TRAUMA, VIOLENCE, & ABUSE
1-15

DOI: 10.1177/1524838018823270
journals.sagepub.com/home/tva
SAGE

An Integrative Review of Safety Strategies for Women Experiencing Intimate Partner Violence in Low- and Middle-Income Countries

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Abstract

Intimate partner violence (IPV) is prevalent and a leading source of morbidity and mortality to women worldwide. Safety planning is a cornerstone of harm reduction and violence support in many upper income countries. Far less is known about safety strategies used by women in low- and middle-income countries (LMICs) where the IPV support service infrastructure may be more limited. This study aimed to review the literature regarding safety strategies in LMICs. A PubMed search was conducted using search terms "safety," "coping," "harm reduction," and "intimate partner violence." Inclusion criteria comprised IPV studies mentioning characterization and utilization of safety strategies that were written in English and conducted in an LMIC. Our search yielded 16 studies (in-depth interviews, $n = 5$; focus group discussions, $n = 2$; case study, $n = 2$; mixed qualitative methods, $n = 4$; mixed methods, $n = 1$; and semi-structured quantitative survey, $n = 2$). Four distinct themes of strategies emerged: engaging informal networks, removing the stressor/avoidance, minimizing the damage to self and family through enduring violence, and building personal resources. IPV-related safety strategies literature primarily emerged from site-specific qualitative work. No studies provided effectiveness data for utilized strategies. Across geoculturally diverse studies, results indicate that women are engaging in strategic planning to minimize abuse and maximize safety. Women highlighted that safety planning strategies were feasible and acceptable within their communities. Further research is needed to test the effectiveness of these strategies in decreasing revictimization and increasing health and well-being. Further adoption of safety strategies into violence programming could increase monitoring and evaluation efforts.

Keywords

cultural contexts, disclosure of domestic violence, domestic violence, intervention/treatment, support seeking, sexual assault

Background

Approximately one in three women experiences violence in her lifetime, the majority of which is perpetrated by an intimate partner (Devries et al., 2013; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Intimate partner violence (IPV) is defined as "any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" (World Health Organization [WHO], 2002). IPV is associated with increased mortality and a range of morbidity conditions including neurological, reproductive, gastrointestinal, and cardiac complications (Devries et al., 2013; Ellsberg, Jansen, Heise, Watts, & García-Moreno, 2008). Most notably, violent intimate relationships put women at an increased risk of homicide, as an estimated 38.6% of female homicides worldwide occur at the hands of an intimate partner (Stöckl et al., 2013). Given the broad range of acute and chronic health outcomes imposed by IPV, mitigating repeat injuries and minimizing the impact of chronic stress should be a top priority for prevention and response programs.

To date, violence prevention programs in low- and middle-income countries (LMICs), defined by the World Bank as countries with a gross national income per capita less than US$3,895, have focused largely on primary prevention (Ellsberg et al., 2015; World Bank, 2018). Yet harm reduction for women who are in violent relationships, and linking them to adequate support services, can substantially reduce the adverse health and social impact of IPV (Campbell, 2002; Coker et al., 2002; Ellsberg et al., 2008). Harm reduction for IPV often takes the form of safety planning, which is a broad term

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encompassing strategies to increase a woman's safety by empowering her with skills and situational awareness prior to violence perpetration. Safety planning focuses on reducing the harm from violence to the individual and family when ending an unsafe relationship is not feasible (Campbell, 2001; McFarlane et al., 2004).

Both overt and covert resistance strategies can be used by women to attempt to minimize harm and gain control over the situation. Overt resistance strategies, such as fighting back, tend to be externally evident and may be easier to identify. Covert resistance strategies (sometimes deemed "coping behaviors"), including thinking about something else during the incident or discretely adapting behaviors, may be safer depending on relationship history and the partner's response (Hayes, 2013).

To date, safety strategies have widely been employed in upper-income countries (UICs) as harm reduction techniques (Goodman, Dutton, Weinfurt, & Cook, 2003). Specifically, the Safety Behavior Checklist assesses use of 15 safety behaviors that women may undertake before or during violent acts including hiding money, hiding extra house/car keys, establishing codes with family or friends, asking neighbors to call the police if violence begins, and removing weapons from the household (McFarlane, Malecha, Gist, Watson, & Batten, 2002). Additional items of the checklist establish having personal records available in case of potential flight including social security numbers, birth certificates, bank account numbers, marriage licenses, and important phone numbers, as well as a hidden bag with clothing and valuables.

Several frameworks and theoretical bases are relevant in understanding safety planning. Following an ecological model for violence prevention and response, safety planning recognizes that while the responsibility for violence falls with the perpetrator, potential victims may be able to enact behaviors to minimize harm or enhance safety. Constraints or enabling factors for enacting safety strategies involve key actors at the microsystem (children and family members), exosystem (social networks, clinical and legal factors) and macrosystem (cultural and political contexts) levels (Heise, 1998). Stress and coping and harm reduction theories offer additional conceptual models for safety augmentation within high stress environments. Stress and coping theory acknowledges that women must first identify the situation and subsequently weigh options and evaluate resources (Lindhorst, Nurius, & Macy, 2005). Coping mechanisms are thought to help women "continue with other aspects of her life while living in an abusive situation," however, involve aspects of strategic decision-making through weighing options (Lindhorst et al., 2005). Harm reduction theory originally emerged out of HIV and substance use fields but has been adopted for several other domains including recurrent violence. This theory adopts engagement of safer practices if one is unable to leave risky or harmful environments (Gielen, Mcdonnell, & Campo, 2002; Melendez, Hoffman, Exner, Leu, & Ehrhardt, 2003; Miller et al., 2017; O'Connor et al., 2014).

Safety planning strategies are aligned with international guidance stating that the response to IPV must be woman centered in recognizing that women may not want to leave or may be unable to leave an abusive relationship. Furthermore, the response should allow women to self-determine the future plans of both themselves and their children (WHO, 2016). Adopting this woman-centered approach, the end goal of enacting safety strategies may not be to leave but rather to survive. Gondolf and Fisher (1988) argue that in their survivor theory that women try to seek help at different stages but may be inhibited. Their lack of further help-seeking is therefore not passive but shaped by their circumstances and relationship dynamics (Gondolf & Fisher, 1988). Our conceptualization of safety planning integrates all of these theories to examine thoughtful strategies that women utilize in overt and covert ways to reduce harm to themselves and their families.

Implementation of these safety planning strategies in UICs has proven promising in helping women exit volatile situations quickly and reducing violence, while maintaining or safely ending their relationship (Bermea, Khaw, Hardesty, Rosenbloom, & Salerno, 2017; McFarlane et al., 2004). However, the limited evidence that exists indicates that the effectiveness of these strategies varies situationally and with strength of available support services (Goodkind, Sullivan, & Bybee, 2004; Goodman, Dutton, Vankos, & Weinfurt, 2005; Messing, O'Sullivan, Cavanaugh, Webster, & Campbell, 2017; E. M. Parker & Gielen, 2014; E. M. Parker, Gielen, Castillo, Webster, & Glass, 2016). In UICs, implementation is most often integrated into formal support services including shelters/safe houses, antenatal and clinical care, as well as within the justice system, particularly civil counseling and protection (McFarlane et al., 2002, 2004; McFarlane, Parker, Soeken, Silva, & Reel, 1998; B. Parker, McFarlane, Soeken, Silva, & Reel, 1999; E. M. Parker et al., 2016; Van Parys, Deschepper, Roelens, Temmerman, & Verstraelen, 2017). Clinical settings have introduced safety planning as part of an educational component with IPV screening that does not require disclosure of violence experiences (Chamberlain & Levenson, 2012; Coker et al., 2012); however, these educational components usually require contact with a medical professional. Safety planning has been proven particularly valuable when integrated with crisis support services (Chamberlain & Levenson, 2012). More recently, efforts are being made to introduce safety planning to women without access to formal services, for example, through free and confidential web-based apps and online-information and resources (Eden et al., 2015; Glass et al., 2017). Although limited by effectiveness data in UICs, there is a clear understanding of the strategies that women in UICs adopt to keep themselves safe and the feasibility and acceptability of these strategies when integrated with support services (Glass et al., 2017; Goodkind et al., 2004; Goodman et al., 2003, 2005; Mcfarlane et al., 1998, 2004; E. M. Parker & Gielen, 2014). This experiential evidence is a critical step in understanding the effectiveness of an intervention and to guide programmatic and policy recommendations (Puddy & Wilkins, 2011). Given UIC implementation via supplementation of formal support services, however, sustainability and reach in settings with limited

health and justice sector engagement warrants further investigation.

Comparatively, there is a dearth of literature regarding the safety planning strategies utilized by women in LMICs, their effectiveness, and systems for implementation. The integration of safety planning strategies into formal IPV care and response systems has made the transferability of UIC strategies to LMICs particularly difficult. Furthermore, some strategies that are helpful within UIC contexts may not be appropriate or valuable within LMICs given cultural, economic, and systemic constraints. Without an understanding of context appropriate safety strategies for women in these settings, it is difficult to integrate safety planning, either as part of existing formal systems or through targeted programmatic implementation. This article reviews the current literature on safety planning strategies in LMICs and evaluates the available evidence for reducing harm and improving health and well-being for women experiencing IPV in LMICs. This review is limited to females, as global homicide data demonstrate that women's risk of homicide by an intimate partner is 6-fold that of men's (Stöckl et al., 2013). This review is further limited to heterosexual couples; homosexual couples were not intentionally excluded from the analysis, but no studies specific to safety planning for homosexual couples emerged in our search. Drawing primarily on qualitative literature, we assess the reviewed strategies and offer further suggestions to guide IPV prevention and response to service providers, programs, and research in LMICs.

Method

A PubMed search was conducted in March 2017 using the medical subject headings terms "safety," "coping," and "intimate partner violence" for years 2003–2017. Terms "safety" and "coping" were selected based on harm reduction theory and stress and coping theory, respectively (Gielen et al., 2002; Lindhorst et al., 2005; Miller et al., 2017) and based on key words for articles known for inclusion. The search was extended in February 2018 to include "harm reduction" as a search term. From the initial search, 522 potentially relevant studies were identified, and abstracts were reviewed for eligibility. Inclusion criteria comprised qualitative or quantitative research characterizing safety strategies specific to IPV, written in English, and conducted in an LMIC. While the majority of products were qualitative (specifically focus group discussions, in-depth interviews, key informant interviews, or case studies), quantitative articles were also included if they reported on safety planning behaviors and not IPV more broadly within the LMIC. As we aimed to examine strategies applicable for women in ongoing relationships, articles were excluded if they did not include safety strategies used with boyfriends or husbands; several studies reported on harm reduction strategies utilized by female sex workers (FSWs) and more broadly on gender-based violence, however, these strategies were slightly different than those implemented in intimate relationships and therefore excluded. Articles were additionally excluded if they only reported on IPV disclosure and did not mention additional safety steps taken when disclosing violence nor added benefits of engaging with formal or informal networks. Three quantitative studies were conducted in LMICs but used safety measures from UICs; as the goal was the characterize strategies specific to LMICs, these articles were excluded. While IPV can be bidirectional, articles were excluded if they did not focus on men perpetrating violence against their female partners given the increased risk of homicide suffered by females and dearth of data on male IPV victimization in LMICs.

After inclusion criteria were applied, the initial review yielded 67 articles. All remaining articles were downloaded, organized, and reviewed in Mendeley in full by the first author to confirm inclusion criteria. Methodologic quality was determined through descriptions of training of interviewers, sampling, coding of data, and ethical guidelines to ensure participant safety and confidentiality. Four articles were found to fit the inclusion criteria from the initial review. Therefore, reference lists of all initial review publications were further reviewed to ensure that all relevant articles were captured. Twenty-eight potentially relevant articles were retrieved from the references lists and a secondary review was undergone; an additional 12 articles were identified from the secondary review. The integrative review process is outlined in Figure 1.

Integrative review was selected as most appropriate for analysis based on the diversity of articles retained (Whittemore & Knafl, 2005). After selected for inclusion, articles were read by the primary author and data on location, methods, and safety strategies were extracted from the articles (Whittemore, 2005). Upon initial review, data also emerged surrounding reasons why participants did not solicit help from formal services. Therefore, an additional category was added for data extraction of "reflections on formal services" from each article. Strategies were then coded for relevant subthemes, and matrices were constructed by emergent subtheme using constant comparative analysis. Stress and coping and harm reduction theories were applied to guide coding of subthemes (Gielen et al., 2002; Lindhorst et al., 2005; Melendez et al., 2003; Miller et al., 2017; O'Connor et al., 2014). Strategies were included in the analysis if they discussed perceived utility in increasing safety or relationship quality, or in decreasing stress. Strategy subthemes were then aggregated into four larger themes with study details included to identify additional patterns (Table 1). Emergent themes and subthemes were discussed with the authorship team to ensure alignment with relevant theory throughout the analysis process.

Results

The literature search yielded 16 studies examining safety strategies in LMICs using a variety of qualitative and quantitative methods (in-depth interviews, $n = 5$; focus group discussions, $n = 2$; case study, $n = 2$; mixed qualitative methods, $n = 4$; mixed methods, $n = 1$; and semi-structured quantitative survey, $n = 2$); results presented in Table 1. The geography of the safety planning literature was evenly distributed between

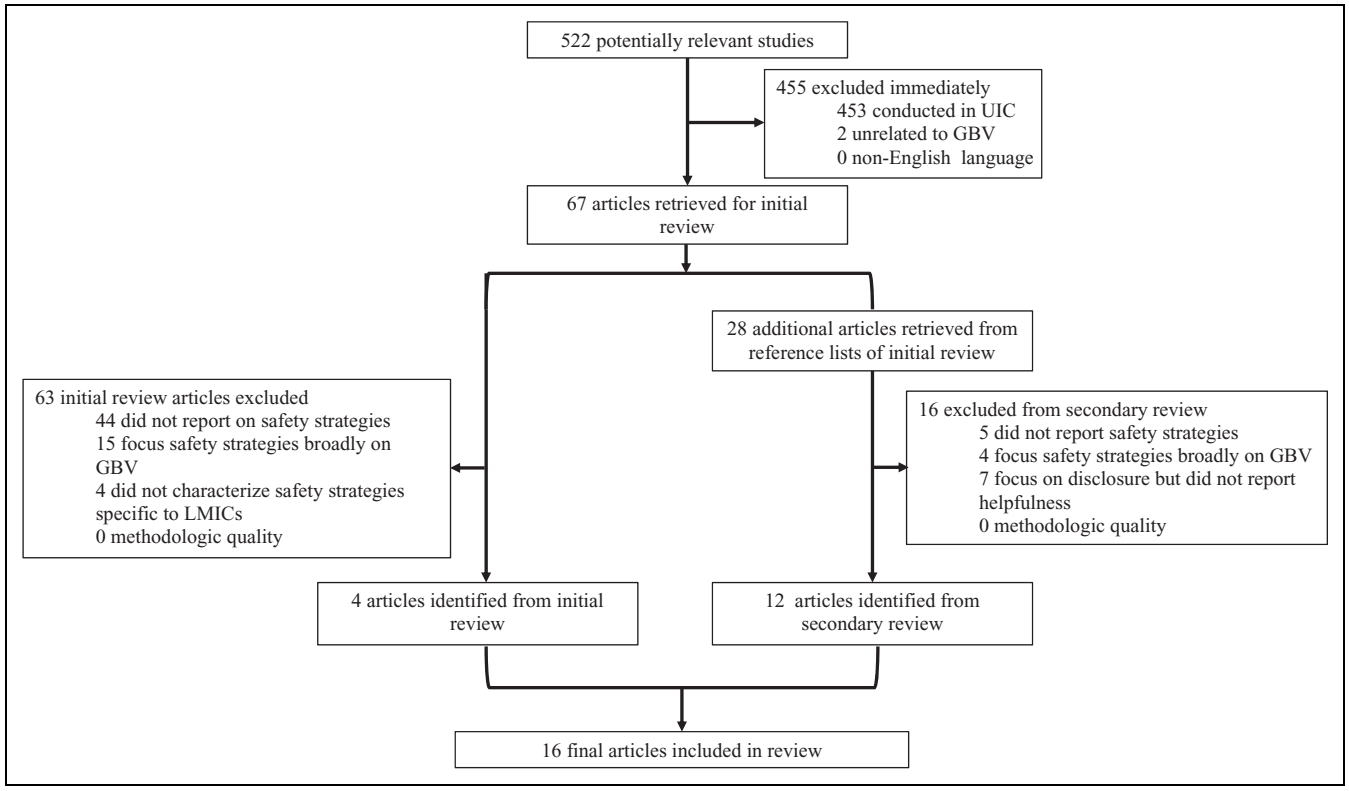

Figure 1. Flowchart of integrative review process.

sub-Saharan African ($n = 8$) and Asia ($n = 7$), with an additional study from Central America (Nicaragua). From these 16 studies, four distinct themes of strategies emerged: engaging informal networks, removing the stressor/avoidance, minimizing the damage through enduring violence, and building personal resources.

Engaging Informal Networks

The first theme engaging informal networks comprised disclosure and counseling primarily from family and friends. While occasionally women confided in their husband's family members, particularly sister-in-laws (Deuba, Mainali, Alvesson, & Karki, 2016; Odero et al., 2014), women usually chose to disclose to their own families, with some even returning to their natal homes for a period of time (Kaye, Ekstrom, Johansson, Bantebya, & Mirembe, 2007; Odero et al., 2014; Ragavan, Iyengar, & Wurtz, 2015). This return to the natal family helped put space between the couple, allowed the woman to seek advice from her family members, and sought to encourage the abusive partner to change his ways (Kohli et al., 2015; Ragavan et al., 2015).

Some studies revealed that discussions with informal networks went as far as to develop detailed safety plans, particularly temporary escape strategies to the confidants' houses (Kaye et al., 2007; Ragavan et al., 2015). Other studies noted that motivation for engagement with informal networks was primarily driven by need for emotional support (Deuba et al., 2016; Horn, Puffer, Roesch, & Lehmann, 2016; Mannell, Jackson, & Umutoni, 2016; Snell-Rood, 2015). One study, in Kenya, noted the need for women to seek emotional support anonymously and therefore utilized social media chat rooms as a confidential peer-counseling service (Gillum, Doucette, Mwanza, & Munala, 2018); however, most women preferred seeking support from someone known and trusted.

Direct intervention with the perpetrator at the height of violence was generally discouraged across studies. One study, in India, reported family and friends occasionally intervening with the perpetrator, either physically or verbally, to reduce harm during acts of violence, but also indicated that these interventions did not decrease future abuse (Decker et al., 2013). Other studies in Kenya and India described that it was viewed as inappropriate for friends or neighbors to intervene given violence was seen as a private matter (Gillum et al., 2018; Snell-Rood, 2015). If family members did intervene, they tried to speak with the partner when he was calm, instead of directly intervening during the violent episode (Decker et al., 2013; Kaye et al., 2007; Ragavan et al., 2015). In Northern India, for example, women practiced a technique called *samjhana*, where the couple would sit with both the husband's and natal families to attempt to make the husband understand the negative effects of his behavior and in turn work to modify them (Ragavan et al., 2015). *Samjhana* was seen as the first step in behavior modification and should be undertaken prior to more drastic measures, such as returning to the natal family or engaging formal help services.

Table 1. Summary of Studies.

Article	Location	Methods	Strategies Utilized	Reflections on Formal Services	EN	RS	MD	BR
Allen and Devitt (2012)	Liberia	Survey of randomly selected women from local market ($n = 229$)	• 35% of women reported obeying and accepting the situation • 16% involved family or community members • 10% reported leaving/separating from her husband either temporarily or permanently	• Few women reported utilizing legal services due to lack of available resources	x	x	x	
Balogun and John-Akinola (2015)	Nigeria	Focus group discussions with 15- to 49-year-olds in Oyo State ($n = 56$)	• Disclosure to in-laws most frequent, but not always the most helpful • Believed that IPV could be prevented through prayers and counseling sessions with religious leaders • Modified behaviors to ensure that they were acting appropriately • As sexual satisfaction was often cause of conflict, they reported giving in whenever he wanted to remove stress	• Reported lack of social services in constraining women from leaving violent relationships	x	x		
Decker et al. (2013)	India	Mixed-methods/in-depth interviews from post-partum women reporting violence from husbands ($n = 32$)	• Use of sexual activity to resolve disputes or avoid conflict • Aimed toward economic independence, however, none had actually achieved • Informal support services from family members and neighbors including food, shelter, and occasional intervention with perpetrator • Crisis counseling with safety planning was deemed most helpful (90% endorsement) from quantitative findings	• Few women knew of formal support services and of those who had sought, many reported negative experiences given police perceptions of violence as a domestic issue • Health services did not emerge during discussions, but quantitative data showed that 68% would want to receive information from a doctor/nurse	x	x		x
Deuba, Mainali, Alvesson, and Karki (2016)	Nepal	In-depth interviews among pregnant women in slums ($n = 20$)	• Sought emotional support from close family members, particularly from sister in-laws, but described need for further social support to decrease IPV experiences • Went to visit their parents during violent episodes to put distance between themselves and partners • Most common coping strategy was tolerance—others fought back or went to open ground outside the house during a violent episode	• No participants reported that they had sought police services—stated police mistrust as the reason	x		x	
Gillum, Doucette, Mwanza, and Munala (2018)	Kenya	Two focus group discussions among females in Nairobi ($n = 19$)	• Many women worked discretely either to reduce economic-related conflict or to build resources to leave the relationship • Some participants reported use of self-defense, especially if alcohol is involved, and discussed this as an empowered response • Selective disclosure to close, trusted friends or to the woman's own parents—in-laws did little to assist	• Many viewed violence as normalized and an unchangeable aspect of Kenyan culture. Violence was viewed as a private matter and community members should not engage in safety strategies within the family • Mediation through chief or police not seen as helpful due to corrupt police system and male-dominated culture. Some women found religious leaders to be helpful confidants • Women had heard of the Gender Violence Recovery Center (medical) but did not know what services they provided	x			x

(continued)

Table 1. (continued)

Article	Location	Methods	Strategies Utilized	Reflections on Formal Services	EN	RS	MD	BR
Horn, Puffer, Roesch, and Lehmann (2016)	Sierra Leone and Liberia	Focus group discussions ($n = 110$) and in-depth interviews ($n = 20$)	• Neighbors were responders at height on conflict to try to stop the violence or advise the couple • Relied heavily on both natal family members and in-laws for mediation and emotional assistance once free from immediate threat of violence—families were seen as most effective even if husband's family was more likely to align with the husband • If violence did not cease, women's family could take her home as a temporary solution • Earning own income provided women with increased options and could decrease violence	• Formal services were only sought when family was not available—typically sought NGOs for GBV survivors or section chiefs • Chiefs had little enforcement power but were seen as effective mediators. • Local Women's Action Groups were able to use collective power to confront perpetrator • Reporting to police was seen as risky given that most men would elect to end the relationship after charges were pressed and courts viewed as corrupt • Even with access to formal resources, women preferred to utilize strategies that allowed them to remain in their relationships	x			x
Kaye, Ekstrom, Johansson, Bantebya, and Mirembe (2007)	Uganda	In-depth interviews among pregnant adolescent domestic violence survivors ($n = 16$)	• Strategies to minimize damage (placating behavior, keeping silent, distraction, feigning sickness, or self-protection) used to prevent arguments from occurring or stop fights once they had begun • Withdrawal from relationship temporarily to live with relatives or situationally fled to neighbors' house if partner was drunk • Retaliation strategies included fighting back, seeking reprimanding from police or local authority member, or destroying property	• Reaching out to health workers, local counsel leaders, and religious leaders with the intent of retribution had mixed-effects	x		x	
Kohli et al. (2015)	DRC	In-depth interviews with female survivors and male perpetrators ($n = 13; 5$)	• Use of placating behaviors (not responding to insults, abiding by husband's needs, meeting household demands) and demonstrating submission • Women leave or send their children out of the house during violent acts • Husband's parents were the first sought marital advisors—if they did not help then they sought advice from other informal sources (wife's family, religious leaders, chiefs, respected members of community) • Temporary separation by staying at in-laws or parents' home occurred, but prolonged periods were not preferred due to fears of losing children or other partners	• Traditional community resources, particularly counseling by chief, were not as common due to lack of trust • Legal resources were unpopular due to adverse familial impact	x	x	x	

(continued)

Table 1. (continued)

Article	Location	Methods	Strategies Utilized	Reflections on Formal Services	EN	RS	MD	BR
Mannell, Jackson, and Umutoni (2016)	Rwanda	Semi-structured interviews with women experiencing violence and focus group discussions with community members ($n = 39$)	• Strategies to "fight back" included behaving differently, getting a job, threatening police action, and leaving the relationship • Behaving differently included managing emotions to calm the situation • Many women chose to remain silent and persevere because this allowed them some control over the situation • Sources of emotional support included groups of women experiencing IPV, prayer and religious groups, and friends or neighbors	• Police were considered responsive, as were GBV community committees, however, reporting was particularly difficult due to social constraints and stigma • Government would only intervene when the couple was married; otherwise, local leaders or family members would mediate	x	x	x	x
Odero et al. (2014)	Kenya	Focus group discussions and in-depth interviews with pregnant women, male partners, and service providers ($n = 20$)	• Do nothing (stay silent), return home to stay with maternal family, discuss with partner's family, report to community structures (clan elders) • Pastors offered couple's counseling	• Clinic was typically first point of contact with formal services • Other lesser-utilized options included reporting to police, pressing charges, and getting support from NGOs after informal services failed	x		x	
Panchanadeswaran and Koverola (2015)	India	Semi-structured, interviewer-administered questionnaire ($n = 90$)	• 83% reported seeking refuge at neighbors or natal parent's homes after violent incident; families were only seen as moderately useful • 28% fought back verbally, though this often led to more severe violence • One third of women sought employment to provide financial support and help with strain caused by fleeing homes for temporary periods of time	• Seeking help from informal sources often continued for several years before women were comfortable seeking formal services • 66% of women who sought police help reported this help as being useless—women noted needing more concrete assistance for protection, vocational training, and shelter • State-run counseling centers, however, proved very useful in providing women with advice and helping them reach turning point	x			x
Puri, Tamang, and Shah (2011)	Nepal	In-depth case stories with women 15–24 years ($n = 15$)	• Avoided situations where husbands might be more likely to use sexual violence against them • Recognition that partners were less likely to be sexually violent if a child was in bed with them and therefore would hold a child or sleep with a child as an avoidance strategy • Make noise or scream within the act, however, neighbors unlikely to respond • Feigned sickness or menstruation to avoid sexual violence	• No women in the study had ever sought formal services and some were disclosing sexual violence for the first time within the interview			x	

(continued)

Table 1. (continued)

Article	Location	Methods	Strategies Utilized	Reflections on Formal Services	EN	RS	MD	BR
Ragavan, Iyengar, and Wurtz (2015)	India	Semi-structured interviews with community members ($n = 56$ women, 52 men) and key informants ($n = 7$)	• Bore abuse if it was infrequent or if it is justified • *Samjhana* (make the husband understand) the negative effects of his behaviors • Return to natal family for a short time to encourage husband to think about his actions • Nata (remarriage) could occur if she had exhausted other resources but could have negative social effects	• Informal justice system (jati-Panchayat) make village decisions, including marital advice, fining or stigmatization of husband, or sending a woman to her natal home, though many women suggested that this system did not provide justice for victims • Police and NGOs were seen as socially inappropriate	x		x	
Salazar, Högberg, Valladares, and Ohman (2012)	Nicaragua	In-depth interviews among women who reported IPV during pregnancy ($n = 27$)	• Temporary separation, building own personal resources and social networks • Economic empowerment and resources shifted power	• Women spoke of turning to NGOs and religious organizations, as well as participation in gender workshops • Rural women noted having less access to police and health services than urban women			x	x
Schuler, Bates, and Islam (2008)	Bangladesh	In-depth interview and focus group discussions with women and men ($n = 110$ IDIs, 16 small group discussions)	• Most used strategy was trying to conform to husband's demands (housework, dowry/economic assistance) • In-laws were known to ignore violence perpetrated by their sons and passive intervention made the violence worse • Fleeing to natal families created pressure for husband to modify his behavior	• Women believed that they did not have any formal rights to their children and therefore did not wish to seek divorce. • Threatening formal court cases more common than actually seeking • The informal justice system, *shalish*, was dominated by men seen as corrupt; women avoided because they were too poor	x	x		
Snell-Rood (2015)	India	Case studies from 10 families	• Hesitantly sought support from closest neighbors for infrequent, immediate needs but did not fully disclose • Families were viewed as a more viable support option; discussions around maintaining family relationships • Neighbors discussed risk in helping women who may not be viewed favorably	• Police or mahila panchayat (women's counsel) were not viewed as suitable options for IPV support due to corruption	x			

Note. EN = engaging informal networks; RS = removing the stressor; MD = minimizing damage; BR = building personal resources; NGO = nongovernmental organization; IPV = intimate partner violence; GBV = gender-based violence.

The motivation for seeking informal networks over formal justice or support systems was fairly consistent across settings: Most women believed that formal systems, particularly police and legal services, were ineffective or that utilization would worsen the violence (Decker et al., 2013; Gillum et al., 2018; Kaye et al., 2007; Mannell et al., 2016; Odero et al., 2014; Ragavan et al., 2015; Salazar, Högberg, Valladares, & Ohman, 2012). Only one studied reported lack of awareness of formal support services as a rationale for not accessing services (Decker et al., 2013). Discussions with informal networks, however, often centered on the need for additional social services, such as shelter or counseling. Some women preferred to end help-seeking with telling a trusted friend or family member, but for many, engaging the informal network was the first step toward seeking formal services (Deuba et al., 2016).

Removing the Stressor/Avoidance

The second group of safety strategies, removing the stressor, first involved the identification of stressors, followed by active behavior change strategies to mitigate the stressor and subsequently minimize violence and reduce harm. Stress removing behaviors were used either to prevent arguments from happening or prevent escalation of violence once a fight commenced, but all involved active choices made by women to remove the source of conflict in hope of decreasing violence. These behaviors varied widely depending on the context of violence and strength/length of the relationship from abiding by husband's needs and meeting household demands to taking good care of the children (Balogun & John-Akinola, 2015; Decker et al., 2013; Kaye et al., 2007; Kohli et al., 2015; Mannell et al., 2016). Women believed that violence was triggered if they failed in their spousal duties; therefore, they did everything possible to ensure that their partner was happy and demonstrate submission (Kohli et al., 2015; Schuler, Bates, & Islam, 2008). Strategies in this category included the use of sex to resolve disputes, especially if this was a point of contention and abstaining was felt to increase risk of abuse (Balogun & John-Akinola, 2015; Decker et al., 2013).

This section additionally included avoidance behaviors, where women tried to actively avoid the situation altogether to prevent violence from occurring. Temporarily leaving the house was commonly discussed, as was temporary separation, where the woman would go to a family member's house for an extended period of time. One study, specific to sexual violence, mentioned avoidance techniques when women thought that violence was inevitable, including holding children/putting them in their bed at night to put space between them and the partner or feigning menstruation (Puri, Tamang, & Shah, 2011). These avoidance techniques appeared helpful at least temporarily, though they were specific to sexual violence. The role of alcohol in increasing violence was also mentioned throughout, with some women seeking informal help or leaving the household in advance if they knew that alcohol use by the husband would trigger conflict and violence (Gillum et al., 2018; Kaye et al., 2007).

Minimizing Damage by Enduring Violence

The third theme involved minimizing the damage of violence through enduring. These strategies focused on passive endurance techniques; women described that the best safety strategy was to tolerate the violence and not do anything to actively put them or their children at increased risk of violence (Deuba et al., 2016; Kaye et al., 2007; Odero et al., 2014; Ragavan et al., 2015). All of the studies in this category mentioned the flaws within the formal justice system and even exacerbation of violence when seeking assistance (Deuba et al., 2016; Kaye et al., 2007; Odero et al., 2014; Ragavan et al., 2015).

Some women who first opted to passively endure noted that violence could only be endured until a certain point before seeking help. Turning points for disclosure or seeking formal services included abuse of children, public or particularly severe abuse, or abuse that they found unjustifiable (occurring daily or when he was not drunk; Panchanadeswaran & Koverola, 2005; Puri et al., 2011; Ragavan et al., 2015). After experiencing turning points, women indicated that they were more likely to modify strategies and shift from enduring and avoidance to more overt defense strategies, such as physically or verbally fighting back, though these strategies were not viewed as any more effective (Salazar et al., 2012). Most women, however, believed that violence would subside over time with the use of previously mentioned stress removing and avoidance techniques.

Building Personal Resources

The final category that emerged from the safety strategy review was building personal resources. Here, women focused on empowerment through building economic and financial resources in order to either secure means to escape violence (Gillum et al., 2018) or shift power dynamics within their relationship (Salazar et al., 2012). Studies noted the failed role of mediation within communities and the need for economic empowerment within male-dominated societies, particularly for women with sustained IPV (Gillum et al., 2018; Salazar et al., 2012).

Discussion

The vast majority of evidence on IPV-related safety strategies in LMICs emerged from qualitative studies. Two of the examined studies utilized semi-structured quantitative surveys; another was a mixed-methods studies that employed both in-depth interviews and quantitative approaches (Allen & Devitt, 2012; Decker et al., 2013; Panchanadeswaran & Koverola, 2005). While these studies were helpful in reporting help-seeking and coping behaviors, they primarily relied on the open-ended nature of the questions to qualify experiences. These studies, in addition to the other reviewed studies, report the nuances of implementation of a variety of safety strategies, as well as feasibility and acceptability of harm reduction approaches within their respective communities.

The IPV-related safety and harm reduction strategies described by women in LMICs were heterogeneous and dependent on setting, cultural norms, strength of informal networks, and intensity and duration of sustained abuse. No distinct differences in safety strategies utilized emerged in one setting versus another. For example, women in Asia used very similar strategies to women in sub-Saharan Africa. However, in both Kenya and India, the only countries from which both urban and rural studies were included, women in urban settings appear to feel more comfortable seeking help from informal or known formal sources (Decker et al., 2013; Gillum et al., 2018; Odero et al., 2014; Panchanadeswaran & Koverola, 2005; Ragavan et al., 2015; Snell-Rood, 2015). Across urban and rural settings in South Asia, sub-Saharan Africa, and Nicaragua, safety strategies appear to be highly acceptable, dynamic, and results demonstrate that multiple strategies may be implemented at one time (e.g., disclosing to friend for support and placating the behavior of the husband). Women are not passive observers in safety planning. For example, in Nicaragua, women highlight the desire to "fight back" against the violence and detail the importance of economic empowerment as acceptable to women who have tried multiple strategies (e.g., disclosing to family/friends, placating, enduring) and would like to mobilize additional resources to strengthen their ability to protect themselves and their children (Gillum et al., 2018; Kaye et al., 2007; Mannell et al., 2016). As noted, safety strategies are dynamic and change as the relationship evolves and the abuse increases or decreases. For some women, the best tactics were more covert strategies such as avoiding, modifying behaviors, or removing stressors; even endurance strategies to minimize the damage were seen to increase safety. For other women, tactics were much more overt and included engagement with formal system or economic networks. Whether overt or covert strategies were adopted, all behaviors involved active decision-making to help increase safety and minimize harm.

The reviewed IPV safety strategies in LMICs differed in comparison to typically considered safety strategies in UICs. In LMICs, there was a particular focus on staying rather than leaving strategies, with women choosing to take action by engaging informal support services, changing the behaviors that they perceive as causing conflict with partner, and enduring violence in place of dissolution of the relationship. Differences in women's equality rooted in sociocultural values (Carter, 2015), and the availability of formal support services (Colombini & Watts, 2008) likely account for observed differences. Furthermore, legal constraints in LMICs include not only the absence of enforcement of laws to protect women but also insufficient implementation of response systems by police and community leaders. Even in settings where sexual violence is criminalized, there is often limited support from both men and women for criminalizing sexual violence within marriage (United Nations Entity for Gender Equality and the Empowerment of Women [UN Women], 2015), hindering women from help-seeking in formal settings. Furthermore, economic dependence and community norms, often deeply embedded in the patriarchal societies, may further prevent women within violent relationships from disclosing their experiences or seeking formal support services (McCleary-Sills et al., 2016; Njuki et al., 2012). Active staying strategies particularly relied on removing sources/triggers of conflict or avoiding violent situations altogether. However, many women felt that the best form of harm reduction was persevering to avoid heightened conflict that may come with initiation of active strategies. These resistance techniques have also been adopted in UIC contexts when women are unable to leave violent relationships, have limited social support, or may have tried an active strategy that increased violence (E. M. Parker & Gielen, 2014). Further work should examine the utility of passive resistance in LMICs, as well as integration with active strategies if the woman's situation permits.

Consistent with global data, women chose to first disclose to informal networks (WHO, 2005). The usefulness for decreasing violence through the engagement of informal networks varied drastically situationally and across settings. In Bangladesh, for example, results highlight in-laws' favoritism of sons and ignorance of spousal abuse, with disclosure oftentimes increasing violence within the household (Schuler et al., 2008). Conversely, the Ragavan study in Northern India noted the utility of informal networks due to their involvement in *samjhana*, where family was brought in to formally intervene directly with the couple, allowing them to reflect on the issues and problem-solve together (Ragavan et al., 2015). This study noted limitations in this method, however, as many women still left home for a short period of time if their relationships did not improve. Several studies, however, mentioned that the value in engaging formal networks was much more than a disclosure and was the first step in help-seeking (Balogun & John-Akinola, 2015; Decker et al., 2013; Deuba et al., 2016; Kohli et al., 2015; Odero et al., 2014). Results further uncovered that women wanted more concrete advice from informal networks than they were receiving. These discussions with informal networks, therefore, often served as a gateway to seeking formal health and justice services. Given the mixed results for helpfulness of engaging informal networks, trained counselors and community health workers may be best positioned to bridge the gap between informal and formal sectors given the confidentiality of their services and referrals to services. Community health workers and lay professions could be trusted supports for violence provided that they have sufficient training. Additional work should examine integration of safety strategies with counseling and crisis support services, which may be more effective in increasing safety behaviors than engaging informal networks, but are rarely available and underutilized in LMICs.

Perceived or real barriers for women to seek formal services, such as lack of confidentiality, victim blaming, lack of awareness of services, and limited capacity of service providers need to be addressed prior to women embracing formal support services in favor of informal networks (Decker et al., 2013; Gillum et al., 2018; Horn et al., 2016; Kaye et al., 2007; Mannell et al., 2016; Odero et al., 2014; Ragavan et al., 2015). Justice systems were largely seen as ineffective and few women discussed seeking health services for IPV. In Nepal, police

mistrust was stated as the reason for low uptake of formal justices services (Deuba et al., 2016). Similarly in Kenya, the chief and police systems were viewed as corrupt, with underlying male dominance preventing survivors from obtaining adequate legal or health services (Gillum et al., 2018). Privacy was highly valued across contexts, with the Kenyan study additionally reporting the utilization of online and anonymous chat rooms to ensure anonymity of participants seeking counseling (Gillum et al., 2018). Two studies in India reported on the use and impact of seeking help from counseling and crisis centers and found that women who sought these services received concrete advice and resources and encouraged them toward an emotional turning point, including leaving the abusive relationship (Decker et al., 2013; Panchanadeswaran & Koverola, 2005). While the justice response remains limited, this review highlights that formal medical or counseling services could be effective avenues for implementation in LMICs. To be most useful, however, service providers must adopt survivor-centered approaches, ensure confidentiality, offer concrete advice, and build appropriate linkages with social services (Watts & Mayhew, 2004). Moreover, given the highlighted gap surrounding safety planning that addresses forced sex by an intimate partner in LMICs, safety planning messaging integrated into sexual and reproductive health services be an effective avenue to protect women while positively impacting health outcomes (Callands, Sipsma, Betancourt, & Nathan, 2013).

Results further indicate that most women did not want to or could not leave their current relationship. From a programmatic standpoint, support services and community organizations must ensure that recommended safety strategies are tailored to women's lives to maximize safety for the woman and children. Safety planning strategies can have serious ramifications—strategies such as reaching out to friends and family for support could intensify violence depending on setting/situation. Strategies can also leave women at risk of violence if they choose to endure or work to minimize the damage in favor of active help-seeking. The reviewed literature highlights the importance of working with women, survivors of IPV, and informal and formal services to examine feasibility and acceptability safety planning in programmatic scale-up. Foremost, adequate formative research and pilot testing should advise safety planning strategies in any setting, given that some strategies may be helpful in some settings and a hindrance in other settings. Particularly, the involvement of friends, extended family or others in the community (e.g., religious leaders, health provider, police officers) without integration of normative work can be challenging and potentially dangerous in settings where privacy and dignity of family is highly valued (Gillum et al., 2018). The literature further highlights the differential effects of family, particularly in-laws, and the protective or harmful nature of their involvement differs across settings (Deuba et al., 2016; Horn et al., 2016). While *samjhana* was incredibly helpful for women in Northern India, studies in East Africa and Bangladesh particularly underscore strong family alignment and likelihood to ignore violence perpetrated by their sons (Ragavan et al., 2015; Schuler et al., 2008). Social norms change programs integrated into community dialogues and service provision have the potential to advance confidence and help-seeking in formal services and reduce norms associated with victim blaming, husbands' rights to use spousal violence as disciplinary, and the protection of privacy and family dignity over the safety of women and children.

As demonstrated by the reviewed studies, women utilize a plethora of strategies to reduce harm and maximize safety; however, there is little evidence supporting their effectiveness in reducing further violence and mitigating health consequences within these settings. The limited evidence that does exist to support safety planning strategies is entirely from UICs, where several strategies have been found to be promising in increasing safety behaviors in a wide variety of contexts, though often require formal support structures (Goodkind et al., 2004; Goodman et al., 2003, 2005; Mcfarlane et al., 1998, 2002, 2004; B. Parker et al., 1999; E. M. Parker & Gielen, 2014). This review of safety strategies utilized within LMICs equips researchers with a better understanding of the employed strategies. Furthermore, it positions them to study the effectiveness of these strategies in increasing women's safety and well-being. Future research should aim to quantify the feasibility, uptake, and effectiveness of these strategies within settings where formal support services may not be obtainable or when seeking these services may intensify violence. The qualitative evidence provides insight into the acceptability of these site-specific strategies, but the effectiveness of these tactics in preventing further harm and improving health should be quantified to inform policy and scale-up. Suggestions to guide IPV prevention and response to service providers, programs, and research in LMICs are outlined in Table 2.

Limitations of this review include that it was limited to safety strategies among cis-gendered females with heterosexual intimate partners given the available body of research. Furthermore, we narrowed the inclusion criteria to limit intimate partners to husbands and boyfriends. An additional body of literature addresses IPV in LMICs among men, FSWs, and gender minorities; further research should address the dearth of literature surrounding safety planning in both LMICs and UICs for these subpopulations. These inclusion criterion, as well as limiting articles to English language, and non-grey literature, may impact the diversity of the articles that were examined.

Given the substantial overlap in strategies presented across geoculturally diverse LMICs contexts, we further recommend that a formal set of strategies be created and then adapted for specific contexts after substantial formative work and pilot testing. This comprehensive checklist could include any strategy included in this review found helpful by women to increase safety and would draw on the literature particular to LMICs rather than the safety planning strategies implemented within UICs, given sociocultural and legal constraints faced by women in LMICs. Additionally, strategies found highly effective in UICs may not be relevant to the violence that women face in LMICs, particularly strategies surrounding gathering personal records or focused on leaving the relationship. We recommend

Table 2. Implications of Findings for Practice, Policy, and Research.

Finding	Implication
Practice	
• Women utilize several strategies, often simultaneously, to maximize safety; employed strategies varied depending on duration and intensity of abuse, as well as strength of informal networks	• No single option should be recommended, and women should be given several choices for safety planning; recommended strategies must be tailored to women's lives
• Strategies differ substantially from UIC contexts to focus further on harm reduction and maximizing safety when remaining within the relationship	• Standard safety planning lists used in UICs should not be utilized in LMICs; LMICs should adapt their own set of safety strategies to be adapted situationally
• Disclosure to an informal source was often the first step in help-seeking as women often wanted more concrete advice from their informal networks	• Trained counselors and community workers may be best positioned to bridge the gap between formal and informal sectors
• Privacy was highly valued in these contexts	• Anonymous help lines and crisis counselling may be a viable response option
Policy	
• Women were not passive observers and took active steps to reduce harm and enhance safety	• The implementation of safety planning into standard practice policies should be explored
• Justice systems were seen as largely ineffective and mistrust was cited as reason for low uptake of formal justice services	• Justice response must be addressed and normative work should be further integrated to assist women in help-seeking
Research	
• There was substantial overlap in strategies utilized across LMICs, and these strategies were seen as feasible and acceptable to women	• Future studies should aim to quantify the feasibility and acceptability of strategies used within settings where formal support services are unavailable or underutilized
• No studies have evaluated the effectiveness of safety planning strategies specific to LMICs	• Further research is needed to understand the effectiveness of safety planning strategies in increasing women's safety and well-being in the short- and long term
• Many women felt that the best form of harm reduction was perseverance	• A better understanding of the impact and effectiveness of passive resistance is needed

Note. UICs = upper-income countries; LMICs = low- and middle-income countries.

that this set of strategies is comprehensive in order to be applicable to a variety of settings and given that the usefulness and effectiveness of these strategies will likely vary situationally and regionally. This set of strategies could then serve as a basis for further adaption for context-specific constraints and response. In turn, it would help programs and research understand how common and useful strategies are within a given context. In UICs, these checklists have been found to be helpful in identifying women most at risk of injury and can help practitioners ascertain women that may need additional counseling (Snider, Webster, O'Sullivan, & Campbell, 2009). After adaptation to a context, this set of strategies could then be used to make recommendations for tailored personal safety strategies. While a general list is helpful to assess safety and increase safety monitoring efforts, recommended strategies should be tailored to women's individual needs in order to highlight the complex situations and differing priorities of women facing violence from an intimate partner (Lindhorst et al., 2005).

Conclusion

IPV-related safety and harm reduction strategies employed by women in LMICs differ substantially from those utilized in UICs, with results highlighting staying rather than leaving strategies and reluctance to engage with the limited formal services that exist given cultural constraints in severing the relationship. Future research should focus on the effectiveness of the highlighted strategies, as well as the feasibility, acceptability, and effectiveness of a comprehensive set of safety planning strategies that is generalizable to women across lesser developed settings. Additional programmatic work is needed to examine integration with counseling support and medical services, which may be more effective in increasing safety behaviors than engaging informal networks. Although cultures vary drastically, these results highlight that globally women are strategically planning solutions to minimize abuse to themselves and their children. They recognize that they are not responsible for the abuse and take overt or covert steps to reduce harm. Women may not be able to leave the confines of their marriage or relationship, but they are able and interested in employing tactics that can help shift the power balance within their relationship and begin to enhance safety and healing.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This review was supported by a grant from Ideas42 to Dr. Michele R. Decker.

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References

References marked with an asterisk indicate studies included in the meta-analysis.

*Allen, M., & Devitt, C. (2012). Intimate partner violence and belief systems in Liberia. *Journal of Interpersonal Violence*, *27*, 3514–3531. doi:10.1177/0886260512445382

*Balogun, M., & John-Akinola, Y. O. (2015). A qualitative study of intimate partner violence among women in Nigeria. *Journal of Interpersonal Violence*, *30*, 2410–2427. doi:10.1177/0886260514553112

Bermea, A. M., Khaw, L., Hardesty, J. L., Rosenbloom, L., & Salerno, C. (2017). Mental and active preparation: Examining variations in women's processes of preparing to leave abusive relationships. *Journal of Interpersonal Violence*, 1–24. doi:10.1177/0886260517692332

Callands, T. A., Sipsma, H. L., Betancourt, T. S., & Nathan, B. (2013). Experiences and acceptance of intimate partner violence: Associations with sexually transmitted infection symptoms and ability to negotiate sexual safety among young Liberian women. *Culture, Health & Sexuality*, *15*, 680–694. doi:10.1080/13691058.2013.779030

Campbell, J. C. (2001). Safety planning based on lethality assessment for partners of batterers in intervention programs. *Journal of Aggression, Maltreatment, & Trauma*, *5*, 129–143.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet*, *359*, 1331–1336. doi:10.1016/S0140-6736(02)08336-8

Carter, J. (2015). Patriarchy and violence against women and girls. *Lancet*, *385*, e40–e41.

Chamberlain, B. L., & Levenson, R. (2012). *Addressing intimate partner violence, reproductive and sexual coercion: A guide for obstetric, gynecologic and reproductive health care settings* (2nd ed.). Retrieved from http://www.acog.org/About_ACOG/ACOG_Departments/Violence_Against_Women/w/media/Departments/Violence%20Against%20Women/Reproguidelines.pdf

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine*, *23*, 260–268. doi:10.1016/S0749-3797(02)00514-7

Coker, A. L., Smith, P. H., Whitaker, D. J., Le, B., Crawford, T. N., & Flerx, V. C. (2012). Effect of an in-clinic IPV advocate intervention to increase help seeking, reduce violence, and improve well-being. *Violence Against Women*, *18*, 118–131. doi:10.1177/1077801212437908

Colombini, M., & Watts, C. (2008). Health-sector responses to intimate partner violence in low- and middle-income settings: A review of current models, challenges and opportunities. *Bulletin of the World Health Organization*, *86*, 635–642. doi:10.2471/BLT.07.045906

*Decker, M. R., Nair, S., Saggurti, N., Sabri, B., Jethva, M., Raj, A., … Silverman, J. G. (2013). Violence-related coping, help-seeking and health care–based intervention preferences among perinatal women in Mumbai, *India.* Journal of Interpersonal Violence, *28*, 1924–1947. doi:10.1177/0886260512469105

*Deuba, K., Mainali, A., Alvesson, H. M., & Karki, D. K. (2016). Experience of intimate partner violence among young pregnant women in urban slums of Kathmandu Valley, Nepal: A qualitative study. *BMC Women's Health*, *16*, 11. doi:10.1186/s12905-016-0293-7

Devries, K. M., Mak, J. Y. T., García-Moreno, C., Petzold, M., Child, J. C., Falder, G., … Watts, C. H. (2013). The global prevalence of intimate partner violence against women. *Science*, *340*, 1527–1528. doi:10.1126/science.1240937

Eden, K. B., Perrin, N. A., Hanson, G. C., Messing, J. T., Bloom, T. L., Campbell, J. C., … Glass, N. E. (2015). Use of online safety decision aid by abused women: Effect on decisional conflict in a randomized controlled trial. *American Journal of Preventive Medicine*, *48*, 372–383.

Ellsberg, M., Arango, D. J., Morton, M., Gennari, F., Kiplesund, S., Contreras, M., & Watts, C. (2015). Prevention of violence against women and girls: What does the evidence say? *The Lancet*, *385*, 1555–1566. doi:10.1016/S0140-6736(14)61703-7

Ellsberg, M., Jansen, H. A. F. M., Heise, L., Watts, C. H., & García-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet*, *371*, 1165–1172. doi:10.1016/s0140-6736(08)60522-x

Garcia-Moreno, C., Jansen, H. a F. M., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *The Lancet*, *368*, 1260–1269. doi:10.1016/S0140-6736(06)69523-8

Gielen, A. C., Mcdonnell, K. A., & Campo, P. J. O. (2002). Intimate partner violence, HIV status, and sexual risk reduction. *AIDS and Behavior*, *6*, 107–116.

*Gillum, T. L., Doucette, M., Mwanza, M., & Munala, L. (2018). Exploring Kenyan women's perceptions of intimate partner violence. *Journal of Interpersonal Violence*, *33*(13), 2130–2154. doi:10.1177/0886260515622842

Glass, N. E., Perrin, N. A., Hanson, G. C., Bloom, T. L., Messing, J. T., Clough, A. S., … Eden, K. B. (2017). The longitudinal impact of an internet safety decision aid for abused women. *American Journal of Preventive Medicine*, *52*, 606–615.

Gondolf, E. W., & Fisher, E. R. (1988). *Battered women as survivors: An alternative to treating learned helplessness*. Lexington, MA: Lexington Book.

Goodkind, J. R., Sullivan, C. M., & Bybee, D. I. (2004). A contextual analysis of battered women's safety planning. *Violence Against Women*, *10*, 514–533. doi:10.1177/1077801204264368

Goodman, L., Dutton, M. A., Vankos, N., & Weinfurt, K. (2005). Women's resources and use of strategies as risk and protective factors for reabuse over time. *Violence Against Women*, *11*, 311–336. doi:10.1177/1077801204273297

Goodman, L., Dutton, M. A., Weinfurt, K., & Cook, S. (2003). The intimate partner violence strategies index: Development and application. *Violence Against Women*, *9*, 163–186. doi:10.1177/1077801202239004

Hayes, B. E. (2013). Women's resistance strategies in abusive relationships: An alternative framework. *SAGE Open*, *3*, 1–10. doi:10.1177/2158244013501154

Heise, L. L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women*, *4*, 262–290.

*Horn, R., Puffer, E., Roesch, E., & Lehmann, H. (2016). "I don't need an eye for an eye": Women's responses to intimate partner violence in Sierra Leone and Liberia. *Global Public Health*, *11*, 108–121. doi:10.1080/17441692.2015.1032320

*Kaye, D. K., Ekstrom, A. M., Johansson, A., Bantebya, G., & Mirembe, F. M. (2007). Escaping the triple trap: Coping strategies of pregnant adolescent survivors of domestic violence in Mulago hospital, Uganda. *Scandanavian Journal of Public Health*, *35*, 180–186. doi:10.1080/14034940600858490

*Kohli, A., Perrin, N., Mitima, R., Banywesize, L., Bacikenge, A., Heri, J., & Murhula, C. (2015). Family and community driven response to intimate partner violence in post-conflict settings. *Social Science & Medicine*, *146*, 276–284. doi:10.1016/j.socscimed.2015.10.011

Lindhorst, T., Nurius, P., & Macy, R. J. (2005). Contextualized assessment with battered women: Strategic safety planning to cope with multiple harms. *Journal Social Work Education*, *41*, 331–352.

*Mannell, J., Jackson, S., & Umutoni, A. (2016). Women's responses to intimate partner violence in Rwanda: Rethinking agency in constrained social contexts. *Global Public Health*, *11*, 65–81. doi:10.1080/17441692.2015.1013050

McCleary-Sills, J., Namy, S., Nyoni, J., Rweyemamu, D., Salvatory, A., Steven, E., … Rweyemamu, D. (2016). Stigma, shame and women's limited agency in help-seeking for intimate partner violence. *Global Public Health*, *11*, 224–235. doi:10.1080/17441692.2015.1047391

McFarlane, J., Malecha, A., Gist, J., Watson, K., & Batten, E. (2002). An intervention to increase safety behaviors of abused women: Results of a randomized clinical trial. *Nursing Research*, *51*, 347–354.

McFarlane, J., Malecha, A., Gist, J., Watson, K., Batten, E., Hall, I., & Smith, S. (2004). Increasing the safety-promoting behaviors of abused women. *American Journal of Nursing*, *104*, 40–50.

McFarlane, J., Parker, B., Soeken, K., Silva, C., & Reel, S. (1998). Safety behaviors of abused women after an intervention during pregnancy. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *27*, 66–69.

Melendez, R. M., Hoffman, S., Exner, T., Leu, C.-S., & Ehrhardt, A. a. (2003). Intimate partner violence and safer sex negotiation: Effects of a gender-specific intervention. *Archives of Sexual Behavior*, *32*, 499–511. doi:10.1023/A:1026081309709

Messing, J. T., O'Sullivan, C. S., Cavanaugh, C. E., Webster, D. W., & Campbell, J. (2017). Are abused women's protective actions associated with reduced threats, stalking, and violence perpetrated by their male intimate partners? *Violence Against Women*, *23*, 263–286. doi:10.1177/1077801216640381

Miller, E., McCauley, H. L., Decker, M. R., Levenson, R., Zelazny, S., Jones, K. A., … Silverman, J. G. (2017). Implementation of a family planning clinic-based partner violence and reproductive coercion intervention: Provider and patient perspectives. *Perspectives on Sexual and Reproductive Health*, *49*, 85–93. doi:10.1007/s12026-008-8082-5.Thymus

Njuki, R., Okal, J., Warren, C. E., Obare, F., Abuya, T., Kanya, L., … Askew, I. (2012). Exploring the effectiveness of the output-based aid voucher program to increase uptake of gender-based violence recovery services in Kenya: A qualitative evaluation. *BMC Public Health*, *12*, 426.

O'Connor, E., Lin, J. S., Burda, B. U., Henderson, J. T., Walsh, E. S., & Whitlock, E. P.(2014). Behavioral sexual risk-reduction counseling in primary care to prevent sexually transmitted infections: An updated systematic evidence review for the U.S. Preventive Services Task Force. Evidence Synthesis No. 114. AHRQ Publication No. 13-05180-EF-1. Rockville, MD: Agency for Healthcare Research and Quality.

*Odero, M., Hatcher, A. M., Onono, M., Romito, P., Bukusi, E. A., & Turan, J. M. (2014). Responses to and resources for intimate partner violence: Qualitative findings from women, men, and service providers in rural Kenya. *Journal of Interpersonal Violence*, *29*, 783–805. doi:10.1177/0886260513505706

*Panchanadeswaran, S., & Koverola, C. (2005). The voices of battered women in India. *Violence Against Women*, *11*, 736–758. doi:10.1177/1077801205276088

Parker, B., McFarlane, J., Soeken, K., Silva, C., & Reel, S. (1999). Testing an intervention to prevent further abuse to pregnant women. *Research in Nursing & Health*, *22*, 59–66.

Parker, E. M., & Gielen, A. C. (2014). Intimate partner violence and safety strategy use: Frequency of use and perceived effectiveness. *Women's Health Issues*, *24*, 584–593. doi:10.1016/j.whi.2014.08.001

Parker, E. M., Gielen, A. C., Castillo, R., Webster, D. W., & Glass, N. (2016). Intimate partner violence and patterns of safety strategy use among women seeking temporary protective orders: A latent class analysis. *Violence Against Women*, *22*, 1663–1681. doi:10.1177/1077801216631436

Puddy, R. W., & Wilkins, N. (2011). *Understanding Evidence Part 1: Best Available Research Evidence. A guide to the continuum of evidence of effectiveness*. Atlanta, GA: Centers for Disease Control and Prevention.

*Puri, M., Tamang, J., & Shah, I. (2011). Suffering in silence: Consequences of sexual violence within marriage among young women in Nepal. *BMC Public Health*, *11*, 29.

*Ragavan, M., Iyengar, K., & Wurtz, R. (2015). Perceptions of options available for victims of physical intimate partner violence in northern India. *Violence Against Women*, *21*, 652–675. doi:10.1177/1077801215573332

*Salazar, M., Högberg, U., Valladares, E., & Ohman, A. (2012). The supportive process for ending intimate partner violence after pregnancy: The experience of Nicaraguan women. *Violence Against Women*, *18*, 1257–1278. doi:10.1177/1077801212470549

*Schuler, S. R., Bates, L. M., & Islam, F. (2008). Women's rights, domestic violence, and recourse seeking in rural Bangladesh. *Violence Against Women*, *14*, 326–345.

*Snell-Rood, C. (2015). Informal support for women and intimate partner violence: The crucial yet ambivalent role of neighbours in urban India. *Culture, Health and Sexuality*, *17*, 63–77. doi:10.1080/13691058.2014.950333

Snider, C., Webster, D., O'Sullivan, C. S., & Campbell, J. (2009). Intimate partner violence: Development of a brief risk assessment for the emergency department. *Academic Emergency Medicine*, *16*, 1208–1216. doi:10.1111/j.1553-2712.2009.00457.x

Stöckl, H., Devries, K., Rotstein, A., Abrahams, N., Campbell, J., Watts, C., & Moreno, C. G. (2013). The global prevalence of intimate partner homicide: A systematic review. *The Lancet*, *382*, 859–865. doi:10.1016/S0140-6736(13)61030-2

United Nations Entity for Gender Equality and the Empowerment of Women. (2015). *Process of the world's women 2015-2016: Transforming economies, realizing rights*. New York, NY: UN Women.

Van Parys, A. S., Deschepper, E., Roelens, K., Temmerman, M., & Verstraelen, H. (2017). The impact of a referral card-based intervention on intimate partner violence, psychosocial health, help-seeking and safety behaviour during pregnancy and postpartum: A randomized controlled trial. *BMC Pregnancy and Childbirth*, *17*, 1–16. doi:10.1186/s12884-017-1519-x

Watts, C., & Mayhew, S. (2004). Reproductive health services and intimate partner violence: Shaping a pragmatic response in sub-Saharan Africa. *International Family Planning Perspectives*, *30*, 207–213.

Whittemore, R. (2005). Analysis of integration in nursing science and practice. *Journal of Nursing Scholarship*, *37*, 261–267.

Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing*, *52*, 546–553. doi:10.1111/j.1365-2648.2005.03621.x

World Bank. (2018). *World Bank country and lending groups*. Retrieved from: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

World Health Organization. (2002). *World report on violence and health*. Geneva, Switzerland: Author.

World Health Organization. (2005). *WHO multi-country study on women's health and domestic violence against women*. Geneva, Switzerland: Author.

World Health Organization. (2016). *Ethical and safety recommendations for intervention research on violence against women*. Geneva, Switzerland: Author.

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