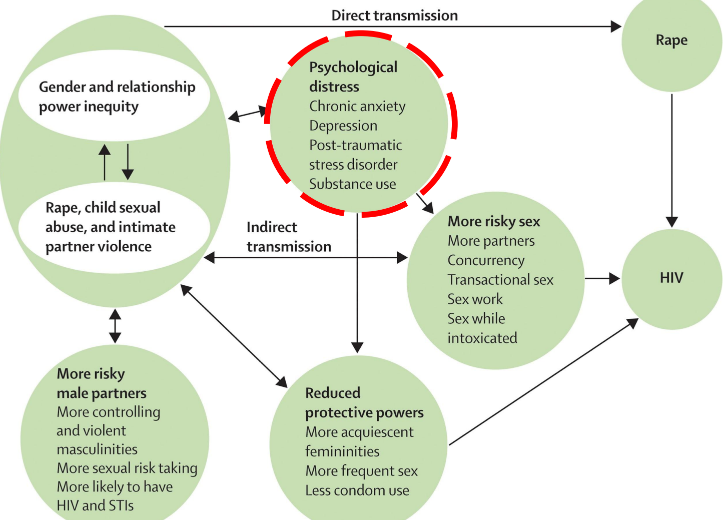
- are 2x as likely to report a disability
- experience problems related to chronic stress
- report lower productivity (decreased earnings)

NCTVDMH (2014). Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness. Retrieved from http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/FactSheet_IPVTraumaMHChronicIllness_2014_Final.pdf.

Risk-Taking Behaviors Become Coping Mechanisms

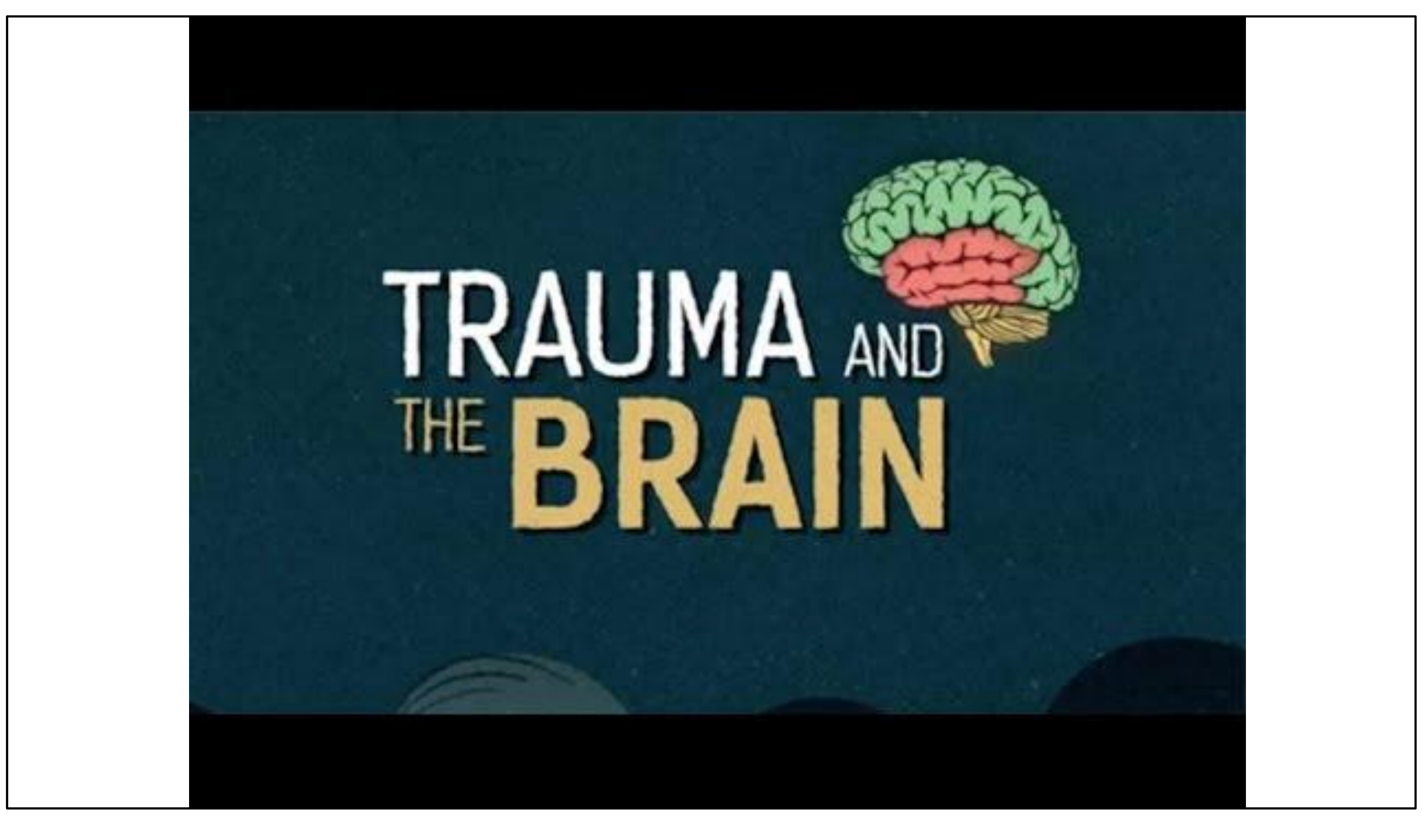
Early sexual victimization is linked to **greater risk-taking behaviors and poor outcomes**, including:

- Smoking
- Attempts to Self Medicate (WHO 2016)
  - 2x as likely - "problem drinking"
- Eating Disorders
- Sleep Difficulties
- Self Harm/Suicide (NCDVTMH 2014)
  - 3x as likely - self-harm
  - 3x as likely - suicidal ideation
  - 4x as likely - attempted suicide



Jewkes, R et al. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. Retrieved from http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60548-X/fulltext

Although we have already discussed the impact of risky behavior on unwanted pregnancy and STIS, it is important to note that there is also a relationship between risk-taking and psychological distress (outlined in red). Those who experience sexual violence at a younger age have a greater predisposition for risky behavior and poor mental health outcomes. In many ways, these risk-taking behaviors become coping mechanisms to respond to chronic anxiety, depression, or PTSD and may manifest themselves in a number of ways, such as substance use, eating disorders, and increased smoking.



https://www.youtube.com/watch?v=4-tcKYx24aA

How might an understanding of trauma be useful for GBV researchers? For practitioners?

Next Steps

Add discussion questions for group/pair work or assignments/readings for the next class