WHAT WORKS TO PREVENT VIOLENCE AGAINST WOMEN AND GIRLS?

A rigorous global evidence review of interventions to prevent violence against women and girls

WhatWorks
TO PREVENT VIOLENCE
A Global Programme To Prevent Violence Against Women and Girls

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A rigorous global evidence review of interventions to prevent violence against women and girls

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The photos in this report do not necessarily represent women and girls who themselves have been affected by gender-based violence or who accessed services.

Cover photograph: Video still by Stephan Bachenheimer/World Bank.

ABOUT WHAT WORKS

The **What Works to Prevent Violence against Women and Girls** programme was a flagship programme from the UK Department for International Development, which invested an unprecedented £25 million over six years from 2013 to 2019 on the prevention of violence against women and girls. It supported primary prevention efforts across Africa and Asia seeking to understand and address the underlying causes of violence, and to stop it from occurring. Through three complementary components, the programme focused on generating evidence from rigorous primary research and evaluations of existing interventions to understand what works to prevent violence against women and girls generally, and in fragile and conflict areas. Additionally, the programme estimated social and economic costs of violence against women and girls, developing the economic case for investing in prevention.

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WhatWorks

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Violence Against Women and Girls

CONTENTS

ACRONYMS

AA	Alcoholics Anonymous
AUDIT	Alcohol use disorders identification test
BCC	Behaviour change communication
CBT	Cognitive behaviour therapy
CETA	Common elements treatment approach
CONSORT	Consolidated standards of reporting trials
CSA	Child sexual abuse
DV	Domestic violence
DFID	UK Department for International Development
FSW	Female sex worker
GBV	Gender-based violence
HIC	High-income country
HIV	Human immunodeficiency virus
IGA	Income generating activity
IPV	Intimate partner violence
KHPT	Karnataka Health Promotion Trust
LGBTQI+	Lesbian, gay, bisexual, transgender, queer or questioning and intersex plus
LMIC	Low and middle-income country
MI	Motivational interviewing
MIFB	Motivational interviewing with feedback
MSM	Men who have sex with men
NGO	Non-governmental organisation
PBI	Parent-based intervention
RCT	Randomised control trial
SARR	Sexual assault risk reduction
STI	Sexually transmitted infection
SRGBV	School-related gender-based violence
TOC	Theory of change
UN	United Nations
US	United States
VATU	Violence and alcohol treatment intervention
VAW	Violence against women
VAWG	Violence against women and girls
VSLA	Village savings and loans association
WHC	Women's Health Coop
WHO	World Health Organization

Photo: Anisa Sabiri

Executive summary

Violence against women and girls (VAWG) is preventable. Over the last two decades, VAWG-prevention practitioners and researchers have been developing and testing interventions to stop violence from occurring, in addition to mitigating its consequences. The evidence base now shows that we can prevent VAWG through a range of interventions, within programmatic timeframes. Globally, there is also a growing consensus around 'what works' – the critical elements required for effective VAWG prevention. Key elements of effective design and implementation are summarised in Jewkes et al (2020) and in Box 1 (page iv).

To advance the field of VAWG prevention, the UK Department for International Development (DFID) has invested in the ***What Works to Prevent Violence against Women and Girls*** programme (*What Works*), which evaluated 16 VAWG-prevention interventions in 14 sub-Saharan African, Asian and Middle Eastern contexts, over six years (2014–2019). At the start of the programme, *What Works* reviewed the global evidence on VAWG prevention published between 2000 and 2013 (Fulu, Kerr-Wilson and Lang, 2014). The rigorous, in-depth review of the state of the field presented in this report is an update of the 2014 review and has been undertaken at the end of *What Works* to summarise what is now known five years on about what works to prevent violence, and to capture the contribution that *What Works* has made to this wider evidence base.

The growth in knowledge and evidence on VAWG prevention has inspired the RESPECT framework (WHO, 2019), which captures the violence prevention strategies known to be effective. In addition to the evidence-informed programming discussed in this review, RESPECT emphasises the importance of strengthening enabling conditions for prevention, including laws and policies supporting gender equality and women's rights, an effective and accountable justice system, comprehensive services for survivors, and resourcing women's rights organisations and movements.

Methodology

This review presents global evidence on what works to prevent women's experience and men's perpetration of physical and/or sexual intimate partner violence (IPV) and non-partner sexual violence. Child and youth peer violence is, to a limited extent, also considered, encompassing physical and verbal abuse. Reflecting on the current availability of evidence around interventions, the review does not include violence perpetrated within same-sex partnerships. While many of the evaluations measure additional secondary outcomes, the review's determination of intervention effectiveness is based exclusively on reduction of physical and/or sexual violence, or peer violence. As a result, this review may categorise interventions differently from other reviews.

The review has followed the core principles of a full systematic review to assess the current evidence base around strategies to prevent VAWG.

To be included, studies had to:

- Be published in the peer-reviewed literature or as working papers between 1 January, 2000 and December 31, 2018, although some exceptions are noted below.
- Assess whether the intervention prevented physical IPV, sexual IPV, or non-partner sexual violence experienced by women or perpetrated by men globally, or child and youth peer violence in low- and middle-income countries only.
- Be a randomised controlled trial (RCT) or a quasi-experimental study with a comparison group and/or be a study conducted under *What Works*.

In addition to this criteria for identification of studies, we included 11 randomised controlled trials (RCTs) conducted as part of *What Works*, and the Maisha trial (Kapiga et al., 2019), which all fell outside the review timeframe (to end 2018).[1] Systematic reviews (including reviews of reviews) were also drawn upon (particularly, Arango et al., 2014; Ellsberg et al., 2015; Ellsberg et al., 2018). The overall evaluation of which interventions are effective comes from the studies we identified in the review process, plus these additional studies. No limits were imposed based on the geographical scope of the review or the age range of study participants.

A search was conducted of PubMed, Google Scholar and Google, as well as searches of websites of bilateral and multilateral donors. The *What Works* International Advisory Board and expert reviewers from the VAWG-prevention field were also consulted.[2]

In the report we also describe (but do not include in our assessment of the evidence base) five *What Works* studies and three additional pre-post-test studies (Mennicke et al., 2018; Reza-Paul et al., 2012; Beattie et al., 2015) that did not have a comparison group.[3]

Interventions were allocated to a category based on their approach to the prevention of VAWG. Some of the intervention designs spanned more than one category; these have been cross-referenced appropriately (see Annex D for details). Overall conclusions have been drawn on the evidence available for each of the categories of interventions, based on the RCTs and quasi-experimental trials. Within each category there were often diverse intervention and evaluation designs, and implementation varied. Recognising this, the review addresses the question: **Is there evidence from well-designed and well-executed evaluations that well-designed, well-implemented interventions[4] of this category are effective in reducing VAWG?**

1 Although data was collected and largely analysed in 2018, some of the *What Works* studies and the Maisha trial (Kapiga et al., 2019) were not published until 2019.

2 See Acknowledgements section for details of peer reviewers

3 Sammanit Jeevan, Nepal (Shai et al., 2019); Transforming Masculinities, DRC (Le Roux et al., 2019; Zindagii Shoista, Tajikistan (Mastonshoeva et al., 2019); Peace Education, Afghanistan (Corboz et al., 2019); and the Syrian Cash Transfer Project (Falb et al., 2019)

4 Some of the key elements of well-designed and implemented interventions are described in Box 1 (Jewkes et al., 2020)

The classification of the effectiveness of intervention categories, based on RCTs and quasi-experimental studies, is outlined in Table 1 below. Criteria for determining the effectiveness of interventions were based on: 1) whether interventions reported a statistically significant impact on VAWG;[5] and, 2) overall rigour of the reported findings based on evaluation design, method of analysis, and reporting.

TABLE 1: CLASSIFICATION OF INTERVENTION CATEGORIES BY EFFECTIVENESS

Classification	Definition
Effective	• At least two high or moderate quality impact evaluations, using randomised controlled trials and/or quasi-experimental designs (which make use of a comparison group), have found statistically significant ($p<0.05$) reductions in physical IPV, sexual IPV or non-partner sexual violence (or peer violence in low- or middle-income countries). • An intervention is deemed effective based on high-quality meta-analyses and systematic reviews of findings from evaluations of multiple interventions.
Promising	One high or moderate quality impact evaluation, using a randomised control trial, or quasi-experimental study, has found statistically significant ($p<0.05$) reductions in physical IPV, sexual IPV or non-partner sexual violence (or peer violence in low or middle income countries) or a pattern of change across multiple violence outcomes (i.e. physical IPV, sexual IPV, or non-partner sexual violence) and is suggestive of this (but $p>0.05$).
Conflicting	Evidence from different high-quality studies shows conflicting results on one or more VAWG domains, e.g., some are found to be effective and some are found to have no effect or cause harm.
No effect	At least two high or moderate quality impact evaluations, using randomised controlled trials and/or high-quality quasi-experimental designs, have found no significant reductions in physical IPV, sexual IPV or non-partner sexual violence (or peer violence in low- or middle-income countries).

Limitations

There were a number of limitations of the review. It was not a systematic review and did not include searches of all possible databases. Although we consider it unlikely that our strategy would have missed many large trials, we may have missed some studies. We have not drawn on evidence from qualitative research or less rigorous evaluation designs, and thus do not consider their findings. We only reviewed evidence published in English, and as such may have missed studies. As mentioned above, we have not considered any work that only assessed impact on risk factors for VAWG.

In assessing the evidence, possible sources of bias in reporting studies were considered, particularly the risks from multiple testing for outcomes,[6] which was a commonly found practice. Care has also been taken not to lose important contributions to knowledge from studies that were underpowered[7] for their VAWG outcome.

The science of evaluation of VAWG prevention is still evolving. Many studies have different ways of measuring VAWG outcomes, as there is no consensus around gold-standard outcomes in the field. Many evaluations are also underpowered due to lack of resources or researchers encountering prevalence of VAWG in a study population different from the one they expected, and unanticipated changes in the control arm. We have taken a cautious position and have drawn conclusions from the overall picture of findings of a study, rather than concentrating only on the presence or absence of $p<0.05$ (statistically significant) for an outcome. This has led to some differences in classification of studies from some other reviews, but we consider that it is a scientifically justifiable approach, and much more appropriate for understanding the VAWG field in 2019. We recognise that this is not an exact science; we have used extensive peer review to check our conclusions, and welcome future approaches to review methodology in VAWG prevention that will systematise reviewing while remaining sensitive to the nature of research in the field.

What Works has sought to establish a standardised set of IPV measures, based on the WHO's Domestic Violence study scales (WHO, 2005) as adapted for the research with men in the UN multi-country study on Men and Violence in Asia and the Pacific (Fulu et al., 2013), to enable comparability across studies. The *What Works* IPV measure includes five physical and three sexual items, which are all behaviourally specific, with the outcomes coded consistently across the *What Works* body of studies, to enable some comparability.

5 'Statistically significant' refers to there being little chance that the impact reported in evaluations was caused by chance, rather that the likelihood is that it was caused by the intervention.

6 This is where many outcomes are reported in a trial, which increases the likelihood that positive outcomes are chance, rather than because of the intervention.

7 'Underpowered' refers to cases where the sample in studies was not large enough to give precise estimates of VAWG prevalence, with the consequence that fairly large differences between intervention and control arms were not statistically significant.

Findings

We identified 104 individual studies to include in the review, including 73 from lower- and middle-income countries (LMICs) and 31 from high-income countries (HICs), including the five *What Works* pre-post-test studies. *What Works* has funded five evaluations from Central and South Asia and has contributed significantly to increasing the evidence base from this region.

Our assessment of the evidence-base on what works to prevent VAWG comes from a total of 96 RCT or quasi-experimental evaluations identified as meeting our criteria for inclusion in the review. An additional eight pre-post-test studies were included, five from *What Works*, one on social marketing campaigns (Mennicke et al., 2018) and two studies of female sex worker interventions (Reza-Paul et al. 2012; Beattie et al., 2015). The results of the pre-post-test studies were not included in the overall classification of evidence and we indicate in the summary tables whether studies are RCTs, quasi-experimental, or pre-post-tests. These 104 studies evaluate 95 separate interventions (see Annex D for interventions). Table 2 presents the overall conclusions of the review on the effectiveness of the different categories of intervention.

TABLE 2: INTERVENTION EFFECTIVENESS FOR THE PREVENTION OF VAWG

Classification	Intervention Type
Effective, when well designed and executed	• Economic transfer programmes. • Combined economic and social empowerment programmes targeting women. • Parenting programmes to prevent IPV and child maltreatment. • Community activism to shift harmful gender attitudes, role and social norms. • School-based interventions to prevent dating or sexual violence. • School-based interventions for peer violence. • Interventions that work with individuals and/or couples to reduce their alcohol and/or substance abuse (with or without other prevention elements). • Couples' interventions (focused on transforming gender relations within the couple, or addressing alcohol and violence in relationships). • Interventions with female sex workers to reduce violence by clients, police or strangers (i.e., non-intimate partners) through empowerment/collectivisation or alcohol and substance use reduction.
Promising, but requires further research	• Cognitive behaviour therapy (CBT) based interventions with pregnant women. • Self-defence interventions to prevent sexual violence for women at college. • Economic and social empowerment programmes targeting men. • Interventions with female sex workers to reduce violence by non-paying intimate partners.
Conflicting evidence	• Self-defence interventions to prevent sexual violence for girls at primary and secondary schools. • Working with men and boys alone. • Home visitation programmes in the antenatal and postnatal period to prevent IPV.
No effect	• Good evidence that as standalone interventions these do not reduce levels of VAWG: – Microfinance, savings and livelihood programmes. – Brief bystander interventions. – Brief counselling and safety planning for pregnant women. • Insufficient evidence[8] but unlikely to work as standalone interventions to reduce levels of VAWG: – Social marketing campaigns and edutainment. – Digital technologies for VAWG prevention.

8 Insufficient evidence means we were unable to find RCT/ quasi-experimental studies for these intervention categories.

Box 1: Ten elements of the design and implementation of more effective *What Works* interventions to prevent VAWG

1. Rigorously planned with a robust theory of change, rooted in knowledge of local context.
2. Tackle multiple drivers of VAWG, such as gender inequity, poverty, poor communication and marital conflict.
3. Especially in highly patriarchal contexts, work with women and men, and where relevant families.
4. Based on theories of gender and social empowerment that view behaviour change as a collective rather than solely individual process, and foster positive interpersonal relations and gender equity.
5. Use group-based participatory learning methods for adults and children, that emphasise empowerment, critical reflection, communication and conflict resolution skills-building.
6. Age-appropriate design for children with a longer time for learning and an engaging pedagogy such as sport and play.
7. Carefully designed user-friendly manuals and materials supporting all intervention components to accomplish their goals.
8. Integrate support for survivors of violence.
9. Optimal intensity: duration and frequency of sessions and overall programme length enables time for reflection and experiential learning.
10. Staff and volunteers are selected for their gender equitable attitudes and non-violence behaviour, and are thoroughly trained, supervised and supported.

Source: Adapted from Effective design and implementation elements in interventions to prevent violence against women and girls (Jewkes et al., 2020)

Good evidence of effectiveness in reducing VAWG

Overall, there is good evidence that nine categories of interventions can be effective in reducing IPV and/or non-partner sexual violence globally, or physical or verbal peer violence in low- and middle-income countries, where interventions are well designed and executed (see Box 1):

- **Economic transfer programmes**. Cash or food transfers, often in the form of national social protection programmes, particularly when combined with social components (group discussions, or other conditionalities[9]), are effective in preventing women's experiences of IPV.
- **Combined economic empowerment and social empowerment interventions for women.** Combining economic interventions (such as microfinance) with gender transformative programming for women is effective in preventing their experience of IPV.
- **Couples' interventions** (conducted among couples in the general population, whether or not they experience IPV) are effective in reducing women's experiences of IPV. Well-designed approaches focused on transforming gender relations within the couple, or addressing alcohol and violence in relationships.
- **Parenting programmes to prevent IPV and child maltreatment**, which are delivered through sessions on improving parenting skills rather than home visits, are effective in reducing IPV, and, through a focus on gender norms around children and pregnancy, may provide an opportunity to improve parenting skills and relationships between parents.
- **Community activism to shift harmful gender attitudes, roles and social norms** is effective in reducing VAWG at the community level in the general population through multi-year intensive community activism. However, only very strongly designed and implemented interventions are able to achieve this.
- **School-based interventions to prevent dating or sexual violence**; the more effective approaches were longer, and focused on transforming gender relationships.
- **Interventions that work with individuals and/or couples to reduce their alcohol and/or substance abuse** are effective in reducing IPV and non-partner sexual violence and may be particularly effective when working with couples.
- **Interventions with female sex workers** to reduce violence by clients, police or strangers (i.e., non-intimate partners) focused on collectivisation

9 For example, the transfer is conditional on specific behaviours (e.g., school attendance, vaccination), or attendance at health programmes (e.g., nutrition counselling).

and sex-worker empowerment, or short interventions addressing substance misuse, have been found to be effective in reducing female sex workers' experiences of violence from clients, police and others, but not from intimate partners.

- **School-based interventions for peer violence, with a gender component.** In Africa and Central and South Asia, these interventions have been found to be effective in reducing violence when using participatory methods, building skills and addressing violence prevention through a gender lens.

Promising but insufficient evidence of effectiveness

The following four approaches show promise in their ability to reduce VAWG but require additional evaluations to confirm their effectiveness:

- **CBT-based interventions with pregnant women**. One study of a CBT intervention during the antenatal and postnatal period showed reductions in women's experiences of IPV.
- **Economic and social empowerment programmes targeting men.** Combining economic strengthening (such as livelihood programmes) with explicit gender-transformative approaches shows promise for reducing men's self-reported perpetration of IPV.
- **Self-defence interventions to prevent sexual violence for women of college age (18+ years).** One large, well-run study demonstrated that this approach is promising in reducing women's experiences of sexual violence when delivered over multiple sessions, with an explicit feminist approach that includes general empowerment alongside physical self-defence training. Other evaluations have had methodological weaknesses.
- **Interventions with female sex workers to reduce violence by non-paying intimate partners.** One small RCT demonstrated that an alcohol- and drug-focused intervention could reduce female sex workers' experiences of violence from their intimate partners.

Conflicting evidence

There is good but conflicting evidence about the effectiveness of three categories of intervention in reducing IPV and/or non-partner sexual violence globally, or physical or verbal peer violence in low- and middle-income countries:

- **Self-defence interventions to prevent sexual violence for girls at primary and secondary schools.** Two RCTs had differing findings and both have methodological limitations. Caution is required around implementing these types of interventions.
- **Working with men and boys alone.** There is some evidence that more intensive intervention approaches show positive impacts although the number of interventions overall is low. Many of the interventions that work with men and boys also work with women and girls, and although some of these interventions have been shown to be highly successful at reducing perpetration by men (e.g., Stepping Stones) they did not reduce reported experiences of IPV among women.
- **Home-visitation programmes to prevent IPV, in the antenatal and postnatal periods** consisted of multiple visits from nurses, to support women with young children. Unlike many of the other categories, these studies were implemented only in high-income settings.

Good evidence of no effect

There is good evidence that the following three interventions are not effective in directly reducing women's experiences of violence. These interventions may successfully achieve other outcomes which are protective factors for VAWG, however they are not recommended as a primary prevention strategy on their own.

- **Microfinance, savings and livelihood programmes.** Three different evaluations all showed no reduction in women's experiences of IPV from these approaches.
- **Brief bystander interventions.** Mainly evaluated in the US, these brief interventions (often one- to two-hour sessions) typically targeting men, showed no impact on IPV or non-partner rape perpetration.
- **Brief counselling and safety planning for pregnant women.** These short psycho-educational interventions (often one to two hours) showed no impact on reducing women's experiences of IPV.

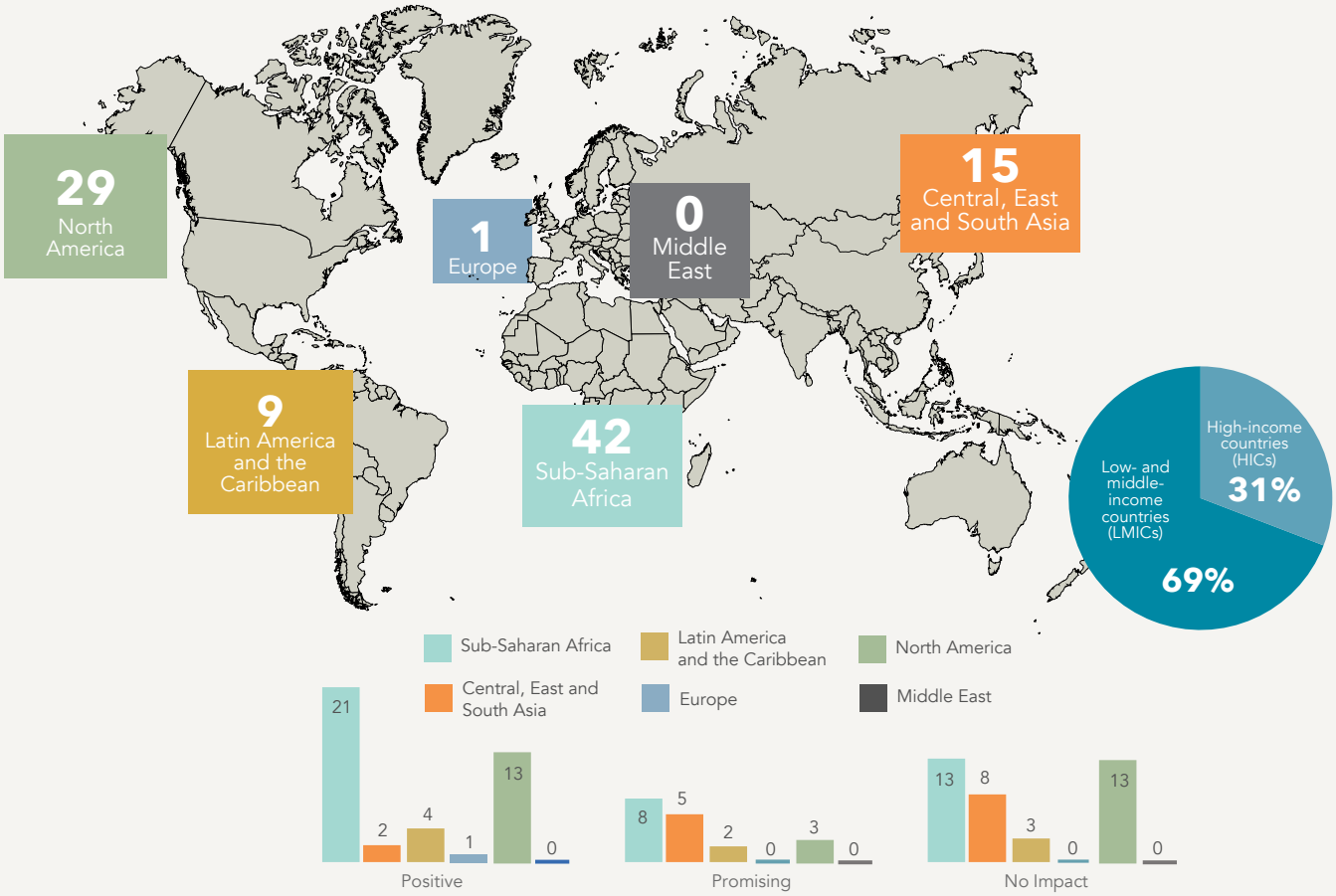
Insufficient evidence and no effect

Two intervention approaches have limited evidence and thus far show no effect for the prevention of VAWG, and there are concerns that as standalone interventions, they are unlikely to be effective.

- **Social marketing campaigns and edutainment and digital technologies**, despite their potential to reach large numbers of people, have not been shown to change violent behaviour, although they may raise awareness of issues and influence attitudes and decision-making. They are most likely to be useful as part of multi-component interventions that include elements with robust design and implementation (see Jewkes et al., 2020).

GEOGRAPHICAL SCOPE AND IMPACT OF 96 RCT/ QUASI-EXPERIMENTAL STUDIES

Of the 96 RCTs/quasi-experimental studies, 69% (n=66) were from LMICs and 31% from HICs (n=30). Just under half were from sub- Saharan Africa (SSA) (44%; n=42); and 30% were from North America, including the US and Canada (n=29). 16% are from Central, East and South Asia (n=15); 9% from Latin America and the Caribbean (n=9) and 1% from Europe (n=1) and 0 from the Middle East. Even among those from Africa there is considerable geographical imbalance, with a large representation from South Africa (13%; n=13) and Uganda (8%; n=8).



KEY POPULATIONS

There are major gaps in evaluations of interventions for the most marginalised groups of women and girls, who experience disproportionately high rates of violence.

Adolescent girls	Although there were 40 separate RCT/ quasi-experimental studies of interventions working with adolescent girls, these were almost entirely provided to girls in school or college settings, and very few were among out-of-school young women.
Conflict-affected populations	There were only six RCT/ quasi-experimental studies among conflict-affected populations. Rates of VAWG, including intimate partner violence, are substantially higher in conflict and post-conflict populations because of the enduring impacts of conflict, including higher levels of poverty, poorer mental health and social disruption caused by war. In addition, interventions in conflict-affected populations were, in general, not as effective at preventing VAWG as in more stable settings, which reflects the review by *What Works* on conflict-affected populations (Murphy et al., 2019).
Women and girls living with disabilities	There were no interventions that evaluated impact among women and girls living with disabilities. Studies have consistently shown that women and girls living with disabilities experience higher rates of IPV, non-partner sexual violence, and are also at risk for violence from their caregivers.
Lesbian, gay, bisexual, transgender, queer or questioning and intersex plus (LGBTQI+) persons	The review did not examine the literature on VAWG prevention among lesbian, gay, bisexual, transgender, queer or questioning and intersex plus (LGBTQI+) persons and the heterosexual bias of this review is acknowledged.

RECOMMENDATIONS FOR PREVENTING VIOLENCE AGAINST WOMEN AND GIRLS, AND ADVANCING THE GLOBAL RESEARCH AGENDA

Based on this global evidence review on VAWG prevention, recommendations for funding, programming and research are as follows:

FOR DONORS:

1. INCREASE INVESTMENT IN EVIDENCE-BASED PREVENTION PROGRAMMING AND EVALUATION

Priorities include:

- Evidence-based interventions in new or challenging settings, populations, or a combination of both, that reflect best practice in violence prevention programming (see Box 1) and evaluations thereof.
- Adaptation and careful scale-up and evaluation of interventions that were effective within trial evaluations, to evaluate their impact at scale, in the original setting or in new contexts.
- Evaluations of intervention approaches that show promise in preventing VAWG.
- Where evidence is insufficient (i.e., where there are only one or two evaluations in low- to middle-income countries), explore whether approaches are effective at preventing VAWG in multiple settings and how they could most effectively be used.
- Evaluations of well-designed and well-implemented interventions for vulnerable populations, including but not limited to, adolescent girls in out-of-school-settings, conflict-affected populations, women and girls living with disabilities, female sex workers and LGBTQI+ persons.
- Interventions in different social and cultural contexts, be this conflict-affected populations, facing particular challenges and needs, or global regions where evidence is limited, such as Asia, the Middle East and North Africa.
- Expanded investment in VAWG response services, which are a critical element of effective prevention.

2. STOP FUNDING APPROACHES PROVEN NOT TO WORK TO PREVENT VAWG

Some intervention domains and approaches to intervention design and implementation do not work as standalone approaches to the prevention of VAWG. VAWG-prevention resources should not be used to fund standalone awareness-raising campaigns, brief bystander interventions, brief counselling and safety planning for pregnant women or standalone microfinance, savings and livelihoods interventions, as the evidence base shows that they are ineffective in preventing VAWG. They may be considered, however, as part of multi-component approaches.

FOR PRACTITIONERS:

3. ADAPT AND SCALE UP EFFECTIVE PROGRAMMES TO DIFFERENT POPULATIONS AND CONTEXTS

Support the adaptation of programmes shown to be effective in one context in new populations and contexts, and assess their impact when adapted and taken to scale through high quality programme monitoring and evaluation. It is also important to support the documentation of adaptation processes to learn how effective adaptation and scale-up occurs. VAWG-prevention practitioners and researchers are still learning about different approaches to scale-up, and this work needs to be undertaken iteratively and carefully evaluated. This should not be to the exclusion of robustly evaluating new, locally developed prevention models that are promising but have not yet been evaluated.

4. INNOVATE

Some approaches have a limited evidence base and require further investigation, for example, digital interventions and workplace-based interventions for VAWG prevention. These areas need further innovation, building on evidence of best practice in intervention design (see Box 1), and rigorous formative and operational research.

FOR RESEARCHERS:

5. INCREASE THE RIGOUR OF RESEARCH METHODS

What Works has shown the value of using a standardised set of outcome indicators, with multiple questions on violence and robust research methods, particularly with 18- to 24-month follow-ups, in establishing medium- to long-term impact and reducing concerns about social desirability bias in reporting.

6. REPORT EVALUATION STUDIES USING STANDARDISED APPROACHES

Consistent and comparable reporting on trials, using standardised approaches, enables comparisons by other researchers, policy makers, activists and development workers. Using the Consolidated Standards of Reporting Trials (CONSORT) guidelines provides a robust approach to providing the information needed for interpretation and repeatability of studies.

7. MEASURE IMPACT ON MULTIPLE FORMS OF VAWG

The evidence base needs to expand outwards to understand not only what works to prevent physical and/or sexual IPV but also to measure impact on multiple forms of VAWG (i.e., psychological/emotional and economic IPV, sexual harassment, and non-partner sexual violence).

8. MEASURE THE EFFECTIVENESS OF INTERVENTIONS AMONG WOMEN FACING MULTIPLE FORMS OF DISCRIMINATION

The evidence base on effective interventions for women and girls who face multiple and intersecting forms of discrimination (e.g., based on disability, age, sexuality, gender identity and ethnicity), is almost non-existent. Collecting this data and disaggregating intervention effects along these lines is critical to understand whether interventions are as effective for the most excluded groups and help strengthen inclusive VAWG prevention efforts in the future.

Photo: Anisa Sabiri

SECTION 1

Introduction

Violence against women and girls (VAWG) is one of the most widespread violations of human rights worldwide, affecting a third of women (WHO, 2013). It has long-term negative consequences for women's health and well-being and is a fundamental barrier to eradicating poverty and building peace.

VAWG is driven by gender inequalities and patriarchy and related social norms around the acceptability of violence in communities (Alexander-Scott et al., 2016; Jewkes, Stern and Ramsoomar, 2019; Heise, 2011). These intersect with other important drivers related to access to resources, low levels of education, and experiences of violence and abuse in childhood. In addition, factors such as poor mental health, poor relationship and communication skills, and alcohol and substance abuse are key drivers of VAWG at individual and interpersonal levels (Heise, 2011).

Over the last two decades, VAWG prevention practitioners and researchers have been developing and testing interventions to prevent VAWG. This has expanded knowledge and understanding in the international arena of the elements required for effective VAWG prevention. This growth in evidence inspired the development of the RESPECT framework on preventing VAWG by the WHO and UN Women (WHO, 2019). In addition to evidence-informed programming, RESPECT emphasises the importance of strengthening enabling conditions for prevention. This includes an enabling framework of laws and policies to support gender equality and women's rights, an effective justice system to ensure accountability for acts of violence, and resourcing and building on the work of women's rights organisations and movements.

1.1 *What Works* global programme and evidence review

This review seeks to highlight the advances in knowledge that have resulted from increased global investment in VAWG prevention and research in the recent period. *What Works to Prevent Violence against Women and Girls (What Works)* was a UK Department for International Development (DFID) programme that invested £25 million over six years (2014-2019) on designing and rigorously evaluating interventions to support primary prevention of VAWG across Africa and Asia.

At the start of the programme, *What Works* reviewed the evidence on prevention published between 2000 and 2013 (Fulu, Kerr-Wilson and Lang, 2014). This report is an update of the 2014 review; it presents an overview of the evidence five years on and demonstrates the contribution *What Works* has made to this field.

Due to the growing number of evaluations of VAWG interventions, this review only includes studies that specifically measure VAWG as an outcome and does not consider interventions and studies that assess their impact only on underlying risk factors, as was done in the 2014 review. It also only discusses results from methodologically stronger studies, defined as randomised controlled trials (RCTs) and quasi-experimental studies (with comparison groups). Although five of the *What Works* studies did not have comparison groups, they are discussed in this review to ensure that all *What Works* evidence is included.[10] However, because they do not have comparison groups unlike the other studies, we have been clear in the summary tables that they are pre-post-test studies, and their findings are not taken into consideration in the overall categorisation of effectiveness.

1.2 Scope and goals of the review

The purpose of this review is to examine the evidence on the effectiveness of interventions to prevent physical and/or sexual intimate partner violence or non-partner sexual violence globally, or child and youth peer violence in low- and middle-income countries to:

- Assess the state of global knowledge on VAWG prevention and the contribution made by the *What Works* programme.[11]
- Inform violence-prevention programming and research and priorities for future funding, innovation and scale-up.

The review is intended to provide an overview for policy makers, donors, researchers and practitioners interested in a robust assessment of VAWG-prevention evidence to inform their work. The Executive Summary is also available as a separate, shorter brief and can be found at: **www.whatworks.co.za**

1.3 Types of violence covered by the review

This review presents the global evidence on what works to prevent women's experience and men's perpetration of physical and/or sexual IPV and non-partner sexual violence. The rationale for these categories is that they are similar to the VAWG categories covered by the interventions in the *What Works* programme – IPV and non-partner sexual violence – and in the 2014 *What Works* Evidence Review (Fulu, Kerr-Wilson and Lang, 2014).

10 Sammanit Jeevan, Nepal; Transforming Masculinities, DRC; Zindagii Shoista, Tajikistan; Peace Education, Afghanistan; and the Syrian Cash Transfer Project

11 These include 15 evaluations from Component 1 and one evaluation of the IRC Syria cash-transfer programme from Component 2.

Child and youth peer violence are also considered to a limited extent, and encompass physical and verbal abuse, social exclusion and destruction of property. Although it is not easy to work directly on VAWG prevention with children in some cultural contexts, it is included because the opportunity to work with children on building gender equality and social and emotional child empowerment is important and because peer violence is often a precursor to VAWG.

Sexual harassment is beyond the scope of this review.

Reflecting the current availability of evidence around VAWG prevention interventions, the review does not include violence perpetrated within same-sex partnerships, and, as such, intimate partners are defined heterosexually to include a woman's or a girl's current or ex-husband or boyfriend. We recognise this as a limitation.

While many of the evaluations measure additional secondary outcomes, the review's determination of intervention effectiveness is based exclusively on reduction of physical and/or sexual violence, or peer violence. We feel this is appropriate given the recent growth of evidence in the field. As a result, this review may categorise interventions differently from other reviews.

For the review, we drew on these definitions:

- **Physical intimate partner violence:** Any act of physical attack by a current, or former, husband, partner or boyfriend. This could include slaps, pushing, being beaten, or the use of a knife or gun to threaten or harm a person.
- **Sexual violence:** Any act where a person uses force, coercion or intimidation to force another person to carry out a sexual act against her or his will. When carried out by a current or previous husband, partner or boyfriend, this is sexual intimate partner violence (IPV), and when by someone else, is non-partner sexual violence.
- **Peer violence:** Two or more acts of physical or verbal violence (verbal abuse or name calling); many measures also assess damage to property and social exclusion.

Across all definitions, the way in which individual studies operationalised them often varied substantially, and we have sought to highlight this throughout.

1.4 Content and structure of report

Most of the studies reviewed in this report examined interventions that specifically sought to reduce physical and/or sexual IPV and non-partner sexual violence. A smaller number of studies measured the impact of interventions to reduce peer violence. These interventions have been grouped into the intervention categories below, which represent the main approaches used by VAWG prevention programmes globally, as well as in the *What Works* programme. The categories are similar to the WHO/UN RESPECT Framework strategies (WHO, 2019). Corresponding RESPECT strategies are shown next to our categories on page 3.

In the health sector, we have included interventions in the antenatal and postnatal periods, with growing and substantial evidence of the ability of these interventions to prevent or reduce VAWG. We have excluded all other health sector interventions because most focus on identifying women who have experienced violence and responding to their needs through the health, social and criminal justice sectors.

For interventions that cut across more than one category, we have assigned a primary category. However, eleven interventions[12] either had separate evaluations of two components or study results from two different categories to reflect the body of evidence, and are thus included in two sections of this report (e.g., the *What Works* study, **Indashyikirwa** in Rwanda is included twice because it has two separate evaluations: the couples' intervention and the community activism intervention) (See Annex D for details).

Section One starts with introducing the scope and goals of the review and details of intervention categorisation**. Section Two** outlines the methodology used for the report and how we made decisions on categorising intervention effectiveness. **Section Three** summarises the evidence according to the intervention typology listed above. For each intervention type we include:

- A description of the intervention type, including a case study example for intervention types where studies show positive and/or promising impact on VAWG.[13] A summary of the global evidence available, including from *What Works* (indicated by purple text)
- A discussion on the effectiveness of interventions.

In **Section Four,** we discuss what this evidence means for the prevention agenda and in **Section Five** we make recommendations about priorities for future innovation and research.

12 The following ten studies appear in two sections: Green et al, 2015; Ismayilova et al., 2018; Roy et al., 2018; Pettifor et al., 2018; Clark et al., 2019; Doyle et al., 2018; Feinberg, 2016; Minnis et al., 2015; Murray et al., 2019; Javalkar et al., 2019. Indashyikirwa in Rwanda had two separate evaluations (Dunkle et al., 2019 and Chatterji et al., 2019)

13 There are no case study boxes for the following categories either because studies showed no impact on VAWG, or there was no evidence available: microfinance, saving or livelihoods intervention (no impact) and digital technology for VAWG prevention (no studies).

WHAT WORKS
INTERVENTION CATEGORIES

ECONOMIC INTERVENTIONS

Economic transfer programmes	Microfinance, savings and livelihood	Economic empowerment + social empowerment

RELATIONSHIP AND FAMILY-LEVEL INTERVENTIONS

Couples' interventions	Parenting programmes to prevent IPV and child maltreatment

COMMUNITY-LEVEL INTERVENTIONS

Social marketing and edutainment	Digital technology for VAWG prevention	Community-activism approaches to shift harmful gender attitudes, roes and social norms

SCHOOL-BASED INTERVENTIONS

Preventing dating and sexual violence	Preventing gendered peer violence

SELF-DEFENCE INTERVENTIONS IN SCHOOLS AND COLLEGES TO PREVENT SEXUAL ASSAULT

INTERVENTIONS IN ANTENATAL AND POSTNATAL SETTINGS

INTERVENTIONS WITH MEN AND BOYS ONLY

INTERVENTIONS TO TACKLE ALCOHOL AND/OR SUBSTANCE ABUSE

INTERVENTIONS WITH FEMALE SEX WORKERS

CORRESPONDING STRATEGIES: RESPECT FRAMEWORK
(led by WHO and UN Women and endorsed by 12 other UN agencies and bilateral partners)*

P – Poverty reduced R – Relationship skills strengthened
R – Relationship skills strengthened C – Child and adolescent abuse prevented
R – Relationship skills strengthened S – Services ensured T – Transformed attitudes, beliefs, and norms
R – Relationship skills strengthened E – Environments made safe C – Child and adolescent abuse prevented
E – Empowerment of women C – Child and adolescent abuse prevented
S – Services ensured C – Child and adolescent abuse prevented
R – Relationship skills strengthened
R – Relationship skills strengthened E – Empowerment of women S – Services ensured
E – Empowerment of women S – Services ensured

* These include: UNFPA, UNODC, UNDP, OHCHR, World Bank, and Governments of Australia, Canada, Netherlands, Sweden, United Kingdom and USA.

Photo: Peter Caton

SECTION 2
Methodology

2.1 Search process and inclusion criteria

We conducted a rigorous evidence review that not only followed the core principles of a full systematic review but also allowed space to reflect on the *What Works* studies. We focused on robust quantitative studies – primarily RCTs and quasi-experimental studies rather than qualitative studies, pre-post-test designs or practice-based learning. The inclusion and exclusion criteria and search strategy are set out in Table 3.

TABLE 3. INCLUSION AND EXCLUSION CRITERIA AND SEARCH STRATEGY

Dates	Published from 1 January 2000 to 31 December 2018, with the exception of the *What Works* group of studies (n=16) and the Maisha trial (Kapiga et al., 2019) which fall outside this period and were published in 2019 or were in peer review at the time of writing.
Outcomes	Women's experience or men's perpetration of physical IPV, sexual IPV or non-partner sexual violence were included in the review. Other types of violence e.g., psychological or emotional violence, may be mentioned but are not used to evaluate the effectiveness of interventions. Peer violence (physical and verbal) for interventions with peer-violence prevention as their goal, in low- and middle-income countries.
Prevention	Studies had to assess the prevention of violence, i.e., they had to evaluate the impact of the intervention either on future cases of violence or on reducing the frequency or severity of ongoing abuse.
Age groups	There was no restriction on age groups included.
Study design	Experimental, either randomised control trial, or quasi-experimental with a counter-factual included. Five *What Works* studies and three additional studies included in the text, but not in the overall evaluation of the evidence base, do not meet these design criteria. They are all pre-post-test designs and are included to highlight innovative practice and emerging evidence.
Reviews	We also drew on 12 completed and published high-quality, systematic or comprehensive reviews of the evidence base to provide an overview of the evidence. These were updated with further studies conducted outside their time period (but within ours) or outside the area of interest. In particular, we reviewed Arango et al., 2014; Ellsberg et l., 2015; and, Ellsberg et al., 2018.
Countries/regions	Searches were conducted for all countries and regions information on countries and regions is provided in the summary tables (Tables 6, 7 and 8). In the summary boxes, we highlight the body of evidence from Africa, and from Central and South Asia, the geographical foci of *What Works*.
SEARCH STRATEGY	
Key-word search	Conducted in PubMed, Google Scholar and Google (Key words in Annex C).
Grey literature	Websites of bilateral and multilateral donors, the United Nations (UN) and other international agencies, international non-government organisations (NGOs), and research institutes.
Expert input	We worked with the *What Works* International Advisory Board (IAB) and other *What Works* staff, as well as international experts, to identify any missing articles and for conceptual advice (see Acknowledgements).

Once papers were identified, we systematically extracted key information about the authors, study design, and outcomes into a spreadsheet. Interventions were allocated to one of our categories, based on their approach to the prevention of VAWG. We recognise that some of the interventions contributed knowledge to more than one category; we have appropriately cross-referenced these.

First, within an intervention type, each evaluation was classified as being in one of three categories (Table 4), according to whether it had a positive impact, promising impact or no impact on VAWG. In studies with women and men (or girls and boys) where both reported outcomes, if one sex reported significant reductions this was classified according to whether it had a positive impact, even if the other sex did not, assuming they were not intimate partner dyads, in which case reports of one sex would have been incompatible with those of the other.

Second, we assessed the overall evidence of each intervention type, and classified them into one of four categories (effective; promising; conflicting; no effect), based on the strength of the overall evidence of studies within an intervention category. We are aware that some papers have been described elsewhere as showing an impact in reducing VAWG; we have classified them in a different way because of concerns around bias or overstating their conclusions.

TABLE 4. CLASSIFICATION OF EVIDENCE FOR INDIVIDUAL INTERVENTIONS[14]

Positive impact on VAWG or peer violence	A significant ($p<0.05$) reduction in the perpetration or experience of physical IPV, or sexual IPV (or combined), or non-partner sexual violence, or where relevant, peer violence.
Promising impact on VAWG or peer violence	Three groups of outcomes were considered promising: 1. A non-significant trend ($p<0.1$) towards a reduction in the perpetration or experience of physical IPV, or sexual IPV (or combined), or non-partner sexual violence, or, where relevant, peer violence. 2. A significant ($p<0.05$) reduction amongst a sub-group for the perpetration or experience of physical IPV, or sexual IPV (or combined), or non-partner sexual violence (e.g. among those attending more than 50% of sessions), or, where relevant, peer violence. 3. A significant ($p<0.05$) reduction in IPV overall, but with evidence of a significant ($p<0.05$) increase in IPV at another time point, or, where relevant, peer violence.
No impact on VAWG or peer violence	Showing none of the above and/or significant reductions only in other forms of VAWG (e.g., emotional or economic IPV).

2.2 Assessment criteria

We have drawn overall conclusions on the evidence available for our categories of interventions, based on an aggregation of all available evidence. The assessment criteria of categories of interventions is outlined in Table 5. Although Table 4 has three categories for evaluations of individual interventions (Positive, Promising and No Impact), Table 5 has four categories for groups of interventions, including an additional category – Conflicting – if studies within one category had conflicting findings. We recognise that within a category there was often considerable diversity in the design and implementation of interventions, as well as evaluation design. Some of the evaluation reports did not report consistently – i.e., by following well-established guidelines for trials or quasi-experimental trials – which at times made interpretation of outcomes challenging. This highlights the need for more rigorous standards to be applied in reporting evaluations (e.g., Consolidated Standards of Reporting Trials [CONSORT] guidelines).

Recognising this, our conclusions address the question: **Is there evidence from well-designed and well-executed evaluation studies that well-designed, well-implemented interventions of this category are effective in reducing VAWG?**

TABLE 5. ASSESSMENT CRITERIA OF GROUPS OF INTERVENTIONS

CLASSIFICATION	DEFINITION
Effective	At least two high- or moderate-quality impact evaluations, using randomised controlled trials and/or quasi-experimental designs (which make use of a comparison group), have found statistically significant ($p<0.05$) reductions in physical IPV, sexual IPV or non-partner sexual violence (or peer violence in low- or middle-income countries (LMICs). An intervention is deemed effective based on high-quality meta-analyses and systematic reviews of findings from evaluations of multiple interventions.
Promising	One high or moderate quality impact evaluation, using a randomised control trial, or quasi-experimental study, has found statistically significant ($p<0.05$) reductions in physical IPV, sexual IPV or non-partner sexual violence (or peer violence in low or middle income countries) or a pattern of change across multiple violence outcomes (i.e. physical IPV, sexual IPV, or non-partner sexual violence) and is suggestive of this (but $p>0.05$).
Conflicting	Evidence from different high-quality studies shows conflicting results on one or more VAWG domains, e.g., some are found to be effective and some are found to have no effect or to cause harm.
No effect	At least two high- or moderate-quality impact evaluations, using randomised controlled trials and/or high-quality quasi-experimental designs, have found no significant reductions in physical IPV, sexual IPV or non-partner sexual violence (or peer violence in LMICs).

14 All changes are assessed in the intervention arm in comparison to the control arm.

2.3 Limitations of the review

Although we conducted a rigorous evidence review that followed the core principles of a full systematic review, the review was rapid, and there are several limitations:

- This report represents a summary and analysis of the evidence published in peer-reviewed journals and organisational reports that evaluate diverse VAWG interventions from around the world. The evidence assessed here thus relies on the existence of published reviews and evaluations of interventions with designs that met our particular inclusion criteria. We recognise that there may be many other promising interventions that are not included here because they use other evaluation methodologies or have not yet had evaluations published.
- There are still significant methodological challenges with published studies – even in RCTs – including small sample sizes, which made interpretation difficult. Cluster RCTs, in particular, were often underpowered[15] and their ability to show meaningful effects was thus limited.
- Studies also had multiple ways of measuring VAWG, particularly physical and sexual IPV. In some studies, one question was used to assess whether a woman had experienced IPV. Single-question measures of IPV often fail to capture the true prevalence of IPV in populations, and lead to potential measurement errors that drive significant intervention findings. A lack of standardised measures of IPV also limits comparability of intervention outcomes. *What Works* has sought to establish a standardised set of IPV measures based on the WHO's Domestic Violence study scales (WHO, 2005) as adapted for the research with men in the UN multi-country study on men and violence in Asia and the Pacific (Fulu et al., 2013), to enable comparability across studies. The *What Works* IPV measure includes five physical and three sexual items, which are all behaviourally specific, with the outcomes coded consistently across the *What Works* body of studies, enabling some comparability.
- Where impact on the occurrence of VAWG is measured, it is important to note that measurement of short-term outcomes may overestimate effect, and long-term impact is required for population-level effects; unless assessed, these are unknown.
- The approach to data analysis also varied considerably. Many of the studies did not use conventional best practice, for example, they used individual-level analysis for cluster RCTs with very few clusters, or analyses that did not adjust for key baseline covariates including the outcome variable. Some of the studies reported very large numbers of associations, without prior planning, and any adjustment of their p-values for reporting. Some of the studies did not provide full details of report findings, effect sizes and measure of confidence.
- A major challenge in the evidence review was that within intervention categories there was often great heterogeneity in the actual components of the intervention and (most likely) its implementation, which made comparison and synthesis challenging.
- The review is limited by the fact that we only drew on literature published in English.
- An imbalance in funding for VAWG-prevention research has led to more evidence coming from high-income countries (HICs) and these findings may not be directly transferable to very different cultural and economic settings of LMICs.
- The quality of the studies varies considerably. Some are very robust and have endeavoured to minimise bias; others have not addressed this. This review will comment on bias where possible but we are aware that we do not always have full information in this regard. In assessing what we know across a group of studies, we do consider known biases and do not merely repeat the interpretation of the authors.
- In assessing the evidence, possible sources of bias in reporting studies were considered, particularly the risks from multiple testing for outcomes,[16] which was a commonly found practice. Care has also been taken not to lose important contributions to knowledge from studies that were underpowered for their VAWG outcome. The science of evaluation of VAWG prevention is still evolving; many studies have multiple VAWG outcome measures because there is no consensus around gold-standard outcomes in the field, and many evaluations are underpowered due to lack of resources or researchers encountering prevalence of VAWG in a study population that was different from that expected, and because of unanticipated change in the control arm. We have taken a cautious position and have drawn conclusions from the overall picture of findings of a study, rather than just concentrating on the presence or absence of $p<0.05$ for an outcome. This has led to some differences in classification of studies from some other reviews, but we consider that it is a scientifically justifiable approach, and much more appropriate for understanding the VAWG field in 2019. We recognise that this is not an exact science and have used extensive peer-review to check our conclusions, and welcome future approaches to review methodology in VAWG prevention that will systematise reviewing while remaining sensitive to the nature of research in the field.
- We focused only on certain types of interventions or areas. In terms of the health sector, we only include studies on antenatal and postnatal interventions because they provide an opportunity to intervene with women around IPV. We did not cover the entire health-sector response to VAWG, as this was undertaken by the WHO in a comprehensive manner in 2013.
- The review also did not examine the literature on VAWG prevention among LGBTQI+ persons; the heterosexual bias of this review is acknowledged.

15 Underpowered refers to cases where the sample in studies was not large enough to give precise estimates of VAWG prevalence with the consequence that fairly large differences between intervention and control arms were not statistically significant

16 This is where many outcomes are reported in a trial, which increases the likelihood that positive outcomes are chance, rather than because of the intervention

Photo: Peter Caton

SECTION 3

Review of the Evidence

Table 6 summarises the evidence reviewed in this report. In total, we identified 114 studies[17] across 15 different categories,[18] including 104 individual studies of which 85 were RCTs or quasi-experimental studies from the global evidence review and 11 were from *What Works*; there were also five *What Works* and three other pre-post-test studies (Mennicke et al, 2018; Reza-Paul et al. 2012; Beattie et al., 2015). We also found 12 systematic evidence reviews.[19] From the 104 individual studies, we identified 95 individual interventions (see Annex D). The 104 studies were in 32 different countries; 41% (n=43) were in Africa – many from South Africa and Uganda – and around a fifth (19%, n=20) were from Central, East and South Asia. A large proportion of interventions (29%; n=30) were from the US and Canada.

In terms of specific groups, a substantial proportion – 40% (n=42) – of the 104 studies targeted adolescents, although most of these interventions were in school or college settings. Only 10% (n=10) were in conflict or humanitarian settings. No studies specifically targeted women and girls living with disabilities. In terms of impacts on reducing VAWG, for the 96 RCTs and quasi-experimental studies only, just under half (44%, n=43) had significant reductions in physical or sexual IPV, non-partner sexual violence or peer violence, while 19% (n=18) had promising findings, either a significant reduction in a sub-group, or non-significant ($p<0.1$) impacts in reducing VAWG. 37% (n=36) reported no impact on VAWG. Annex B provides more detail on the studies and their results by intervention category. Annex D provides more detail on the intervention types.

TABLE 6. A SUMMARY OF EVIDENCE REVIEWED IN THIS REPORT

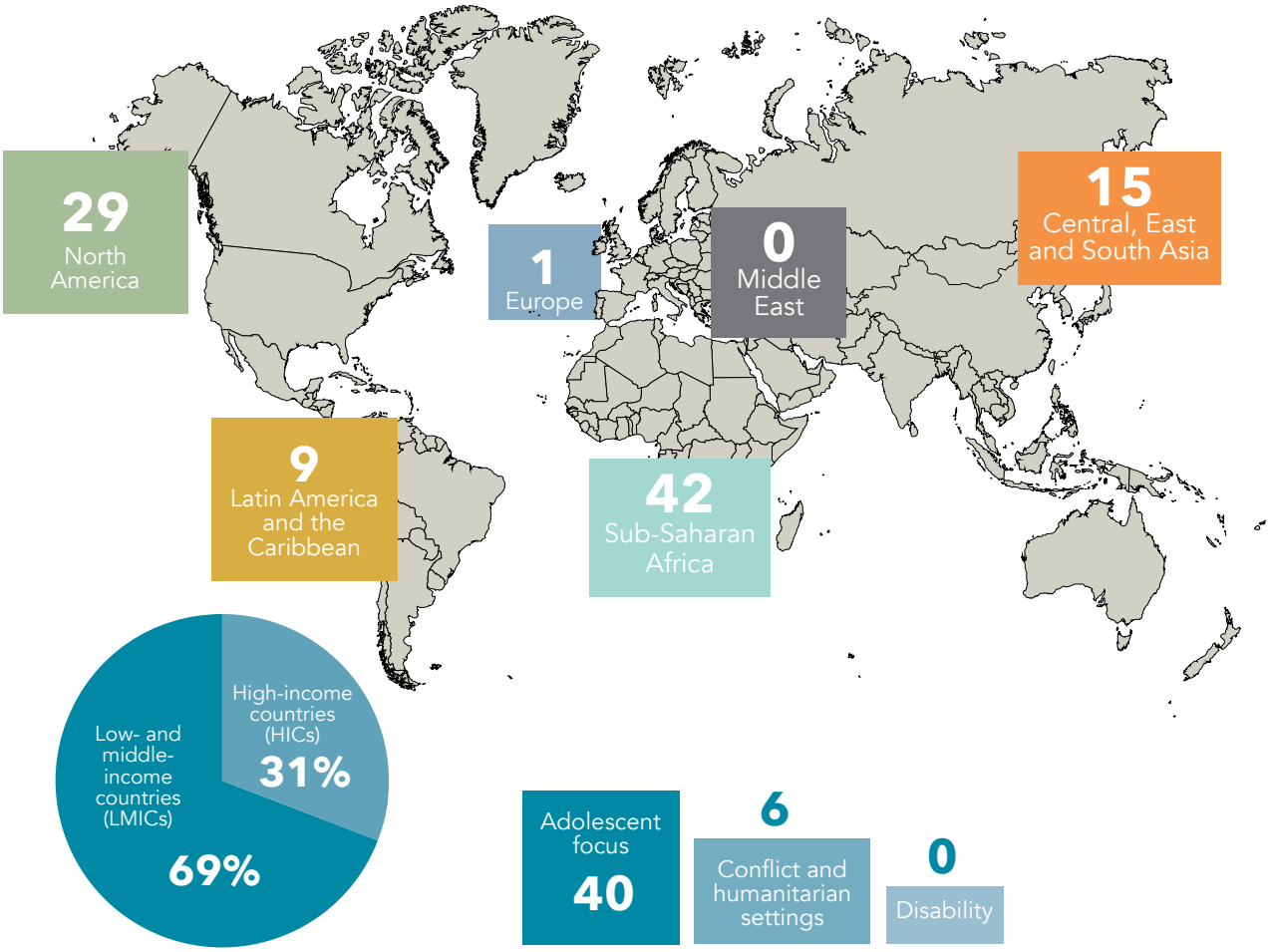
Number of studies included across all categories	114
Number of individual studies	104
Number of evidence reviews	12
Number of intervention categories	15
96 RCT/quasi-experimental studies	85 from global evidence review 11 from *What Works*
8 pre-post-test studies	3 from global evidence review 5 from *What Works*

17 See summary tables under intervention category sections for details of the studies.

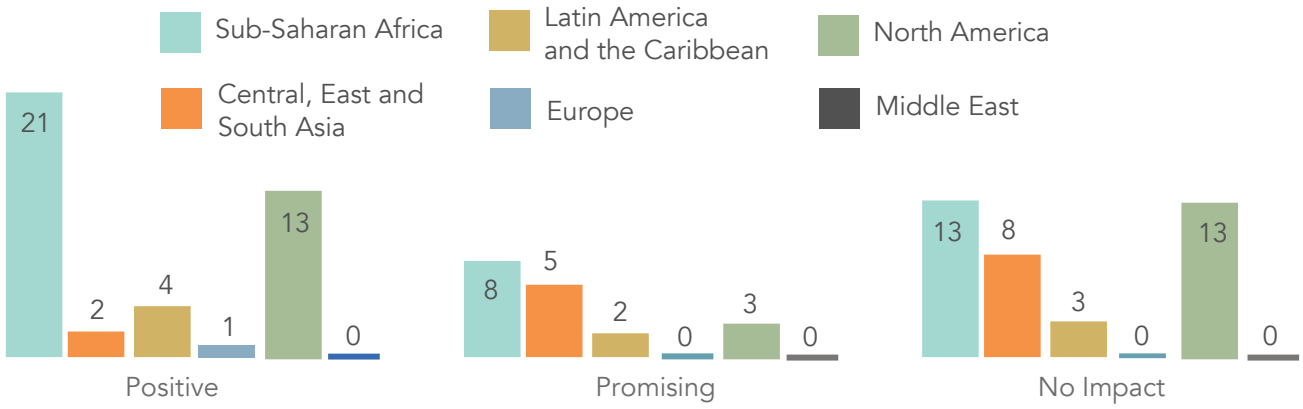
18 See p3 for the 15 categories.

19 Arango et al., 2014; Ellsberg et al., 2015; Ellsberg et al., 2018; Buller et al., 2018; Gibbs et al., 2017; Karakurt et al , 2016; Lester, Lawrence, & Ward, 2017; Parkes et al., 2016; Van Parys et al., 2014; Jewkes et al., 2015; Kettery and Marx, 2019; Katz and Moore, 2013.

LOCATION AND IMPACT OF 96 RCT/ QUASI-EXPERIMENTAL STUDIES



SUMMARY OF INTERVENTION EFFECTIVENESS BY REGION
(RCTs AND QUASI-EXPERIMENTAL STUDIES ONLY)



A detailed review of the evidence about each of the intervention categories, the types, nature and extent of the evidence, and the overall assessment follows.

3.1 Economic interventions

The relationship between poverty and VAWG is bidirectional: poverty is a key risk factor for VAWG (Vyas and Watts, 2008), and VAWG increases women and girls' poverty (Gibbs, Duvvury and Scriver, 2017). Women and girls who are poorer typically have greater dependency in relationships with men and less decision-making power in households, which exacerbates their risk of IPV and makes it harder for them to leave abusive relationships (Gibbs et al., 2017). Poverty also increases other risk factors for IPV including ill-health and reduced educational opportunities, and worsens household stress (Gibbs et al., 2017).

Interventions that include a substantive economic component have been used in efforts to prevent VAWG. This is highlighted in the WHO's RESPECT framework, where economic approaches are reflected in two separate sections: Empowerment of Women, and Poverty Reduced (WHO, 2019). Interventions focus on three types of economic approach:

1. Economic transfers, including cash, food transfers and food vouchers.
2. Microfinance, savings or livelihood strengthening only interventions, which include using microfinance, village savings and loans associations (VSLAs) or other income-generating activities (IGAs), or vocational/job training approaches only.
3. Combined economic- and social-empowerment interventions, whereby social-empowerment components (often with a strong emphasis on gender transformation) are complemented with a range of economic-empowerment interventions.

Box 2: World Food Programme (WFP) in Northern Ecuador (Hidrobo et al., 2016)

The WFP instituted a transfer programme to support the integration of Colombian refugees into Ecuadorian communities. The intervention provided one transfer per month, over 6 months, valued at approximate US$40 per month (~11% of households' consumption costs). Transfers could be in cash, food, or food vouchers. In addition, those receiving the transfer had to attend monthly nutrition training sessions to receive the transfer.

The study randomised 145 clusters into four arms (control, cash, food, food vouchers) and conducted a baseline and endline (six months post baseline) questionnaire. At endline, those receiving the intervention had an absolute percentage decrease in sexual/physical IPV of seven points, compared to the control arm (representing a 30% relative reduction in physical and/or sexual IPV).

3.1.1 ECONOMIC TRANSFER PROGRAMMES

Description of interventions

Economic transfer programmes have grown rapidly within LMICs, but vary substantially in their approach, delivery mechanism and broad objectives. Transfers can be:

- Cash, food, or food vouchers.
- Part of a large-scale social protection intervention implemented by governments.
- Short-term interventions, often delivered by NGOs, and linked to specific, acute crises.
- Unconditional, or include 'Plus' Components (Cash Plus), whereby the transfer is conditional on specific behaviours (e.g., school attendance, vaccination), or attendance at health programmes (e.g., nutrition counselling), or hybrid models with soft (non-punitive) conditions, or behavioural nudges.
- Targeted at a woman in the household, the household head (often male), or not specified.

Economic transfers have the potential to reduce violence in relationships through three mechanisms. First, improving economic security is likely to improve the psychological wellbeing of household members, which protects against IPV. Second, if poverty and food insecurity are key stressors and triggers of conflict in a relationship, economic transfers alleviate this immediate stress, and reduce the potential for conflict (Buller et al., 2018). Third, economic theories of IPV suggest that if women receive this cash it can increase their bargaining power in relationships and provide them with an option to exit violent relationships (Aizer, 2010; Anderberg et al., 2015).

However, economic theories also suggest there may be a point at which men seek to extract the additional economic value women gain through violence, and this is shaped by gender norms of appropriate levels of women's empowerment. In post-conflict or crisis settings, transfers may also enable a household to retain productive assets, rather than sell them, which in turn enables them to rebuild their livelihoods more rapidly once circumstances stabilise (ODI, 2015).

SUMMARY OF EVIDENCE AVAILABLE

10 interventions	**9 interventions from a global evidence review:** World Food Programme Transfer – women received the transfer (Ecuador); Bono de Desarrollo Humano cash transfer (Ecuador); HIV Prevention Trials Network (HPTN) 068, girls and families received the transfer (South Africa); Transfer Modality Research Initiative transfer and nutrition discussion, women received the transfer (Bangladesh); Juntos, women received the transfer (Peru); Oportunidades, women received the transfer (Mexico x 3), Give Directly, women and men received the cash transfer (Kenya); Jigisémèjiri, a national unconditional cash transfer to head of household (Mali); Familias en Acción conditional cash transfer to women (Columbia). **1 What Works intervention:** Short-term cash transfer to head of household (Syria).
	3 Africa / **1 Central and South Asia**
13 RCT/ quasi-experimental studies:	**7 with positive impact on VAWG:** HPTN068, a conditional cash transfer for schooling in South Africa (Pettifor et al., 2018); World Food Programme, a cash, voucher and food transfer and nutrition discussion in northern Ecuador (Hidrobo, Peterman and Heise, 2016); Transfer Modality Research Initiative, a cash transfer and nutrition discussion in Bangladesh (Roy et al., 2018); Give Directly, a cash transfer in Kenya (Haushofer & Shapiro, 2016); Juntos, a conditional cash transfer in Peru (Perova, 2010); Oportunidades, a conditional cash transfer in Mexico (Bobonis, Gonzales-Brenes and Castro, 2013); Familias en Acción conditional cash transfer in Columbia (Camacho and Rodríguez, n.d.). **2 with promising impact on VAWG:** short-term RCT of Oportunidades for sub-group (Angelucci, 2008); RCT of Jigisémèjiri for polygamous households (Heath et al., 2018). **4 with no impact on VAWG:** a cash transfer in Ecuador (Hidrobo & Fernald, 2013/5); in Bangladesh, a cash/food transfer alone had no impact on women's experiences of IPV 8-10 months post-intervention (Roy et al., 2018); long-term impacts in Mexico of Oportunidades (Bobonis and Castro, 2010.
1 What Works pre-post test	1 with potential increase in IPV: Syrian Cash Transfer Project (Falb et al., 2019).
1 evidence review	1 mixed methods review of cash transfers and IPV (Buller et al., 2018).

1 with adolescent focus (Pettifor et al., 2018)	**2 in conflict/humanitarian** (Falb et al., 2019; Hidrobo et al., 2016)	**0 with disability focus**

OVERALL FINDINGS

Effective: Economic transfers are effective in reducing women's experiences of IPV. There is no consensus about whether the transfer should target women, or the head of the household (often male), and the relative importance of Cash Plus approaches. Further research is required to understand the impacts of economic transfers in conflict/post-conflict settings.

Effectiveness of economic transfers

Overall, economic transfers are effective in reducing women's experiences of physical and/or sexual IPV. Further research is required to understand whether interventions with social components (Cash Plus approaches) have greater impacts on reducing IPV than economic transfers alone. One study (Roy et al., 2018), has shown this to be true. In addition, in the case of short-term economic transfers, little is known about whether the impact on VAWG is sustained once the intervention ends. There is also a lack of evidence on whether women should be directly targeted to receive the transfer or if targeting the head of the house (often male) achieves the same positive outcomes; there is also a lack of evidence on whether impacts vary substantially depending on the initial position of the woman in relation to her husband or partner.

Four RCTs examined the impact of economic transfer programmes without social components on VAWG outcomes. In Kenya, **Give Directly** was evaluated using an RCT, and provided unconditional cash transfers to households randomised in the study (whether the recipient was male or female), and either once-off or over a number of transfers (Haushofer & Shapiro, 2016). They also varied the amount of transfer received by the household. Households that received the transfer reported reduced physical and sexual IPV (Haushofer & Shapiro, 2016). Subsequent analysis demonstrated that if the transfer was received by the woman, both physical IPV and sexual IPV were reduced, while if the transfer was received by the man, only physical IPV reduced (Haushofer et al., 2019).

In Ecuador, an RCT evaluation of the roll-out of a national social-protection programme (**Bono de Desarrollo Humano**) that transferred cash to women, showed no overall impact on women's experiences of physical IPV (Hidobo & Fernald, 2013). In Bangladesh, an RCT of a cash/food transfer found no evidence of impact on IPV among women who received the transfer, eight to ten months post-transfer. However, the RCT found decreases in physical IPV when transfers were paired with intensive nutrition behaviour-change communication (BCC) (Roy et al., 2018), which is discussed below. IPV data were only collected post-intervention (eight to ten months after the transfers ended), which limited the ability of authors to determine if impacts on IPV were evident immediately after the end of the programme. In addition, because IPV was not assessed at baseline, any baseline imbalance in IPV could not be adjusted for in the analysis.

In Mali, the national cash-transfer programme **Jigisémèjiri**, was an unconditional cash transfer to the head of the household with optional training sessions to boost human capital. The programme was evaluated in an RCT with a one-year follow-up. At the follow-up, there was no overall impact on women's experiences of physical IPV. However, among women in polygamous relationships there was a significant seven percentage-point reduction (Heath et al., 2018), with the biggest changes among women who were second wives (Heath et al., 2018).

What Works conducted a pre-post-test evaluation of a short-term cash transfer programme in northern Raqqa Governorate, Syria. This mirrored an acute humanitarian emergency, with large influxes of displaced people after the withdrawal of ISIS from villages. One response to this emergency was cash transfer programmes. In the evaluation, 456 households received unconditional and multi-purpose transfers of $76 a month for three months to help households meet their basic needs. The transfers went to the heads of the households, regardless of whether they were men or women, as is standard practice in the humanitarian sector. In the study, nearly two-thirds (63.3%) of heads of household were women, and only 41.8% of women were married. The evaluation found that two to three weeks after receiving the final transfer, women reported increased food security and reductions in negative coping, but married women's experiences of IPV (n=171) increased during the cash transfer delivery period. However, given the study design (no control arm), it is hard to attribute the increase in IPV to the transfer; further, the very short-term nature of the programme caused anxiety and may have been related to the finding (Falb et al., 2019).

Eight studies (four RCTs and four quasi-experimental) evaluated the impact of Cash Plus approaches to reducing VAWG. Most studies showed a significant reduction in women's experiences of IPV.

Three studies (one RCT and two quasi-experimental) explored the impact of **Oportunidades** in Mexico, a national cash-transfer programme that includes a monthly transfer to women conditional on education of children and health check-ups. Angelucci (2008), used the initial roll-out of **Oportunidades** as an RCT to examine its impact on women's experiences of IPV while their husband was drunk. There was no overall impact of **Oportunidades** on male-perpetrated IPV (while drunk). However, there was some evidence that small transfers led to a decrease in IPV (while men were drunk), while larger transfers led to an increase in IPV (while men were drunk) (Angelucci, 2008).

Two quasi-experimental studies also assessed the impact of **Oportunidades** at the national level. The first assessed its impact two to six years after implementation (depending on where households were in the roll-out), and found a 40% reduction in women's experiences of IPV (Bobonis, Gonzales-Brenes, Castro, 2013). A second study assessed the impact of **Oportunidades** five to nine years after implementation (again depending on where households were in the roll-out). The analysis showed no reduction in women's experiences of IPV (Bobonis and Castro, 2010) and hypothesised that the lack of impact was because the regular cash transfer enabled women to leave violent husbands or partners (Bobonis and Castro, 2010). Both quasi-experimental studies have weaknesses: their authors had to construct a control arm using cross-sectional data, and while they go to considerable lengths, there are significant differences between the samples (e.g., those receiving the transfer had less secondary-school education) which made direct comparison between households receiving the transfer and those not receiving the transfer complicated. In addition, the authors did multiple tests of association, and used a significance level of $p<0.1$, rather than the public health standard, $p<0.05$, as evidence of effect. Although their preferred model was only significant at $p<0.1$, other models did show evidence of significant reductions at $p<0.05$.

In Peru, a large-scale, quasi-experimental evaluation of the **Juntos** social protection programme combined a cash transfer programme tied to children's education and health behaviours. It found that the programme significantly reduced women's experiences of physical IPV, but not sexual IPV (Perova, 2010). In Colombia, the social-protection programme **Familias en Acción**, combined a cash transfer to the female head of the household with conditionalities, which included that children seven and under were to access health services, and those over seven had to be in school. The impact of **Familias en Acción** was assessed using a quasi-experimental design, focusing on different payment periods of the transfer and reported rates (at health or police stations) of domestic violence (Camacho and Rodríguez, n.d.). The analysis shows a significant decrease in IPV in communities of approximately five percentage points shortly after the transfer was paid, and this was significant (Camacho and Rodríguez, n.d.).

There are a number of limitations to this analysis: specifically, data on violence are from administrative sources which likely under-report the rates of IPV. The analysis also assumes that the impact of cash on IPV occurs very quickly, within two months of receipt, and then disappears.

Three studies (all RCTs) evaluated the impact of short-term economic transfer programmes, combined with a Plus component, and all showed significant positive impacts on reducing VAWG. In Ecuador, a six-month World Food Programme (WFP) transfer and nutrition discussion group programme showed a significant reduction in physical and/or sexual IPV experience (see Box 1). In South Africa, an individually randomised RCT evaluated the impact of a cash transfer conditional on school attendance by adolescent girls (13-20). Cash was transferred to the girls and their families. The evaluation found that receipt of the cash significantly reduced young women's experiences of physical IPV, after three years (Pettifor et al., 2016). IPV was not a pre-specified primary or secondary outcome, which enhanced the risk that the finding was due to chance. In Bangladesh, a three-arm RCT demonstrated the added benefit of an intensive nutrition behaviour-change communication (BCC) intervention alongside economic transfers. Women receiving only food or cash transfers had no reduction in IPV (discussed above), but those randomised to receive a nutrition discussion programme as well as food or a cash transfer saw a significant reduction in IPV eight to ten months after the intervention had ended (Roy et al., 2018). More recent analyses suggest that these impacts were sustained four years after the programme ended, but were primarily driven among those who had received cash transfers, rather than food, alongside the BCC intervention (Roy et al., 2019).

The criteria for the systematic review by Buller et al. (2018) were more inclusive and permitted qualitative studies. The review also considered potential pathways through which transfers could impact on IPV and found compelling evidence that economic transfers could reduce IPV and impact on hypothesised mechanisms through which cash may work to reduce IPV (Buller et al., 2018).

3.1.2 MICROFINANCE, SAVINGS OR LIVELIHOOD INTERVENTIONS

Description of the interventions

Microfinance, savings or livelihoods interventions seek to strengthen the economic position of a person or household. As with economic transfer programmes, the rationale is that to the extent that violence in relationships is driven by poverty, stronger household economics can reduce stress and increase women's bargaining power in relationships.

Effectiveness of microfinance, savings or livelihood interventions

Overall, there is good evidence to suggest that microfinance, savings and livelihood interventions on their own are not effective in reducing women's experiences of IPV. Such approaches may have other positive outcomes, such as improved economic wellbeing for women and households, which are recognised protective factors for IPV experience.

We identified three RCTs with microfinance, savings and livelihood interventions as standalone interventions. One RCT evaluated the **Trickle-Up** programme with a three-arm cluster randomised control trial amongst women in rural Burkina Faso. The **Trickle-Up** programme comprised a control arm and an economic intervention-only arm, with VSLA, livelihoods training and start-up capital for women over a six-month period. A third arm is discussed in the combined economic and social empowerment section below. Two years after the baseline, women reported a non-significant reduction in physical IPV, which may have been the same as that seen in the control arm (Ismayilova et al., 2018). This study had considerable residual bias, as the design was a cluster RCT with four villages per arm and an imbalance in past-year IPV between arms at baseline.

The second RCT, **Pigs for Peace**, utilised a productive asset-transfer programme, with a piglet as the transfer, and training on animal husbandry to households, with expected repayment comprising two piglets. At the endline evaluation, the authors reported that there were no differences in experience or perpetration of physical or sexual IPV between the arms, although the percentage difference was not reported (Glass et al., 2017).

A third RCT, conducted in post-conflict Uganda, looked at the provision of microloans and business training in an intervention for women (Green et al., 2015). This showed no impact on women's experiences of violence.

The null effects of these three studies is reflected in a comprehensive review (Gibbs et al., 2017), which also highlights that microfinance, savings and livelihood only interventions have had mixed outcomes relating to IPV. Further, several studies have shown the benefit of layering a social empowerment intervention over economic interventions (Gibbs et al., 2017). While microfinance, savings and livelihood interventions may have important broader outcomes, they do not directly translate into impact on IPV. Importantly, there was no evidence of any specific 'backlash' or increase in IPV reported in any arms. Other studies, particularly economic transfer interventions, have suggested increases in emotional IPV and/or controlling behaviours, negative outcomes that were not reported in these three studies.

SUMMARY OF EVIDENCE AVAILABLE

3 interventions	**3 interventions from a global evidence review:** WINGS (Uganda); Trickle-Up (Burkina Faso); Pigs for Peace (DRC).
	3 Africa / **0 Central and South Asia**
3 RCT/ quasi-experimental studies	**0 with positive impact on VAWG and 0 with promising impact on VAWG.** **3 with no impact on VAWG:** Trickle-Up, a comprehensive livelihoods intervention for women in Burkina Faso (Ismayilova et al., 2018); WINGS, a business and microloans intervention in Uganda (Green, Blattman, Jamison and Annan, 2015); Pigs for Peace, a livestock productive asset transfer programme in DRC (Glass, Perrin, Kohli, Campbell and Remy, 2017).
1 evidence review	**1 mixed methods review** of cash transfers and IPV (Buller et al., 2018).

0 with adolescent focus	**2 in conflict/humanitarian** (Glass et al., 2017; Green et al., 2015)	**0 with disability focus**

OVERALL FINDINGS

No effect: There is good evidence that microfinance, savings and livelihoods interventions alone are not effective at reducing women's experiences of IPV. They are not recommended as standalone interventions to reduce women's experiences of IPV. However, they have potential to improve economic wellbeing, a known protective factor for IPV.

3.1.3 ECONOMIC EMPOWERMENT AND SOCIAL EMPOWERMENT INTERVENTIONS

Description of the interventions

In these interventions, economic components are overlaid with social empowerment components. Although there is much variety across these approaches, there are two dominant combinations. First, short-term, 'two-component' interventions have approaches that combine economic strategies such as microfinance, or VSLA, approaches, with group-based social empowerment interventions (up to a year in length, but often 10 to 15 sessions). These interventions primarily target women, although men are sometimes included as women's partners. In *What Works*, in **Stepping Stones and Creating Futures**, men were included as full participants in the intervention (as well as women), and whole families were included in two other studies (in Tajikistan and Nepal).

The second approach, which layers multiple components (more than two) is delivered over longer periods. In Uganda, for example, the **Multi-Faceted Women's Empowerment** programme combined multi-year microfinance, vocational and life-skills intervention for adolescent girls (Bandiera et al., 2018), and in Kenya, the **Adolescent Girls Initiative** provided cash transfers and savings accounts, schooling support, health and life skills training delivered at girl only 'safe spaces' and community dialogues on violence prevention (Austrian et al., 2018).

Interventions are premised on the assumption that IPV is driven by poverty and gender inequalities. The economic components of the intervention are assumed to reduce poverty and the immediate stress in relationships, as well as offering women greater bargaining power and the potential to exit violent relationships. In addition, they recognise that violence exists within social contexts and that social empowerment can support women (and men) to reflect on the underlying drivers, build confidence and improve communication in relationships, and transform gender relations.

Box 3: What Works Studies: Stepping Stones and Creating Futures (South Africa)

In South Africa, the **Stepping Stones and Creating Futures** intervention for young women and men (not in relationships), comprised 21, three-hour sessions delivered over three months (Gibbs et al., 2019a). The livelihoods component focused on supporting young people to consider opportunities and strategies for strengthening their economic position, and the social empowerment intervention was explicitly focused on gender transformation.

At endline, men in **Stepping Stones and Creating Futures** reported significantly less physical IPV and economic IPV perpetration, as well as reductions in sexual IPV and non-partner sexual violence perpetration. There was no impact on women's experiences of IPV. This is the first evaluation of a short, two-component economic empowerment and social empowerment intervention for men, that has shown impact on reported experiences of IPV perpetration.

Photo: Anisa Sabiri

SUMMARY OF EVIDENCE AVAILABLE

18 interventions

13 interventions from global evidence review: Intervention for Microfinance for AIDS and Gender Equity (IMAGE) Project (South Africa); SHAZ! (Zimbabwe); VSLA + Couples' Discussions (Burundi); Mashinani (Kenya); Multi-Faceted Women's Empowerment (Uganda); Wings Plus (Uganda); Reduction of Gender-Based Violence Against Women (Cote d'Ivoire); Trickle-Up and Family Counselling (Burkina Faso); Safe and Smart Savings Products for Vulnerable Adolescent Girls (SSSPVAG – Kenya and Uganda); Adolescent Girls Initiative (Kenya); Adolescent Girls Empowerment Program (Kenya); Maisha (Tanzania); Sumaq Warmi (Peru).

5 What Works interventions: Stepping Stones and Creating Futures (South Africa); Sammanit Jeevan (Nepal); Zindagii Shoista (Tajikistan); Women for Women International (Afghanistan); HERrespect (Bangladesh)

13 Africa	4 Central and South Asia

16 RCT/ quasi-experimental studies

5 with positive impact on VAWG: IMAGE combining microfinance and gender training for women (Pronyk et al., 2006); Multi-Faceted Women's Empowerment combining microfinance, vocational training and life skills for adolescent girls in Uganda (Bandiera et al., 2018); Adolescent Girls Initiative combining schooling, cash transfer, violence prevention at community level, group discussions for adolescents in Kenya (Austrian, Soler-Hampejsek, Maluccio, Mumah and Abuya, 2018); "Mashinani" micro-loans, business training and psychosocial support sessions in Kenya (Sarnquist et al., 2018); Maisha, a microfinance and gender transformative intervention for women (Kapiga et al., 2019).

4 with promising impacts on VAWG: Livelihoods training and gender transformative intervention with young people in South Africa – men self-reported perpetration only (Gibbs et al., 2019a); Reduction of Gender-Based Violence Against Women combining a gender dialogue and savings group in Ivory Coast (Gupta et al., 2013); SHAZ!, combining vocational training and life skills for adolescent girls (Dunbar et al., 2014); Women for Women International, evaluating one-year economic and social empowerment intervention for women in Afghanistan (Gibbs et al., 2019b).

7 with no impact on VAWG: Safe and Smart Savings Products for Vulnerable Adolescent Girls (SSSPVAG), combined savings, financial education and safe spaces for adolescent girls in Uganda and Kenya (Austrian & Muthengi, 2013); Wings Plus, a microenterprise and short gender discussion in Uganda (Green et al., 2015); Adolescent Girls Empowerment Program combined safe spaces, health vouchers, and savings (Austrian et al., 2018); Trickle-Up Plus, combined economic strengthening and family coaching (Ismayilova et al., 2018); VSLA and couples' discussions (Iyengar and Ferrari, 2011); microfinance and gender training for women based on the IMAGE study (Agüero & Frisancho, 2018); HERrespect a gender transformative intervention in garment factories (Naved et al., 2019).

2 What Works pre-post test

1 with positive impacts on VAWG: Zindagii Shoista in Tajikistan combined gender empowerment, training in setting up an income generating activity and micro-grants to support this within households (Mastonshoeva et al., 2019).

1 with promising impacts on VAWG: Sammanit Jeevan in Nepal combined gender empowerment, training in setting up an income generating activity and micro-grants to support this (Shai et al., 2019).

1 evidence review

1 comprehensive review of economic interventions to prevent IPV and HIV risk behaviours (Gibbs et al., 2017).

5 with adolescent focus: SHAZ! In Zimbabwe (Dunbar et al., 2014); Multi-Faceted Women's Empowerment in Uganda (Bandiera et al., 2018); Adolescent Girls Initiative in Kenya (Austrian, Soler-Hampejsek, Maluccio, Mumah, and Abuya, 2018); Safe and Smart Savings Products for Vulnerable Adolescent Girls (SSSPVAG) (Austrian and Muthengi, 2013); Adolescent Girls Empowerment Program (Austrian et al., 2018).	**3 in conflict/humanitarian:** (Reduction of Gender-Based Violence Against Women (Ivory Coast; Gupta et al., 2013); Wings Plus (Green et al., 2015) (Uganda); Women for Women International (Afghanistan) (Gibbs et al., 2019b.	**0 with disability focus**

OVERALL FINDINGS

Effective: Combined economic empowerment and social empowerment interventions are effective in reducing women's experiences of IPV. For short-term two-component interventions these worked better with older (>30) women, in more stable contexts; for adolescents, longer-term, multi-layered interventions were more effective. There was one study which showed that engaging men directly in these interventions (rather than as women's partners) could reduce men's self-reported perpetration of IPV. There is very limited evidence that short-term two-component interventions work with young women and adolescents in complex contexts.

Effectiveness of combined economic- and social-empowerment interventions

Overall, there is good evidence from multiple, well-conducted RCTs that combined economic-empowerment and social-empowerment interventions can reduce women's experiences of IPV. This was particularly the case with short-term, two-component interventions delivered to older (>30) women in more stable contexts, and where interventions were more clearly focused on theories of gender and power. There is also promising evidence that engaging men from highly marginalised settings in economic and social empowerment interventions (rather than only as women's partners) can reduce their self-reported perpetration of IPV. For adolescent girls, the two effective RCTs were both multi-component interventions, delivered over a year or more (rather than the three- to twelve-month duration of other studies), suggesting that for this age group, more intensive interventions are necessary.

There is a lack of evidence on whether these interventions work in conflict settings; there is no well-evaluated intervention that shows conclusive reductions in women's experiences of IPV. In addition, the engagement of men and boys in such interventions as direct recipients is limited to one RCT (**Stepping Stones and Creating Futures**). In other studies, men were brought in as women's partners, and were not primary beneficiaries. Given the large number of vocational training and livelihoods interventions that include men, this remains a critical gap.

For 'short', two-component interventions with women as the direct recipients, two RCTs and one quasi-experimental study showed positive impacts, three studies showed promise, and two RCTs showed no impact. In South Africa, the **IMAGE** RCT combined microfinance and ten gender transformative group sessions for women, alongside community action around gender and violence. After two years, women who had received the intervention had a 55% reduction in physical IPV (Pronyk et al., 2006). In addition, while falling outside of the review period, the **Maisha** trial compared the impact of women receiving microfinance and a ten-session (20-hour) gender-transformative training intervention, to those receiving microfinance only; and showed a significant reduction in women's experience of physical IPV among those receiving the combined intervention (Kapiga et al., 2019). **Sumaq Warmi** was also very similar to the **IMAGE** RCT and **Maisha** trial, it drew heavily on the gender curriculum of **IMAGE** and was implemented among women attending microfinance groups in Peru (Agüero & Frisancho, 2018). However, unlike **IMAGE** and **Maisha**, at follow-up two years later, there was no evidence of impact on women's experiences of IPV (Agüero & Frisancho, 2018). The specific reasons for this are not evident, although this highlights that despite two-component interventions often being effective, this may not always be the case and will depend on efficient design and implementation.

A quasi-experimental study also showed effect of reducing IPV. In Kenya, the **Mashinani** intervention comprised micro-loans and a 12-session intervention providing psychosocial support for survivors of violence, and in a quasi-experimental study saw significant reductions in experiences of physical IPV (Sarnquist et al., 2018). However, this study had significant limitations because of a lack of balance at baseline between arms, and short-term follow-up (four to five months from baseline), leaving open the possibility of residual bias.

Three two-component interventions with women as the primary recipients showed promise in reducing women's experience of IPV. In Ivory Coast, the addition of gender dialogue groups (which included women's husbands) to a women's village savings and loans scheme, showed no overall reduction in women's experiences of IPV among the whole sample, however it led to significant reductions in physical IPV amongst women who attended ≥75% of sessions (Gupta et al., 2013).

In the *What Works* evaluation of the **Women for Women International (WfWI)** economic and social empowerment in Afghanistan, the intervention was delivered over a year, and combined vocational training, a cash transfer and social empowerment sessions. There was no overall reduction in married women's experiences of IPV. However, a secondary, analysis, which was not pre-specified, showed that women with medium levels of food insecurity at baseline (as opposed to high levels, or none), reported a significant reduction in severe IPV (a combined physical and/or sexual IPV measure) by endline (Gibbs et al., 2019b). This reduction may be because of improved levels of food security reported among participants. However, caution is required in interpretation, as the analysis was not pre-specified. While an RCT in Burundi evaluating an ongoing microfinance intervention layered on couples' discussion sessions saw a reduction in IPV, this was not significant. The analysis strategy is unclear and has never been fully published (Iyengar & Ferrari, 2011).

The only RCT targeting women in conflict-affected communities layered a social empowerment intervention on an economic empowerment intervention in Uganda but showed no impact on women's experiences of IPV (Green et al., 2015). However, the social intervention was a brief intervention (one day) that included women's partners (Green et al., 2015).

Another set of short-term, 'two-component' interventions looked at the potential of working directly with whole families, rather than only the woman as the primary recipient of the intervention. In Burkina Faso, **Trickle-Up Plus** combined VSLA, livelihoods training and start-up capital for women, over six months, with family coaching sessions around gender and conflict. Two years post-baseline, women reported no significant reduction in physical IPV and there was considerable residual bias in the report, with imbalance between arms, and individual, rather than cluster-level analysis (see the section above) (Ismayilova et al., 2018).

What Works also evaluated (using pre-post-test designs and qualitative research), innovative approaches implementing short-term, 'two-component' interventions with whole families, rather than individual participants. The two interventions in Tajikistan and Nepal had similar approaches, with 20 structured group sessions delivered around gender empowerment, training on how to establish an income generating activity (e.g., baking or growing vegetables), some start-up capital for the economic activities, and ongoing support over several months. In Tajikistan, **Zindagii Shoista** showed that women's experiences and men's perpetration of IPV declined significantly, and the reductions were sustained 30 months after baseline, which was 15 months after the intervention and support had been completed (Mastonshoeva et al., 2019). Although extensive qualitative research supported the quantitative findings, the study had no comparison group. In Nepal, **Sammanit Jeevan** used much the same intervention and found a reduction in young women's experiences of physical IPV that was not statistically significant (p=0.077) (Shai et al., 2019). The sample of young women was very small.

Only one intervention worked directly with men as recipients of the intervention, on the assumption that men's perpetration of IPV is associated with gender inequitable attitudes and poverty. The *What Works* study in South Africa (Box 3), **Stepping Stones and Creating Futures** was implemented with young women and men (18 to 30 years old) not in relationships with one another but in relationships with other people and living in urban informal settlements. Evaluated with an RCT, the findings showed significant reductions in men's self-reported physical and economic IPV perpetration, as well as promising ($p<0.1$) reductions in sexual IPV and non-partner sexual violence. However, women (not the men's partners) did not see a reduction in IPV experience, despite strengthened livelihoods, which reflected wider evidence showing that short interventions for women in challenging contexts may not be enough to change their experiences of violence. There was potential bias in the study; participants were recruited after clusters were randomised (because of political sensitivities) potentially leading to self-selection bias, and men's self-reporting of IPV had the potential for social desirability bias (i.e., men report what they think researchers want to hear). The findings of the **Stepping Stones and Creating Futures** trial were very similar to those of the original **Stepping Stones** evaluation among young men in school (see Section 3.4.1), where men's self-reported physical and/or sexual IPV perpetration was significantly reduced two years after the baseline (Jewkes et al., 2008). There was also no impact on women's experiences of IPV.

Five RCTs focused on combined economic empowerment and social empowerment interventions for adolescent girls. Two of these were long-term, multi-component interventions and showed evidence of reducing IPV. In Uganda, a two-year, multi-component intervention comprised of safe spaces, vocational training and life skills, was found to reduce coerced sex to almost zero, and this effect was sustained two years after the main programming ended (Bandiera et al., 2018). In Kenya, among adolescent girls living in informal settlements, an RCT of an intervention combining cash transfers conditional on school attendance, schooling kits, group discussions on health and wellbeing, and community-level action around violence by adults, found a reduction in girls' experiences of physical, sexual and/or emotional violence, with greater impact for those involved in all interventions (Austrian et al., 2018). This final study, however, was a midline evaluation 12 months post-baseline; endline results are still to be presented.

In contrast, three evaluations of less intensive interventions – short-term two-component interventions for adolescent girls – showed little evidence of reducing girls' experiences of IPV. In Zimbabwe, **SHAZ!** worked with adolescent girls on vocational training, micro-grants, social support and life skills training. The evaluation showed a reduction in IPV compared to the control arm, but this was not significant ($p<0.1$) (Dunbar et al., 2014). One RCT and one quasi-experimental study showed no impact on adolescent girls' experiences of violence. In Kenya and Uganda, a savings intervention, combined with safe spaces and group discussions, evaluated in a quasi-experimental study, showed no impact on girls' experiences of violence (Austrian & Muthengi, 2013). In addition, because of a delivery error, a sub-group of girls in Uganda received only the savings intervention (with no safe spaces and group discussions), and they reported higher rates of inappropriate sexual touching (Austrian & Muthengi, 2013). Similarly, in Zambia, when girls were provided with health vouchers, savings

accounts and safe spaces in an intervention evaluated in an RCT, there was no impact on their experiences of violence (Austrian et al., 2018). In addition, in the *What Works* **Stepping Stones and Creating Futures** evaluation, young women (though some were past adolescence) living in urban informal settlements in South Africa who received the intervention, reported no reduction in their experiences of IPV, despite improvements in economic outcomes (Gibbs et al., 2019a). These studies reinforce the notion that relatively short, or circumscribed interventions for adolescent girls and young women may not be intensive enough to meaningfully reduce their experiences of violence.

One study by *What Works* implemented a gender transformative training intervention (**HERrespect**) for female garment workers and their managers in garment factories in Dhaka, Bangladesh, to assess its impact on women's experiences of IPV, and violence within factory settings. There were challenges with the evaluation; at endline, management at the factories intervened with workers and encouraged them to 'not show factories in a bad light' (Naved et al., 2019), which led to reduced reporting of violence. As such, the evaluation findings cannot be trusted (it was a null finding), and we did not consider it in the evaluation of evidence.

HERrespect did demonstrate some of the challenges of working in factories. Specifically, the intervention comprised six three-hour sessions, primarily delivered to women workers, male workers and (mostly male) managers, in separate groups. The intervention was supplemented in the factory by an awareness-raising campaign on violence. However, the intervention was delivered very differently from the way it had been planned because of lack of management buy-in at factories. As such, much more substantive research is needed to understand how best to work in factories and workplaces.

Workplace interventions to reduce violence in the workplace and/or IPV have potential, given their ability to reach large numbers of women and men engaged in formal work. However, current intervention approaches to reducing IPV through workplace interventions are limited; a recent systematic review highlights that their primary focus is on recognising signs of violence and referral to services, rather than on the primary prevention of IPV (Adhia et al., 2019).

Photo: Anisa Sabiri

3.2 Relationship and family-level interventions

Women are at increased risk of IPV where gender, power and the practices of gender relations within an intimate relationship are inequitable, violence is readily used to assert dominance, and relationship discord is high. An association has also been established between witnessing abuse of one's mother as a child and either perpetrating or experiencing abuse in adulthood, which suggests that VAWG may have elements of learnt behaviour and/or trauma that need to be addressed. This section examines the evidence on the impact on VAWG prevention of working with couples to strengthen gender equality and relationship dynamics, as well as working specifically with parents to promote positive parenting practices.

3.2.1 COUPLES' INTERVENTIONS

These interventions work directly with both members of a couple. They employ gender-transformative strategies implemented through participatory group sessions run by trained facilitators. They are either delivered to men and women together, or to single-sex groups. Sessions typically use methods that employ critical reflection on gender attitudes and relations and sources of conflict, as well as building communication and relationship skills.

Two main types of couples' interventions have been developed and evaluated:

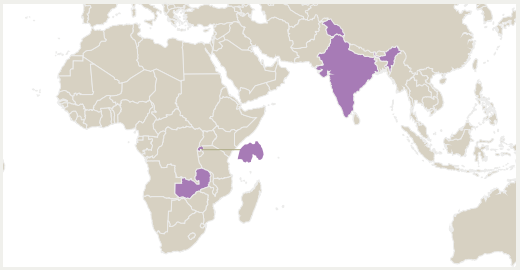
- **Intensive group interventions** following a gender equity and relationships skills building programme using participatory methods delivered to couples from the general population (e.g., **Indashyikirwa**)
- **Brief couples' interventions** focused on health behaviours that include gender issues and are delivered to couples accessed through a clinical setting (e.g. **Partner Plus**)

We recognise that couples' therapy is also a couples' intervention and for completeness have included a systematic review thereof. However, we did not include a search specifically for individual studies on couples' therapy, as it is thus far a professionally delivered treatment rather than a VAWG-prevention intervention and there is no published literature that points to adaptation by other delivery environments in low- and middle-income countries. Its use has also been controversial due to some early reports of backlash violence after sessions.

Box 4: Examples of relationship-level interventions

What Works evaluated couples-based interventions in Rwanda (**Indashyikirwa**), Nepal (**Change Starts at Home**), Zambia (**Violence and Alcohol Treatment trial [VATU] of the Common Elements Treatment Approach [CETA]**) and India (**Samvedana Plus**).

Indashyikirwa in Rwanda had two components: a couples' intervention and a community activism intervention. Initially, couples were recruited from Village Savings and Loan Associations (VSLAs) and enrolled in a workshop programme with a curriculum of 21 three-hour sessions provided weekly over five months. The programme was delivered to groups of 15 couples with two facilitators. The curriculum built on SASA! and Journeys of Transformation and included an integrated gender framework emphasising positive and negative types and uses of power and critical reflection. Just over a quarter of the couples received an additional ten half-days of training to equip them to contribute as community activists to the broader community interventions. **Indashyikirwa** was evaluated through an RCT and was found to have substantial impact on physical and sexual IPV, with reductions seen 12 and 24 months after the baseline.



The ten main couples' interventions considered in this section were very different, ranging from two to 40 sessions. Apart from the **VATU** intervention evaluated by *What Works*, where couples who were known to have a problem with IPV and alcohol abuse, couples were not necessarily known to have a problem with IPV. In all studies, couples were heterosexual.

There were four longer interventions (comprising of 15 or more sessions). *What Works* evaluated two of these longer couples' interventions. In Nepal, the **Change Starts at Home** intervention had a 30-minute radio show and weekly listening groups (each lasting one-and-a-half hours) over 39 weeks for couples. **Indashyikirwa** in Rwanda (see Box 4) had 21 three-hour sessions.

In Rwanda, **Bandebereho** had 15 sessions for men of about three hours on a weekly basis (45 total hours); eight of these sessions were also attended by their female partners (24 hours in total).

In a fourth intervention in India, *What Works* evaluated the **Samvedana Plus** curriculum with female sex workers and (separately) their intimate partners; the intervention was supplemented by an ongoing programme of community support on safety and encouragement of collectivisation for the women. It was designed as 12 participatory, group sessions (of one to two hours) for the women and their male intimate partners, but delivery was often over five to six months, and participation in the men's sessions was hard to implement.

Six much shorter interventions (six to twelve hours) were delivered in clinical settings. In the US, a couple-focused prevention intervention for expectant first-time parents had nine sessions in a manualised format (five prenatal and four postnatal classes), comprising a psychoeducational programme delivered in small groups.

In Zambia, *What Works* evaluated the **Common Elements Transdiagnostic Approach (CETA)**, in the **Violence Alcohol Treatment (VATU)** trial (see case study box in Section 3.8) which was delivered over six to twelve individual sessions (60 to 90 minutes) for men and women separately by a well-trained lay counsellor intensively supported by a clinical psychologist.

In South Africa, the **Partner Plus** intervention was based on the **Partner Project** in Zambia; both had four 90- to 120-minute weekly sessions. In India, the **Charm** intervention was a three-session intervention (two for men and one for their wives) and in South Africa, the **Couples' Health Cooperative** consisted of two, three-hour sessions delivered one week apart by peer leaders within the community.

SUMMARY OF EVIDENCE AVAILABLE

10 interventions

6 interventions from global evidence review: Partner Project (Zambia); Charm (India); Partner Plus (South Africa); Couples' Health Coop (South Africa); Bandebereho (Rwanda); Couple-focused intervention at transition to parenthood (US).

4 What Works interventions: Indashyikirwa (Rwanda); Change Starts at Home (Nepal); Common Elements Treatment Approach (Zambia); Samvedana Plus (India).

6 Africa	3 Central and South Asia

10 RCT/ quasi-experimental studies

6 with positive impact on VAWG: Indashyikirwa in Rwanda (Dunkle et al., 2019); a transdiagnostic (CETA intervention) to reduce intimate partner violence and hazardous alcohol use (VATU) in Zambia (Murray et al., 2019); Couples' Health Co-op in South Africa (Minnis et al., 2015); Partner Plus couples-based intervention on prevention of mother-to-child transmission of HIV in South Africa (Jones et al, 2013); a nine-session transition-to-parenthood intervention ('Family Foundations') in the US (Feinberg, 2016); Participatory, small group sessions of critical reflection and dialogue ('Bandebereho') with expectant/current fathers and their female partners in Rwanda (Doyle et al., 2018).

1 with promising VAWG findings: A gender-equity and family-planning intervention ('Charm') for young married men and couples aged 18-30 in rural India (Raj et al., 2016).

3 with no impact on VAWG: Change Starts at Home in Nepal (Clark et al., 2019); Samvedana Plus intervention with FSWs and their intimate partners in India (Javalkar et al., 2019); a relationship and communications skills intervention ('The Partner Project') in Zambia (Jones et al 2014).

1 evidence review

1 systematic review of couples' therapy for IPV that found that couples' therapy can be an effective way to prevent intimate partner violence in certain situations. All six shortlisted studies were RCTs where therapy was conducted in the US (Karakurt et al , 2016)*

0 with adolescent focus	0 in conflict/humanitarian	0 with disability focus

OVERALL FINDINGS

Good evidence that couples' interventions are an effective approach for reducing women's experiences of IPV and can be delivered safely. Well-designed, well-implemented couples' interventions have been shown to be effective in transforming gender relations within the couple. A couples' approach to addressing IPV and alcohol abuse has been shown to be particularly impactful, as have parenting interventions that engage couples around the birth of a child. Couple- or family-centred programming is particularly beneficial when combined with economic and gender empowerment interventions. The 'couple' needs to be prepared to work to strengthen their relationship.

* In the systematic review of couples' therapy (Karakurt et al., 2016) four studies utilised individual couple therapy as the intervention, one study utilised conjoint group therapy, and one study used a combination of both. Only one study (the largest) on its own had statistically significant findings on reductions in VAWG.

Effectiveness of the interventions

There is good evidence that couples' interventions are effective if they are robustly designed and implemented (Jewkes et al, 2020). In Section 3.8, which is focused on alcohol and/or other substance-use interventions, couples' interventions were generally more effective in reducing alcohol abuse and IPV than other interventions. There is a lack of evidence about the use of this intervention modality in conflict and humanitarian settings and it has not been tested with adolescents. None of the interventions directly focused on couples with a disability, although the research found that disabled men and women among the couples in **Indashyikirwa** derived similar benefits from the intervention to couples without a disability.

Out of a total of ten individual studies of interventions engaging couples, six had a positive impact on VAWG. These included longer, mid-length and shorter interventions.

Indashyikirwa was a rigorously conducted trial (Dunkle et al., 2019).[20] It had a substantial impact on physical and sexual IPV, with reductions seen 12 and 24 months after the baseline. Among women, there was a 55% reduction in the odds of reporting having experienced physical and/or sexual IPV. Among men, there was a 47% reduction in the odds of reporting having perpetrated physical and/or sexual IPV. This provides good evidence of the potential of this modality of intervention (Dunkle et al 2019). In the **VATU** trial, at 12 months, couples in the intervention reported significantly less alcohol use, and IPV experience (women) and perpetration (men) (Murray et al., 2019).

The **Bandebereho** intervention led to substantial improvements in multiple reported outcomes. Compared to the control group, women in the intervention group reported less past-year physical ($p<0.001$) and sexual IPV ($p<0.001$) (Doyle. et al., 2018).

The **Partner Plus Project** in South Africa found reports of at least one act of physical IPV in the past month, lower in the intervention arm six to eight weeks post-baseline. Although the **Partner Plus Project** was evaluated with an RCT, caution is needed around its conclusions as only immediate post-intervention data has been published (six to eight weeks post-baseline) and the trial was registered as having a post-delivery endline.

In the South African **Couples' Health Cooperative**, a **Women's Health Cooperative (WHC)** for women only was compared to various couples' interventions based on adaptations of the **WHC**. The adaptations were men and their female partners together in a couple's intervention **(Couples Health CoOp [CHC])** and a gender-separate intervention **(Men's Health CoOp/Women's Health CoOp [MHC/WHC])** (Minnis et al., 2015). In both of the couples' interventions, women reported significantly less violence six months post baseline, compared to the women-only control arm (Minnis et al., 2015).

With the **Transition to Parenthood** intervention in the US, couples in the intervention arm demonstrated less physical IPV ten months post-partum (around 12 months post-baseline) (Feinberg et al., 2016). However, the physical IPV measure does not disaggregate by sex of respondent.

In addition to the six studies with a positive impact on IPV, one study had a promising impact. The **Charm** study in India (Raj et al., 2016) found significantly less sexual IPV reported by wives 18 months after the intervention compared to the control arm. However, intervention impact was only seen in sexual IPV and not physical IPV. Levels of IPV reporting were very low at baseline and increased substantially in both study arms, which suggests problems with the reliability of measurement.

Three studies showed no impact on IPV. In Nepal, **Change Starts at Home** was evaluated in an RCT which mostly assessed the impact at a population level of a couples' intervention nested within the community and light-touch, organised diffusion of ideas into the community. It assessed IPV experience among women attending the intervention only with a pre-post design, but for the main part was evaluated on community impact, which is not comparable with other couples' interventions. The evaluation did not show reduced IPV experience 28 months after baseline in the women of the couples who attended, or impact at the community level. There were some weaknesses in intervention implementation.

The **Samvedana Plus** intervention in India was evaluated using a RCT, but at endline found no difference in IPV experienced by arm (Javalkar et al., 2019). There were challenges around data collection, with IPV reports massively reduced in both arms at endline (Javalkar et al., 2019). Notwithstanding the problems with the research, there were considerable challenges in delivering the intervention, particularly in terms of getting male intimate partners to participate. The model is not recommended for further use.

The **Partner Project** in HIV clinics in Zambia found no significant difference in IPV reported between the study arms (Jones et al., 2014). The closely related intervention, the **Partner Plus Project**, delivered in antenatal care South Africa had more promising outcomes, with a marginal reduction in IPV in the intervention arm ($p<0.1$) (Jones et al., 2013), although follow-up was three months post baseline, which might have led to reporting biases.

16 Although this was largely a rigorous trial, it may be subject to some selection bias as sectors were randomised and then interested VSLA members were asked to volunteer with their partner. Actual participants were selected by a public lottery.

3.2.2 PARENTING PROGRAMMES TO PREVENT IPV AND CHILD MALTREATMENT

There is a close association between the use of IPV in a household, and violence towards children. Men who are violent towards their wives or partners are more likely to be violent towards their children (Fulu, McCook & Falb, 2017). Similarly, women who experience IPV are more likely to use violent discipline against their children, and other harsh parenting practices (Fulu et al., 2017). Children who experience violence in childhood are much more likely to experience or perpetrate IPV in later life (Gil-Gonzalez et al., 2008). In addition, children who witness their mother being beaten by her husband or partner are also more likely to perpetrate or experience IPV in later life (Wood and Sommers, 2011).

These associations suggest that preventing children's exposure to IPV and/or their own experience of maltreatment may be essential for the long-term prevention of violence against women, to disrupt the cycle and co-occurrence of abuse. These close associations also suggest that preventing IPV could lead to reduced rates of child maltreatment. The promotion of respectful family relationships, non-violent forms of conflict resolution and parenting practices, and healthy and safe home environments is therefore central to preventing both IPV and child maltreatment

There have been a series of reviews demonstrating that interventions to improve parenting of children, and reduce child abuse, are effective in high-, low- and middle-income countries (Knerr, Gardner, & Cluver, 2013; McCloskey, 2011). These parenting programmes aim to foster healthy family relationships by teaching parenting skills and positive parenting practices and improving parents' mental health, but rarely consider their impact on IPV. Recent interventions have sought to combine approaches to prevent IPV with prevention of violence against children. In this review, we focus on the evidence from such interventions.

Description of interventions

We found three studies of interventions that looked at outcomes related to both IPV and parenting practices. Parenting interventions that did not historically look at IPV as an outcome were excluded. All three interventions were relatively long: **REAL Fathers** was implemented over six months in 12 sessions, **Bandebereho** had 15 sessions, totalling 45 hours of contact time, and **Family Foundations** was nine sessions, five in the antenatal period and four in the postnatal period. In all studies men were actively targeted and/or included in the programme. **REAL Fathers** focused primarily on men, while in **Bandebereho** men were actively targeted for involvement. In all interventions, there was a focus on using participatory group-based techniques; supporting parenting skills was coupled with a focus on building relationships between the parents, and with their child. The three interventions had different age groups of children. **Family Foundations** participants were recruited in the antenatal period, and children were still under the age of one by the end of the study. In **REAL Fathers** the children were toddlers, and in **Bandebereho**, children had to be under five and could include the antenatal period.

Effectiveness of the interventions

We identified two RCTs and one quasi-experimental study examining the impact of parenting programmes on IPV, two interventions showed positive impacts on IPV and one had promising impacts on IPV, and all three

Box 5: Examples of parenting programmes designed to address IPV and prevent child abuse

Bandebereho in Rwanda engages expectant/current fathers (with children under 5) and their partners in participatory, small group sessions of critical reflection and dialogue in an intervention adapted from Program P, which was developed in South America to engage men in active fatherhood and has been implemented but not as rigorously evaluated in other contexts. Trained lay facilitators met with a group of men for 15 sessions of about three hours on a weekly basis (45 total hours); eight of these sessions were also attended by their female partners (24 hours total). Sessions addressed: gender and power; fatherhood; couple communication and decision-making; IPV; caregiving; child development; and male engagement in reproductive and maternal health.

The intervention was evaluated in an RCT. Twenty-one months post baseline, women reported significantly less physical IPV and sexual IPV experience. In addition, women and men reported less use of physical punishment of children (Doyle et al., 2018).

showed positive impacts on parenting measures. In **Bandebereho**, which was conducted among parents of young children (under five) and worked with men and women over multiple sessions in Rwanda, 21 months post-baseline there were significant reductions in women's experiences of physical IPV and sexual IPV (Doyle et al., 2018). Women and men in the intervention also reported significantly less physical punishment of children (Doyle et al., 2018).

An evaluation of the **REAL Fathers** programme in Uganda showed a non-significant reduction in physical IPV and a significant reduction in physical punishment of the child at follow-up (8 or 12 months post-baseline – Ashburn et al., 2017).[21] The **REAL Fathers** evaluation was initially designed as an RCT but evolved into a two-group quasi-experimental study after the arm assignment codes were dropped due to concerns about confidentiality (Ashburn et al., 2017). The two arms used in the analysis were: men who attended at least one group and one individual mentoring session and those who did not. Because this is not a conventional intention to treat analysis,[22] the findings may not be comparable with those of other interventions.

The **Family Foundations** intervention targeted both men and women in couples, in the antenatal and postnatal period and showed significant reductions in physical IPV and physical punishment of children 10 months post birth of the index child (Feinberg et al., 2016). It was evaluated in a well-conducted RCT.

The **Bandebereho** and **REAL Fathers** interventions both targeted men as parents, and, in the case of **Bandebereho**, included women. The **Family Foundations** intervention targeted both men and women in couples. It is interesting to consider whether the interventions were predominantly couples' interventions, where the core was the work on the parents' relationship, or whether the interventions were effective because they were critically placed at the stage of transition to parenthood. If they were predominantly couples' interventions, many of the elements would be expected to work with couples with children of any age, or even no children at home. However, as combined parenting and IPV-prevention interventions, they have provided an opportunity to impact beneficially on two generations and thus, if impact is further sustained, lay the foundations for a less violent society of the future.

21 In addition, the REAL study found overall significant, positive effects of the intervention on the use of psychological and verbal IPV (Ashburn et al., 2017).

22 Intention to treat refers to an outcome analysis where participants are included in the analysis based on the arm they were assigned to (typically intervention or control) whether they received the intervention or not.

SUMMARY OF EVIDENCE AVAILABLE		
3 interventions	**3 interventions from global evidence review**: REAL (Uganda); Family Foundations (US), Bandebereho (Rwanda).	
	2 Africa	**0 Central and South Asia**
3 RCT/quasi-experimental studies	**2 with positive impact on VAWG:** Participatory, small group sessions of critical reflection and dialogue ('Bandebereho') with expectant/current fathers in Rwanda (Doyle et al., 2018); a nine-session transition-to-parenthood intervention ('Family Foundations') in the US (Feinberg et al, 2016). **1 with promising impact on VAWG:** REAL fathers in northern Uganda (Ashburn, Kerner, Ojamuge, & Lundgren, 2017).	
0 evidence reviews	Although there are several systematic reviews of parenting interventions, none look at direct impact on IPV or VAWG perpetration/experiences.	
1 with adolescent focus (Ashburn et al., 2017)	**0 in conflict/humanitarian**	**0 with disability focus**

OVERALL FINDINGS
Good evidence that parenting programmes that also explicitly address IPV are effective in reducing IPV. To be effective they need to include content to transform gender norms and relations, use participatory methods and be of sufficient intensity. It may be that the birth of a child, or the focus on a child, enables a space to change relationships.

3.3 Community level interventions

VAWG is often considered a private issue and all but the most severe violence is accepted in many communities. In recent years, the value of working across whole communities to change attitudes, behaviours and social norms around gender, power and VAWG has been recognised as a valuable approach to VAWG prevention. The goal is to create an enabling environment where a critical mass of support can grow among community members, leaders, and institutions to promote gender equality and non-violence (Michau et al., 2015). This section considers the effectiveness of standalone social marketing campaigns, edutainment and digital technology for VAWG prevention, as well as more intensive multi-faceted interventions using community activism to shift harmful gender attitudes, roles and social norms. Unlike the interventions evaluated in the other sections, which engage with individuals directly and evaluate the intervention impact on them, those working at the community level seek to impact and evaluate change at the population level.

3.3.1 SOCIAL MARKETING CAMPAIGNS AND EDUTAINMENT

Description of the interventions

Social marketing campaigns employ mass communication such as television, radio, billboards, the internet, and printed publications, and are attractive because they can reach many people at a relatively low cost. They aim to raise awareness about VAWG in general, increase knowledge about a service or a law, and challenge ideas on the acceptability or use of VAWG to provoke discussion and impact behaviour. They commonly include an appeal to positive social norms and values and discourage harmful ones through public discussion and social interaction (Paluck and Ball, 2010). Social marketing campaigns have ranged in design from simple messaging to well-planned, longer-term programmes, and overlap with TV or radio-based 'edutainment', integrating social messages into popular and high-quality entertainment media based on a thorough research process (e.g., **Soul City** in South Africa and Puntos de Encuentro's **Sexto Sentido** in Nicaragua).

Effectiveness of the interventions

Although the value of social marketing campaigns and edutainment has often been taken for granted, they have not been well evaluated for their impact on preventing VAWG. It may not be reasonable to expect that they would be able to reduce violence on their own, based on what is known about the necessary features of intervention design and implementation required for impact on VAWG (see Box 1). For instance, it is unclear how social marketing campaigns and edutainment interventions would achieve group-sessions, and support empowerment, critical reflection and communication skills building, as they are didactic, one way interventions.

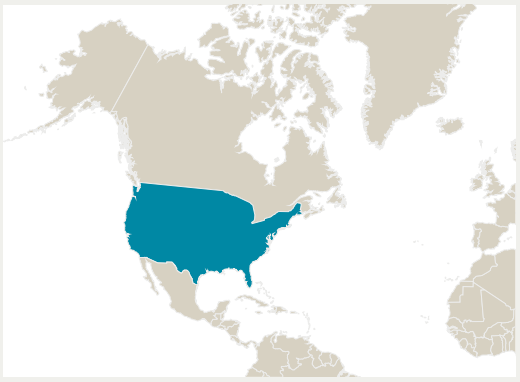
A previous systematic review classified this group of interventions, referred to as awareness-raising campaigns, as ineffective, and concluded that there was insufficient evidence for the effectiveness of longer-

Box 6: Example of social marketing awareness-raising campaign (Mennicke et al., 2018)

A social norms sexual violence prevention marketing campaign was developed at a large university in south-east United States between 2010 and 2014. Each year, the campaign focused on four themes: consent, bystander intervention, rape myths, and sexual activity.

Data on self-reported and perceived peer attitudes, beliefs, and behaviours were collected from male students each spring semester. Each year, two to three advertisements with messaging from this survey were developed. For example, in 2012, survey data indicated that although 95% of men agreed or strongly agreed that that it was important to get consent before sexual intimacy, they perceived that only 76% of their peers agreed or strongly agreed that consent prior to intimacy was important. A visually appealing social norms marketing campaign read, 'Most men understand the importance of getting consent before sexual intimacy.' This statement was advertised across campus with posters, bus wraps, table tents, and billboards with a branded logo and catchy designs, developed by the research team and students.

Over five years, men's beliefs and their perception of their peer's attitudes and beliefs improved and there were self-reported changes in men's sexually coercive behaviour.



term social marketing campaigns or edutainment-plus-group education on VAWG prevention (Ellsberg et al., 2015). We were unable to find any further evidence of any other RCT/ quasi-experimental study of this type of intervention that met our selection criteria.

However, we found one study that used a large repeat cross-sectional survey interviewing 4,158 men to assess changes in male attitudes and behaviour towards sexual violence in the context of a US university-based social norms marketing campaign (see Box 6). The study found that over five years of data collection, men's own beliefs about rape myths decreased, as did men's perception of their peer's attitudes towards rape survivors and beliefs about rape myths. In addition, the difference between men's own beliefs about rape myths, and their perceptions about other men's beliefs about rape myths, decreased, suggesting greater congruency between the two. In addition, there were self-reported changes in men's sexually coercive behaviour (Mennicke et al., 2018). However, in the absence of a control arm and/or other evaluation evidence, caution is needed in attributing the findings to the intervention. Our conclusion is that social marketing campaigns may have a role in combination with other components of interventions designed to impact at a community level.

SUMMARY OF EVIDENCE AVAILABLE

1 intervention	**1 intervention from global evidence review:** University social marketing campaign (US)	
	0 Africa	**0 Central and South Asia**
0 RCT/quasi-experimental studies		
1 pre-post-test study	**Positive impact on VAWG:** social norms sexual violence prevention marketing campaign among university students in the US (Mennicke,et al. 2018).	
1 with adolescent focus (Mennicke et al., 2018)	**0 in conflict/humanitarian**	**0 with disability focus**

OVERALL FINDINGS

There is a lack of robust evidence that social marketing campaigns or edutainment are effective in reducing VAWG experience or perpetration on their own. For the most part they have not been evaluated against a behaviour change outcome, but given what is known about what is required to change behaviour it is very unlikely that evaluations will show that they can do so. They may play a role in combination with other components of interventions designed to impact at a community level.

3.3.2 DIGITAL TECHNOLOGY FOR VAWG PREVENTION

Description of the interventions

Investment in and use of digital tools such as applications (apps) and websites for VAWG prevention and response continues to grow. Examples of digital interventions include online relationship tools and safety decision aids for women experiencing violence (e.g., **isafe**,[23] **IRIS**, **I-DECIDE**,[24] and **Chayn's Do-It-Yourself Online Safety toolkit**[25]); websites and apps that map incidences of violence (e.g., **SafetiPin** in India,[26] Colombia, Kenya, Indonesia and the Philippines, **HarassMap**[27] in Egypt, **Háblame de Respeto** in El Salvador[28]); and digital campaigns aimed at changing men's behaviour (e.g., YouTube video blogs for **Must Bol** in India[29]). Online social media platforms are also being used as a women's advocacy tool to inspire reflection, share experience, challenge social norms and for legislative reform (e.g., **#BringBackOurGirls**, **#RapeMustFall**, **#NiUnaMenos**, and the **#MeToo** movement).

23 https://isafe.aut.ac.nz
24 http://www.idecide.org.au
25 https://chayn.co/about/
26 http://safetipin.com
27 https://harassmap.org/en
28 http://www.hablamederespeto.org/website/
29 Liou, C. (2013) Using social media for the prevention of violence against women: Lessons learned from social media communication campaigns to prevent violence against women in India, China and Viet Nam. Partners for Prevention.

SUMMARY OF EVIDENCE	
0 shortlisted studies	There is a lack of robust evidence on the effectiveness of digital technology to prevent VAWG. It is likely that the most effective role of digital technology in future VAWG prevention is as an adjunct to other intervention components.

Effectiveness of the interventions

Most of these initiatives provide a community for women experiencing violence, knowledge about local services and some provide decision-support related to safety and continuing in a relationship for women experiencing VAWG. On their own these are unlikely to prevent VAWG from occurring, and most of these initiatives have not yet been rigorously evaluated for their impact on VAWG prevention and are not typically based on careful formative research. We were unable to find any studies of digital technology initiatives with a primary prevention of VAWG goal that matched our criteria. Given what is known about the type of intervention design and intensity needed to prevent VAWG (Jewkes et al, 2020), it is likely that the most effective role of digital technology in future VAWG prevention would be as an adjunct to other intervention components.

3.3.3 COMMUNITY ACTIVISM TO SHIFT HARMFUL GENDER ATTITUDES, ROLES AND SOCIAL NORMS

Description of the interventions

Community activism to shift harmful attitudes, roles and social norms in relation to violence against women describes a set of interventions in which multiple components are deployed. This approach built on the premise that community-level work can enable sustained change on VAWG prevention at a population level (Michau et al., 2015). These interventions often work through community activists – usually carefully selected, trained and supported volunteers, organised and deployed in community action teams or groups. Community activists are supported by manuals and other materials to enable structured or guided engagement with men and women in the community in discussions or activities to challenge ideas and norms on gender relations and attitudes towards VAWG. They may directly support survivors or engage couples with known problems with IPV. They often work with local religious and traditional leaders and state actors, such as the police, health and social services, to strengthen their responses to survivors and influence their attitudes and practices in their work. These interventions are challenging to implement because the work takes

Box 7: Examples of community activism to shift social norms

SASA! is a community mobilisation intervention developed by Raising Voices in Uganda that aims to prevent VAWG by addressing gender inequality and social norms around the acceptability of violence, working through trained community activists. Drawing on the theory of stages of change, **SASA!** is organised into four phases: start, awareness, support and action. Different activities are provided to support each phase, although their roll-out in practice is considerably merged, each exploring a different type of power (start [power within], awareness [power over], support [power with], and action [power to]). The approach focuses on analysis and transformation of gender inequality as the core driver of men's power over women and the community's silence about this power, to build an understanding of how power can be used in a positive way with benefit to the couple and change in the community. It was designed to systematically work with a broad range of stakeholders within the community, with deep community coverage to promote critical analysis and discussion to change power inequalities and norms that perpetuate violence against women. It requires three or more years to implement fully (Michau et al., 2015). In 2019, Raising Voices launched a revised version of **SASA!**

SASA! was evaluated over five years in a cluster RCT. At endline women reported a non-significant reduction in physical IPV and sexual IPV experience (Abramsky et al., 2014).

Ghana Gender Centre's **Rural Response Strategy (RRS)** (sometimes referred to as COMBAT) aims to reduce the incidence of VAWG in Ghana, particularly in rural communities, and protect women's rights through state and community-based structures. The intervention is implemented by men and women from the community selected and trained as activists deployed to work in community-based action teams to challenge community attitudes, spread understanding of laws, counsel couples affected by IPV, and support with referrals to relevant social services (police, social welfare, health and health, commission on human rights). The intervention also worked with traditional and religious leaders.

Evaluated over 18 months in a quasi-experimental study, there was a significant reduction in women's experiences of sexual IPV, and a non-significant reduction in women's experiences of physical IPV. There was no change in men's perpetration of IPV (Ogum-Alangea et al., 2019).

time (usually two to three years) and requires extensive engagement over this period to ensure that a high proportion of community members are meaningfully exposed to the intervention.

Effectiveness of the interventions

There is good evidence that VAWG can be prevented through very strongly designed and implemented interventions based on community activism to shift harmful gender attitudes, roles and social norms through multi-year intensive community mobilisation. This has been shown to be possible within 18 months, but generally interventions have spanned 24 to 36, or more, months.

There are now several rigorous impact evaluations of community activism interventions and *What Works* has made a significant contribution to this field (conducting five out of the nine studies included here). However, these studies have a range of different findings, indicating that these types of interventions can be difficult to do well and are not all effective. For this review we found six interventions evaluated in RCTs (**SASA!, SHARE, One Man Can, CHANGE, Indashyikirwa, Change Starts at Home**), two quasi-experimental (**Rural Response System-COMBAT** and the **We Can Campaign**) and one further intervention that was part of the *What Works* portfolio and was evaluated with a pre-post design (**Transforming Masculinities**). All interventions were assessed for impact on IPV at the community level.

Three RCTs and quasi-experimental studies had positive findings, which shows that well-designed community-based interventions, delivered over longer-periods, aimed at changing social norms can reduce experience of IPV. The **SHARE** study had the most conclusive positive findings and showed a 20% reduction in women's reports of past year physical and sexual IPV three years after baseline; however, men's reports of perpetration were unchanged (Wagman et al., 2015).

The **Rural Response System – COMBAT** in Ghana had similar findings. Results show a significant reduction in women's experience of sexual IPV and a non-significant trend towards reduction in women's experience of physical IPV (Ogum-Alangea et al., 2019). There was a non-significant change in the direction of impact for all other measures of IPV reported by men and by women (Ogum-Alangea et al., 2019). The **SASA!** evaluation in Uganda measured IPV experience of women but not perpetration by men. It found a positive impact on reducing physical IPV experienced by women, and other supportive changes in the same direction, but was not statistically significant (Abramsky et al., 2014). Similarly, in the pre-post-test evaluation of **Transforming Masculinities** in eastern DRC, a substantially lower prevalence of physical and sexual IPV was reported 28 months post-baseline. Men's reports of physical IPV perpetration were two-thirds lower than at baseline and the percentage of women experiencing IPV halved, and there were significant reductions in women's experiences of non-partner sexual violence (Le Roux, et al., 2019).

Five studies showed no reduction in IPV. An evaluation of the **We Can** campaign in Bangladesh (Hughes, 2012) found that it did not reduce IPV among community members. The intervention was not evenly implemented, and it is possible that the impact was greater in villages with higher intensity of programming (Hughes, 2012).

Two RCTs evaluated versions of the **One Man Can** intervention in South Africa (Pettifor et al., 2018 and Christofides et al., 2019) and found that IPV perpetration by men was not reduced compared to the control group. In Rwanda, community activism implemented as part of the **Indashyikirwa** intervention demonstrated no impact on physical or sexual IPV at a population level. One reason for this was that although it had a long awareness-raising phase, the period in which community activists were empowered to work in ways that sought to change behaviours around IPV perpetration was limited (Chatterji et al, 2019). The **Change Starts at Home** intervention evaluation found no impact on IPV in the community (Clark et al., 2019), but this may not have been a reasonable expectation from the intervention design, which had a few scattered activities in the community over just three months.

Box 8 highlights key factors that influenced the effectiveness of *What Works* interventions that used community activism to shift attitudes, roles and social norms. In addition, it is important to understand that change is a process and the intervention should be adjusted according to where the community is in this process (Michau et al., 2015). The evidence for their impact in fragile and conflict-affected settings remains limited because only one such intervention has been evaluated in a fragile context (in the DRC, with positive results). There is some evidence that men and women with disabilities face difficulties in engaging in these interventions in the face of community stigma.

SUMMARY OF EVIDENCE AVAILABLE

9 interventions	**4 interventions from global evidence review:** SASA! (Uganda); SHARE (Uganda); Community Mobilisation based on One Man Can (South Africa); We Can Campaign (Bangladesh). **5 What Works interventions:** CHANGE (South Africa) – also based on One Man Can; COMBAT RRS (Ghana); Transforming Masculinities (DRC); Indashyikirwa (Rwanda); Change Starts at Home (Nepal).
	7 Africa | **2 Central and South Asia**
8 RCT / quasi-experimental studies	**3 with positive impact on VAWG:** Safe Homes and Respect for Everyone (SHARE) Project in Uganda (Wagman et al, 2015); SASA!, a community mobilisation intervention in Uganda (Abramsky et al., 2014); RRS in Ghana (Ogum-Alangea et al., 2019). **5 with no impact on VAWG:** Two community mobilisation interventions in South Africa, both based on the One Man Can Campaign (Pettifor et al, 2018 and Christofides et al., 2019) and the community mobilisation component of the What Works Indashyikirwa project in Rwanda) (Chatterji et al., 2019); We Can Campaign engaging local change-makers in Bangladesh (Hughes, 2012); Change Starts at Home in Nepal (Clark et al., 2019).
1 What Works pre-post study	**1 with positive impact on VAWG:** Transforming Masculinities in DRC (Le Roux, et al., 2019).

0 with adolescent focus	**1 in conflict/humanitarian (Le Roux et al., 2019)**	**0 with disability focus**

OVERALL FINDINGS

There is **good evidence** that interventions using community activism to change gender attitudes and social norms can be effective in reducing VAWG through multi-year intensive community mobilisation. However, only very strongly designed and implemented interventions can achieve this.

Box 8: Factors that influence effectiveness of community-activist interventions

What Works research has shown that community-based norm change interventions can achieve significant reductions in violence within a programmatic cycle. However, these are highly complex behavioural change interventions; they require considerable intensity and time and not all of them demonstrated a significant impact on reducing VAWG. For some projects, the intervention design, intensity and duration of implementation were insufficient to achieve an impact on VAWG. Key elements of intervention design and implementation critical in differentiating the interventions that could reduce violence:

1. **Structure:** Successful interventions had a robust theory of change and the intervention elements were carefully designed to ensure that all the different parts of the intervention are able to achieve their specific goals.
2. **Group engagement:** The more successful interventions often worked with groups within the community, rather than solely engaging community members as individuals.
3. **Participatory methods** were used in workshops or other engagements to enable critical reflection on gender relations the individual's experience and, for men, use of violence, skills building and experiential learning.
4. **Manuals and materials** were developed to support implementation by all actors, including the community action team members.
5. More successful interventions had been **previously piloted and refined**.
6. All successful interventions included engagement with women and/or couples experiencing violence and support for survivors.
7. **Intensity:** The more successful interventions had a large (mainly volunteer) workforce on the ground and activities spanned a minimum of 18 months.
8. **Selection of staff and volunteers:** The more effective interventions had very careful personnel selection process (or nomination by communities). Personnel were known to have the desired attitudes and modelled desired behaviours prior to their training.

(Source: Jewkes, et al. 2020)

3.4 School-based interventions

Schools influence children's views on gender relations through their curriculum, peer norms on gender, as well as through policies and staff–student interactions. Schools can either reinforce harmful norms on gender relations and the use of violence, or contribute to transforming them. School systems provide an opportunity to reach many students, teachers and parents in a teaching–learning environment, and thus hold great potential for taking VAWG prevention to scale. School-based interventions use schools as a platform for preventing dating violence, non-partner sexual violence, peer violence and/or corporal punishment. They may be delivered in class by teachers or by facilitators, or after school, usually by facilitators. Some move beyond teacher/facilitator–student learning interactions to engage the wider school and/or others – such as parents or school governing bodies – and are referred to as 'whole school' interventions.

Some school-based interventions focus on preventing peer violence and corporal punishment rather than VAWG. This may be important for longer term VAWG prevention as there is a recognised connection between boys' use of peer violence at school and perpetration of VAWG in intimate relationships (Ozer et al., 2004). Corporal punishment harms children in the short term and longer term by feeding ideas about the acceptability of violence. Interventions addressing peer violence, rather than VAWG, are important for primary school settings, or other settings where there is little dating, or otherwise where talking about dating in public is unacceptable.

In this section, we focus on interventions to prevent dating/sexual violence, but also touch on peer-violence-prevention interventions. Both sets of interventions are generally directed at male and female school students and conducted in government schools. Self-defence-based interventions for adolescent girls and young women in schools or higher education are discussed in Section 3.5.

Photo: London School of Hygiene & Tropical Medicine

3.4.1 INTERVENTIONS TO PREVENT DATING /SEXUAL VIOLENCE

Description of the interventions

We found twelve studies of interventions that were developed to prevent dating and/or sexual violence in high schools (ages 14 to 18), and a thirteenth study that evaluates a school-based intervention in a college settings (**Green Dot**). Most of these (n=10) were from North America and engaged mixed sex groups. Several focused on grade 6 and 7 students (ages 11-12), some on grade 10 and 11 (ages 15-17); others were intended to reach the whole high school.

The approach and length of interventions is described in Table 6. All interventions included a curriculum or formally taught component, but varied substantially in length, from **Stepping Stones**, a 50-hour intervention (Jewkes et al., 2008), and the **Fourth R**, a 21-session intervention over 28 hours (Wolfe et al., 2009), to the **RISE** intervention in Canada, which had two 45-minute sessions (Connolly et al., 2015), and **Ending Violence**, a three-session intervention (Taylor, Stein and Burden, 2010).

Longer interventions used participatory learning approaches focused on empowering participants with communication and relationship skills and challenging and reframing their ideas about gender and the use of violence through critical reflection. They often worked in single-sex groups and were delivered in after-school contexts (Table 6). In contrast, shorter interventions tended to take place in class time, were delivered by teachers, and focused more on providing information and less on skills building, with a less explicit focus on gender (e.g., **Start Strong**).

Some of the interventions sought to strengthen the impact of their curriculum by adding other activities in the school environment and engaging additional actors. For instance, **Amor... pero del Bueno** (**True Love**) had a 16-hour curriculum and included six months of activities for the wider school body, notably distribution of flyers and leaflets in the playground. **Shifting Boundaries** combined six informational sessions in classrooms with a short-term, school-wide intervention with school-based restraining orders, greater staff or security presence in unsafe 'hot spots' mapped by students, and posters to increase awareness and reporting.

The **Green Dot** intervention in the US was different in several ways. It was implemented over multiple years, including whole school (or campus) presentations, and trained peer leaders in five hours of intensive training around bystander interventions. The aim was to encourage students to: 1) recognise situations and behaviours that could lead to sexual assault and 2) develop and implement strategies that could interrupt these. The same basic intervention was also deployed and evaluated in college settings.

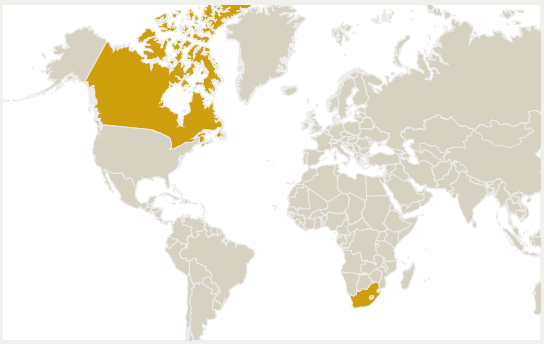
TABLE 6: SUMMARY OF SCHOOL-BASED INTERVENTIONS TO PREVENT DATING/SEXUAL VIOLENCE

Name	Country	Grades	Group	Length	Location	Approach	Reference
Stepping Stones	South Africa	9-10	Single-sex groups	50 hours	After school	Gender transformative, communication, critical reflection	Jewkes et al., 2008
Fourth R	Canada	9	Single-sex groups	21 sessions, 28 hours	In class	Communication skills, role play, problem-solving	Wolfe et al., 2009
PREPARE	South Africa	8	Single-sex groups	21 sessions, 11 hours	After school	Gender transformative, communication	Mathews et al., 2016
Amor ..pero del Bueno (True Love)	Mexico	10	Mixed sex	16 sessions, 16 hours	In class	Critical reflection, gender transformative, with distribution flyers	Sosa-Rubi et al., 2017
Second Step	US	6	Mixed sex	15 sessions, 12.5 hours	In class	Social emotional learning skills, communication, problem-solving	Espelage, Low, Polanin, and Brown, 2013
Safe Dates	US	8, 9	Mixed sex	10 sessions, 7.5 hours	In class	Interactive sessions gender norms, dating violence, awareness of services	Foshee et al., 2004;
Start Strong (variation of Safe Dates)	US	7	Includes engaging key influencers	10 sessions, 7.5 hours	In class	Healthy relationships, social marketing, sexual harassment policy	Miller et al., 2015
Justice and Law Curriculum	US	6, 7	Mixed sex	5 sessions	In class	A fact-based, law and justice curriculum and an interaction-based curriculum	Taylor et al., 2010
Shifting Boundaries	US	7, 8	Mixed sex	6 sessions	In class	Information sessions in class, school wide intervention	Taylor et al., 2015
Ending Violence	US		Mixed sex	3 sessions	In class	Interactive skills building, justice and law curricula	Jaycox et al., 2006
Rise	Canada	7, 8	Mixed sex	2 sessions 1.5 hours	In class	Skills and knowledge understand and respond to peer aggression	Connolly et al., 2015
Green Dot	US	All	Mixed sex	Multi-year implementation	In class	Whole school presentation, 5-hour bystander trainer to student leaders	Coker et al., 2017
Green Dot	US	College	Mixed sex	Multi-year implementation	In college	Whole college presentation (yearly), ongoing peer leader bystander training	Coker et al., 2016

Box 9: Examples of school-based interventions

The **Fourth R** intervention was delivered in 21 lessons over 28 hours in Canadian schools by teachers who had received special training in dating violence dynamics and healthy relationships. The methodology was interactive; dating violence prevention was situated in a broader curriculum that discussed healthy relationships, sexual health, and substance use. There was an emphasis on teaching relationship skills to promote safer decision-making with peers and dating partners (Wolfe et al., 2009). It was evaluated in an RCT in 20 schools with 2.5 years of follow-up. Overall, it showed a significant reduction in the perpetration of physical violence in dating relationships, and this finding was much stronger for boys perpetration, than girls perpetration (Wolfe et al., 2009).

The South African adaptation of **Stepping Stones** has been used in schools after hours. It is a manualised intervention, intended to be used with single-sex peer groups in two- to three-hour sessions over several weeks (10 to 17 sessions depending on the edition used) and led by trained facilitators. Sessions are participatory, allowing participants time for critical reflection, working through all the sessions, each of which builds on previous ones. Topics covered include gender relations, love, relationships, VAWG, STIs and HIV, condom-use and communication skills. It was evaluated in a RCT conducted in 70 schools, with 24 months follow-up. The evaluation showed a significant reduction in young men's perpetration of IPV at endline (Jewkes et al., 2008).



SUMMARY OF EVIDENCE AVAILABLE

12 interventions

12 interventions from global evidence review: Shifting Boundaries (US); Start Strong (US); Amor… pero del Bueno (True Love) (Mexico); RISE (Canada); Second Step (US); Fourth R (Canada); Safe Dates (US); Ending Violence (US); Justice & Law and Interactive curriculum (US); PREPARE (South Africa); Stepping Stones (South Africa); Green Dot (US)

2 Africa	0 Central and South Asia

13 RCT / quasi-experimental studies

5 with positive findings on dating violence: A 21-lesson curriculum (Fourth R) with skills training for dating relationships in Canada (Wolfe et al., 2009); a multi-component, after-school HIV-prevention intervention ('PREPARE') in South Africa (Mathews et al., 2016); South African adaptation of Stepping Stones (Jewkes et al., 2008); 'Green dot' bystander training in high schools in the US (Coker et al., 2017) (a college version is Green Dot bystander training in college [Coker et al., 2016]).

2 with mixed results on VAWG: Amor… pero del Bueno (True Love) (Sosa-Rubi et al., 2017); Shifting Boundaries teen dating violence prevention programme for middle school students in the US (Taylor et al., 2015).

6 with no impact on VAWG: the 'Start Strong' healthy teen relationships initiative for middle-school students in the US (Miller et al., 2015); 10-week curriculum Safe Dates with a poster contest and play (Foshee et al., 2004); 3-lesson curriculum on domestic violence and the law (Jaycox et al., 2006); 5-week curriculum with interactive classes and a 5-week curriculum on justice and law (Taylor et al., 2010); Second Step, 15-lesson curriculum in the US (Espelage et al., 2013); a two-session programme for middle-school in Canada (Connolly et al., 2015).

2 evidence reviews

1 systematic review of systematic reviews to prevent school violence (Lester, Lawrence, & Ward, 2017) includes 36 systematic reviews and has a global focus.

1 rigorous review of global research evidence on policy and practice on school-related GBV (Parkes et al., 2016): The authors conducted a light review of 171 articles and a deep review of 49.*

13 with adolescent focus All studies in the RCT section	0 in conflict/humanitarian	0 with disability focus

OVERALL FINDINGS

There is **good evidence** that school-based interventions can prevent dating violence. The more effective and promising interventions had longer programmes delivered by highly trained facilitators or teachers, used participatory learning approaches, including critical reflection and skills building, and were based on theories of gender and power. They were also evaluated with long-term follow-up. More research is needed to develop interventions to use more effectively in classrooms, especially in LMIC settings, and to ensure impact on both girls and boys

* This review included a broader body of evidence than is included in our selection criteria, including qualitative and mixed method studies and looked at school-related gender-based violence (SRGBV) more broadly than peer or dating violence.

Effectiveness of the interventions

Overall, there is good evidence that well-designed and well-implemented interventions delivered through schools can prevent dating and sexual violence. The more effective and promising interventions had longer programmes delivered by highly trained facilitators or teachers, used participatory learning approaches, including critical reflection and skills building, and were based on theories of gender and power. They were also evaluated with long-term follow-up. However, most interventions either had an impact on girls' experience of physical and/or sexual VAWG or on boys' reported perpetration – not both at the same time. The exception was the Green Dot programme that had an impact on both experience and perpetration. More research is needed to understand this and further develop interventions to optimise their impact. It is especially important to evaluate more school-based interventions for LMIC settings, as most of the evidence comes from North America. There is also no evidence of the effect of an intervention that follows a national curriculum in high-schools.

This review found evidence that the four interventions with the strongest design and implementation, evaluated in five RCTs, were effective in reducing dating and sexual violence (**Fourth R**, **PREPARE**, the South African adaptation of **Stepping Stones**, and **Green Dot**).

The RCT of the South African adaptation of **Stepping Stones** found that the proportion of young men who perpetrated more than one episode of physical or sexual IPV was significantly lower (38% less) in the **Stepping Stones** arm at 24 months post-baseline, and there was some evidence that it was also lower at 12 months (Jewkes et al., 2008). There was also some evidence that fewer men in the **Stepping Stones** arm reported raping or attempting rape at 12 months (27% less). There was no impact on women's risk of experiencing violence. Evaluations of **Stepping Stones** in other settings have also documented an impact on men's perpetration of violence but not women's experience (see Economic Empowerment and Social Empowerment [Section 3.1.3] for more details).

In Canada, the **Fourth R** evaluation found a strong overall reduction in physical dating violence perpetration by both boys and girls, and the analysis showed that this was chiefly a reduction in boys' perpetration of physical dating violence (Wolfe et al., 2009). The **PREPARE** evaluation found a reduction in experience of dating violence in a pooled analysis among girls and boys 12 months post-baseline, but did not impact dating violence perpetration (Mathews et al., 2016). An unpublished sex-stratified analysis showed impact on reducing VAWG experienced by girls (Mathews, personal communication).

In the evaluation of **Green Dot** in schools, annual surveys showed significant reductions in boys' physical and sexual IPV perpetration and girls' physical IPV experience in Years 3 and 4. There were also significant reductions in girls' sexual IPV experience in Year 3 (Coker et al., 2017). This finding was similar to the second **Green Dot** evaluation in colleges, where over the four years, there was significantly less unwanted sex experienced, driven by a reduction in reportedly being too drunk or high to consent to sex. There was no evidence of less perpetration of sexual coercion or physical dating violence (Coker et al., 2016).

The **Safe Dates** intervention was ineffective at reducing dating violence one year after baseline (Foshee et al., 2004). The four-year follow-up paper reported significant reduction in sexual and physical violence perpetration and sexual violence victimisation, but there is a substantial risk this finding is driven by data collection bias (Foshee et al., 2004). **Safe Dates** was also evaluated as part of the holistic Start Strong intervention (Miller et al., 2015) and found to be ineffective 18 months post-intervention. The **Second Step Program** had no evidence of impact on sexual violence perpetration or victimisation (Espelage et al., 2013).

The very short interventions had no effect on preventing dating and/or sexual violence. **Ending Violence** had no impact on dating violence experience or perpetration at the six-month follow-up (Jaycox et al., 2006). The school-based intervention in Cleveland did not reduce dating violence victimisation or perpetration when those in the class were given either version of the curriculum (interactive skills-building classes vs. justice and law classes) compared to the control (Taylor et al., 2010). There may have been less sexual victimisation by peers in the interaction skills-building arm and less non-sexual violence perpetration by peers in the justice and law curriculum, but the authors themselves caution against interpreting findings with a p-value above 0.01 as positive due to the large number of tests used. We thus conclude that these interventions were not effective.

The **RISE** curriculum was ineffective in preventing dating violence (Connolly et al., 2015). The **Shifting Boundaries** evaluation found an overall pattern of lack of impact on most sub-groups examined six months after the baseline. There was significantly more sexual harassment victimisation reported across all study arms except the control, but there was some evidence that the frequency may have been lower in the arms with the building intervention, which included greater supervision of corridors, and some change in patterns of student movement. Dating sexual violence victimisation was significantly lower among students in

the building intervention-only arm, but not in the arm that combined this with a classroom approach, which suggests this may have been a chance finding (Taylor et al., 2015). Similarly, the **Amor... pero del Bueno** (**True Love**) evaluation in Mexico reported no impact on physical or sexual violence victimisation or perpetration reported by boys or girls (Sosa-Rubi et al., 2017).

Quality of the evidence

Interventions were evaluated in 13 RCTs or robust quasi-experimental studies. A notable difference in their design was the follow-up period, which ranged from six months to two-and-a-half years post-baseline. The evaluation of **Stepping Stones** in rural South Africa was the largest (numerically) RCT in this group, and VAWG experience by girls and boys were secondary outcomes. The trial was well designed and had a low risk of bias (Jewkes et al., 2008). The **Fourth R** intervention in Canada was also evaluated in a large two-arm RCT. There was limited bias and the primary outcome was perpetration of physical dating violence (Wolfe et al., 2009). **PREPARE** was evaluated in 41 schools in a two arm RCT and dating violence experience and perpetration were assessed as secondary outcomes. This was a well-designed RCT, but the outcome was presented for a pooled group of boys and girls, and about 40% of the students were boys (Mathews et al., 2016). **Green Dot** was evaluated in an RCT conducted in 26 schools in the US, implemented over a four-year period and evaluated at school level, thus assessing impact beyond those actively attending; however, there were only 13 clusters per arm, which limited the potential power of the study (Coker et al., 2017). A second quasi-experimental evaluation of **Green Dot** was conducted in three US college campuses over four years (six years in one campus), with two controls (Coker et al., 2016). This has potential bias, as the control condition was self-selecting and there was no true baseline rate for inclusion in the analysis.

The initial evaluation of the **Safe Dates** programme was conducted in the US in a two-arm RCT conducted in 14 schools, with follow-up immediately post-intervention, at one year, and at four years post-baseline. There was a substantial risk of bias at the four-year follow-up, as the year-one approach to the data analysis was changed from one with four matched pairs and school-wide means, appropriate to the study design, to an individual level analysis which was not appropriate for the small sample of schools. Four schools and 45% of students had dropped out by year four. The second evaluation of **Safe Dates**, in the **Start Strong** study, was a well-designed RCT with the endline conducted 18 months post-baseline (Miller et al., 2015). The **Ending Violence** curriculum was evaluated in an RCT conducted across 40 school tracks in US schools and had six months follow-up (Jaycox et al., 2006). Similar short follow-up was a feature of the 123-school evaluation in a three-arm RCT of the **Justice and Law** curriculum (Taylor et al., 2010); a risk of bias arises from multiple comparisons with no adjustment for the p-value and the gender-disaggregated impact on VAWG is not presented. The very brief Canadian **RISE** intervention evaluation was conducted in two schools randomly assigned to two arms of a quasi-experimental study. The **Second Step Program**, which sought to reduce peer violence and sexual violence perpetration and victimisation in 6th graders, was evaluated in an RCT with 36 schools (Espelage et al., 2013).

Photo: Raising Voices

3.4.2 PEER VIOLENCE PREVENTION INTERVENTIONS WITH A GENDER COMPONENT

Peer violence prevention interventions with a gender component[30] can be implemented both during and after school, with some being more holistic interventions involving teachers and parents. They often involve mixed or single-sex groups of peers of similar ages involved in facilitated sessions. They may also employ critical reflection on gender roles, attitudes and behaviours, sometimes involving games and play-based learning. They can be implemented at different levels of the school system (i.e., primary and secondary school or junior, middle and high school).

It is beyond the scope of this review to comprehensively assess interventions to prevent peer violence and bullying developed and tested in schools, as there have been many of these. They formed a major part of the systematic review of reviews conducted by Lester, Lawrence, and Ward (2017), who identified 387 school-based studies using randomised controlled trials and 213 quasi-experimental studies. In the entire literature of 963 studies (all designs) only eight studies were identified from LMICs including from Latin America and Asia, with no studies from Africa. The authors comment that the geographic distribution is exceptionally problematic, as peer violence is reported to be more highly prevalent in LMICs than North America. The review of reviews found overall insufficient evidence that interventions can prevent peer violence in LMICs, particularly in Africa and Central and South Asia (Lester et al., 2017).

Beyond this review, we include an RCT of the **Gender Equity Movement in Schools (GEMS)** intervention to prevent peer violence in India, Bangladesh and Vietnam (Achyut, 2017); and an RCT of the **Good School Toolkit** in Uganda (Devries et al., 2015). *What Works* has sought to expand evidence of peer-violence prevention in the critical gap of Central and South Asia through evaluations of two programmes in schools: an RCT of the **Positive Child and Youth Development Programme** in Pakistan (Karmaliani et al., 2019) and a pre-post study of the **Peace Education** intervention in Afghanistan.

Description of interventions

The Lester et al. (2017) review of reviews included a wide range of interventions from 2005 to 2015. We have hand-searched to update this review but have not found other evaluations from LMICs.

30 Peer violence is defined in section 1.3 as encompassing physical and verbal abuse, social exclusion and destruction of property

Box 10: Examples of peer violence prevention interventions

In Pakistan, the What Works **Positive Child and Youth Development Programme** implemented by the NGO Right to Play trained coaches to provide 120 sessions of around 35 to 40 minutes of structured play to schoolchildren (~80 hours), over two years. The programme built children's social and emotional skills and covered an extensive curriculum through play-based learning, including communication skills, gender equity, confidence-building, non-violence and leadership. Each activity had a clear objective, and each session concluded with reflection on what had been learned, connecting this to the children's life, and reflection on how the learning could be applied more broadly to daily life. Children also participated in community-based thematic play days, tournaments, and summer camps. About five children per school were trained as junior leaders to assist the coaches. At the endline, children in the intervention reported significant reductions in perpetration and experience of peer violence, and also significant reductions in corporal punishment at school (Karmaliani et al., 2019).

Raising Voice's **Good School Toolkit** is a complex intervention that aims to change operational culture at the school level. The toolkit uses a six-step process to create a school-wide intervention that engages teachers, students, administration, and parents to reflect on how they can promote quality of education in their school. The toolkit used posters, booklets and school-initiated learning processes to present and discuss key ideas e.g., what is a good learning environment and a good teacher, and how to create positive discipline without using violence. It includes over 60 activities for staff, students and administration, around topics such as setting school-wide goals and action plans, improving teaching techniques, learning non-violent discipline, reflecting on violence, respect and power relationships, and working towards school-wide change through action plans. Work is led by teachers and students and supported by visits from Raising Voices. In the evaluation it was implemented over 18 months, in Uganda. At endline, children in the intervention reported significantly less physical peer violence, and corporal punishment at school (Devries et al., 2015).

In Pakistan **(Play Based, Life-Skills Programme)** and Afghanistan (**Peace Education**) activities were delivered to the whole class over a period of two years, with 120 sessions of 40 minutes (80 hours) in Pakistan and 99 sessions, each 30- to 35-minutes long (about 50 hours) in Afghanistan. The average age of students was 11 to 12 in Pakistan and 13 to 15 in Afghanistan (Jewkes et al., 2020).

The **GEMS** intervention is a school-based programme for young adolescents aged 12 to 14 years, in grades 6 to 8. The programme undertakes activities to promote equitable attitudes and norms related to gender and violence among girls and boys, strengthen their understanding and skills to resolve conflicts without violence and create a safe school culture that supports egalitarian and non-violent attitudes and behaviours (Achyut, 2017).

The **Good School Toolkit** in Uganda, designed to prevent corporal punishment in schools, is described in Box 7 (Devries et al., 2015).

SUMMARY OF EVIDENCE AVAILABLE		
4 interventions in 6 contexts	**2 from global evidence review:** Good School Toolkit (Uganda); GEMS (Bangladesh, India, Vietnam) **2 from What Works:** Positive Youth Development – play based life-skills programme (Right to Play, Pakistan), Peace Education (HTAC, Afghanistan)	
	1 Africa	**5 Central and South Asia**
5 RCT/quasi-experimental studies	**2 with positive findings on peer violence and corporal punishment:** Good School Toolkit in Uganda (Devries et al., 2015); Right to Play's play-based life-skills programme in Pakistan (Karmaliani et al., 2019) **3 with no impact on peer violence:** GEMS in India, Bangladesh and Vietnam (Achyut et al., 2017)*	
1 What Works pre-post study	**1 with positive findings on peer violence:** Help the Afghan Children Peace Education programme in Afghanistan (Corboz et al, 2019)	
1 evidence review	**1 systematic review of systematic reviews (Lester et al., 2017) to prevent school violence including 36 systematic reviews and has a global focus**	
6 with adolescent focus Devries et al., 2015; Karmaliani et al., 2019; Achyut et al., 2017 (three countries) and Corboz et al., 2019	**1 in conflict/humanitarian** Corboz et al., 2019	**0 with disability focus**
OVERALL FINDINGS		
Good evidence: Peer violence can be prevented in Africa and Central and South Asia through the right school-based interventions, even in fragile settings, and results can be sustained. These interventions all used participatory methods, built skills, and addressed violence prevention through a gender lens.		

* The ICRW report, 'Changing Course: Implementation and Evaluation of the GEMS programme in specific sites – Vietnam, Bangladesh and India' (Achyut, 2017) includes three separate studies in one paper.

Effectiveness of the interventions

Findings from the systematic review and individual studies provide emerging good evidence that peer violence can be prevented in Africa and Central and South Asia through the right school-based interventions, even in some of the most fragile settings, and that the results can be sustained. Both *What Works* interventions were delivered over two years of programming, while the **Good School Toolkit** was implemented over 18 months, pointing to the benefits that may come from longer interventions.

The RCT of the **Positive Child and Youth Development Programme** in Pakistan found that the intervention significantly reduced girls' and boys' peer-violence perpetration and experience. There were significant differences between the intervention and control arms at the 24-month endline, and the reduction in peer-violence perpetration for boys and girls in the intervention arm was more than twice that observed in the control arm. In terms of peer violence, boys' victimisation decreased by 33% and by 59% among girls. In addition, there were significant reductions in corporal punishment at both home and school, reported by boys and girls, as well as significantly less patriarchal attitudes, and less depression (Karmaliani et al., 2019).

Although it was not an RCT, the **Peace Education** evaluation in Afghanistan showed statistically significant declines in peer-violence victimisation and perpetration across the time-points as well as a decline in corporal punishment and significantly less patriarchal attitudes. These were reported by both girls and boys and were all sustained to the 18-month endline.

The one RCT from Africa, of the **Good School Toolkit** in Uganda (Devries et al., 2015), found a reduction in physical and emotional violence from peers, as well as reduced corporal punishment. Although the toolkit was effective for girls and boys, the study found that it may have had a stronger effect in boys than in girls. While the reasons for this are unclear, it may reflect the degree to which girls are able to participate in the intervention and competing pressures outside of school, such as girls' responsibility for household duties. Girls may also be more exposed to other forms of violence outside the school environment, which might interact with their exposure to violence in school (Devries et al., 2017).

The International Center for Research on Women's (ICRW) **Gender Equality Movement in Schools** (**GEMS**) intervention was evaluated in two RCTs in India and Vietnam and in a quasi-experimental study in Bangladesh. It did not enable a reduction in peer violence perpetrated or experienced by girls or boys in any setting (Achyut et al, 2017).

Despite the good evidence that interventions are effective in preventing peer violence, many studies identified in the reviews did not measure this, and many of the interventions in the reviews did not work. Selective single interventions did not show effect, and promise was only seen with interventions delivered to a whole school, usually cognitive behavioural programmes. There was a much greater focus on prevention of peer perpetration and 31 reviews examined interventions for this. Interventions showed more success when they addressed the general student body, rather than identifying 'problem' students. Many of the studies did not evaluate beyond one post-test, but those that did showed that intervention effects were often sustained. There seemed to be more evidence for the success of longer (16 or more sessions) social/emotional programmes. Cognitive behaviour and peer-mediation programmes also showed some promise.

Quality of the evidence

The evaluation of Right to Play's play-based **Positive Child and Youth Development** programme in Pakistan was conducted in a two-arm RCT implemented in 40 single-sex schools in Sindh Province. The study had the primary outcome of reducing peer violence and, as secondary outcomes, measured exposure to corporal punishment and physical punishment at home. It also measured gender attitudes. The study had a low risk of bias.

The **Good School Toolkit** in Uganda was evaluated in an RCT conducted in 42 schools randomised to two arms; findings were assessed 18 months after baseline (Devries et al., 2015). There is potential for bias, as peer-violence prevention was not a pre-specified outcome.

The evaluation of **Peace Education** in Afghanistan followed a modified, interrupted time series design with a random sample of children interviewed in 11 intervention schools on three occasions about six months apart. The first round of interviews was not a true baseline as it was conducted about six months after the start of the intervention, with subsequent interviews at 12 and 18 months. In both evaluations, standard multi-item measures of peer victimisation and perpetration were used. Some caution is needed in attribution of effects as there was no control arm.

GEMS was evaluated in two RCTs (with 10 schools per arm in Vietnam, and 40 per arm in India) and in a quasi-experimental study with 30 schools per arm in Bangladesh. A sample of girls and boys per school was selected for interview at each data point in Vietnam and Bangladesh, but in India the sample was a cohort. The evaluation was conducted two years after the baseline and the studies were well conducted and reported. Prevention of peer violence was a secondary outcome.

3.5 Self-defence training delivered in schools and colleges to prevent sexual assault

Description of interventions

Self-defence training for women and girls or sexual assault resistance is an educational process directed at women in general and focused on reducing sexual assault/rape from any perpetrator (whether partner, date, or non-partner) and is evaluated as such. This is in contrast to other studies, which evaluate interventions primarily for their impact on violence in relationships (IPV) or peer violence (in schools).

Although the name implies that these are largely physical strategies, self-defence training often includes a strong emphasis on consent and pressure, assessing risk, and a range of non-physical strategies to reduce risk or avoid/deter attack and physical strategies to fight off-assailants from (Orchowski, & Gidycz, 2018; Hollander, 2018).

Training sessions can range from short, once-off, one-hour sessions to a 10 to 15-week course (Hollander, 2018). In the North American context, there have been three broad groups of work on the approach, which have been adapted and iteratively developed in response to qualitative and quantitative studies undertaken over many years, among college-age (i.e., 17 years +) students. The only type of women's self-defence training that has received rigorous evaluation is empowerment self defence (ESD) based on feminist understandings of violence against women, with its analysis that this violence stems from and maintains gender inequality and the oppression of women (Hollander, 2018). Outside the North American context, evaluations have all focused on the **IMPower** intervention for primary and secondary school girls.

Effectiveness of the interventions

Among college students in North America, there is promising evidence that ESD interventions can reduce women's experience of sexual assault, and that longer interventions demonstrate greater effect than shorter interventions. The RCT of the **Enhanced Access, Acknowledge, Act Sexual Assault Resistance Programme (EAAA)** intervention from Canada provides encouraging evidence of effect with promising outcomes from other interventions. However, there are differential effects according to prior sexual assault exposure; those who had never experienced sexual assault benefitted more than those who had experienced sexual assault. There is insufficient evidence of the effectiveness of this approach because EAAA is the only well-evaluated study; other evaluations

Box 11: Example of self-defence training

Developed in Canada, the **Enhanced Access, Acknowledge, Act Sexual Assault Resistance Programme (EAAA)** involves 12 hours of contact time and consists of four sessions of three hours giving information and teaching skills to enable young self-identified college women to:

ASSESS – Recognise risk cues for sexual violence in situations and in men's behaviour.

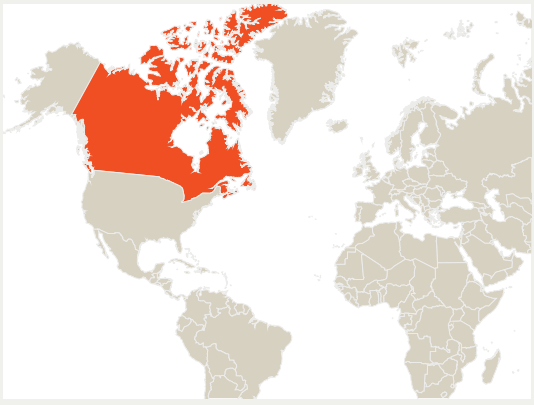
ACKNOWLEDGE – Identify and overcome personal obstacles to prioritising their own sexual rights in acquaintance situations (i.e. support women to overcome the social and emotional barriers to recognising risks)

ACT – Develop a toolbox of effective strategies to defend their bodies and boundaries.

RELATIONSHIPS AND SEXUALITY – Supported with emancipatory sexuality education.

The training uses mini-lectures, group activities, role-play, interactive games, and group discussion to present material on positive sexuality, sexual assault definitions and laws, rape myths and factors that increase risk of sexual assault, as well as effective strategies for recognising danger and resisting sexual assault. Activities allow participants to assess risk based on evidence; practice responding to coercive strategies; discuss emotional barriers to resistance; explore their own relationship and sexual values; and practice negotiating desired sexual activity. It also includes instruction on basic self-defence tactics.

The **EAAA** intervention was evaluated using a large RCT at three Canadian universities. At 12 months, women in the intervention had significantly lower reports of completed rape, attempted rape, any rape, and non-consensual sexual contact (Senn et al., 2015). In a subsequent follow-up at 18 and 24 months (Senn et al., 2017)., women in the intervention group reported lower completed rape but the finding, though large, was not significant.



SUMMARY OF EVIDENCE AVAILABLE

4 interventions in 5 contexts	**3 interventions from global evidence review:** IMPower (Malawi); Ohio University Sexual Assault Risk Reduction Program (US x 4); AAA and EAAA (Canada); Oregon University self-defence classes (US) **1 What Works intervention:** IMPower (Kenya)
	2 Africa / **0 Central and South Asia**
9 RCT / quasi-experimental studies	**3 with positive impact on VAWG:** EAAA in Canada (Senn et al., 2015/2017); Interactive, empowerment self-defence training ('IMPower') in Malawi (Decker et al., 2018); University self-defence classes in Oregon, US (Hollander, 2014) **1 with promising impacts on VAWG:** AAA an earlier version of EAAA in Canada (Senn et al., 2011) **1 with uncertain results:** No impact on rape. However, there are some methodological issues which suggest that these results should be interpereted with caution. Interactive, empowerment self-defence training. ('IMPower') (Baiocchi et al.,*forthcoming*) **4 with no impact on VAWG:** Ohio University Sexual Assault Risk Reduction Program, a sexual assault self-defence and risk reduction programme for college women in the US (Gidcyz et al., 2001; Gidycz et al, 2006; Orchowski et al., 2008; Gidcyz et al., 2015);
0 evidence reviews	NB: No systematic reviews; an article on the state of the field is available (Hollander, 2018)

8 with adolescent focus* Adolescent girls 10 to 19. Includes the school- and college-based interventions (largely with first- and second-year students 17 to 19).	**0 in conflict/ humanitarian**	**0 with disability focus**

OVERALL FINDINGS

Promising evidence that more rigorously developed and tested college-based self-defence interventions can reduce women's experience of sexual assault. Conflicting evidence that self-defence interventions work for schoolgirls.

* Adolescent girls 10 to 19, which includes the school-based interventions as well as the college-based ones which were largely with first and second year students 17 to 19.

have methodological weaknesses. Among schoolgirls, the evidence is conflicting. One independent evaluation showed no effect on rates of sexual assault (Baiocchi et al. *forthcoming*), while a second trial of the same intervention (Decker et al., 2018) showed significant reductions in sexual assault. Both trials had methodological issues, which suggest these results should be interpreted with caution.

College-based training

For this review, we identified a total of six RCTs (Gidcyz et al., 2001; Gidycz et al., 2006; Orchowski et al., 2008; Gidcyz et al., 2015; Senn, 2011; Senn, 2015/2017) and one quasi-experimental study (Hollander, 2014) that evaluated the impact of self-defence interventions on college students in north America.

The **EAAA** intervention was evaluated using a large RCT at three Canadian universities. Those in the intervention received four, three-hour sessions (total 12 hours), follow-up was at one week, six months, and 12 months in the original trial (Senn et al., 2015) and 18 and 24 months in a subsequent study (Senn et al., 2017). At 12 months, women in the intervention had significantly lower reports of completed rape, attempted rape, any rape, and non-consensual sexual contact (Senn et al., 2015). In a subsequent follow-up at 18 and 24 months, women in the intervention group reported lower completed rape but the finding, though large, was not significant. There was, however, a significant reduction in women's experiences of attempted rape in the intervention (Senn et al., 2017). At 24 months, the sample was half the original sample because funding limited follow-up. This required careful interpretation of results, although outcomes were similar at 18 months where follow-up was good (Senn et al., 2017).

Four RCTs since 2000[31] have examined the impact on women's experiences of sexual assault of the **Ohio University Sexual Assault Risk Reduction (SARR) Project** developed and modified by Gidcyz and

31 Gidcyz et al conducted evaluations of similar interventions before the timeframe of this review.

colleagues. This evolved and was tested in repeated large RCTs published between 2001 and 2015. None of the RCTs showed any impact on sexual victimisation and after each evaluation the intervention was adjusted. The first RCT in 2001 combined a three-hour session covering videos about rape risk, and about risky situations, with a focus on encouraging active and personal discussion about risk, among women. This was followed up with role-plays of risk situations and potential strategies, and a handout and discussion about resistance strategies (Gidcyz et al., 2001). After this, it was expanded to two sessions; the first replicated the original session, the second incorporated a two-and-a-half-hour self-defence course. A booster session at three months reviewed strategies (Gidcyz et al., 2006). This was later further adapted to include addressing psychological barriers to using resistance strategies and supported the intention to use strategies as part of the overall programme (Orchowski et al., 2008). At this point, there was a suggestion of reduced sexual assault two months after the intervention but this was not sustained two months later (Orchowski et al., 2008). The fourth RCT (Gidycz et al., 2015) reported results from the same programme as described by Orchowski et al. (2008), but included a separate intervention for men, which focused on social norms and bystander intervention (not reported in the article). For women, there were no differences in rates of victimisation for programme and control groups.

The final evaluation among college students in Oregon in the US was a quasi-experimental study of the **Self Defense From The Inside Out** intervention and compared college students who had chosen to participate in self-defence courses, with a group from other sections of the university who had not received any self-defence courses (Hollander, 2014). The self-defence training was much longer than the interventions described above – a total of 30 hours, made up of ten, three-hour sessions – and students also participated in one-and-a-half-hour discussion sessions weekly (Hollander, 2014). Participants completed baseline and one-year follow-ups. Women in the self-defence course reported significantly fewer sexual assaults during the subsequent year than women enrolled in other courses at the same university (Hollander, 2014). However, this study needs to be interpreted cautiously, as significant bias may have arisen from participants self-selecting and not being randomly assigned, and because of small sample sizes (less than 200 women in intervention and control groups).

School-based training

For self-defence training with schoolgirls, two studies – one RCT and one quasi-experimental study – explored whether self-defence can reduce experience of sexual assault among schoolgirls; both evaluated the 12-hour **IMPower** intervention model, one with primary- and secondary-school girls in rural Malawi and one with primary-school girls in densely populated informal settlements in Nairobi, Kenya.

In Kenya schools in low income housing areas were randomly allocated either the intervention or a wait-list control, in which case they would receive the intervention at a later date (Baiocchi et al., *forthcoming*). In addition, follow-ups with the same girls enabled the study to assess change over time. Girls were age 10 to 14 at baseline. Unlike previous studies of this intervention in high schools that found a positive impact on rape prevention,[32] at 24 months there was no difference between rates of being raped between arms (Baiocchi et al., 2019). In this study, boys received an intervention (**Sources of Strength**) which was not effective in preventing rape perpetration. The research team was independent of the schools and NGO delivering the intervention, however there were some methodological issues which suggest that the results for girls and boys should be interpreted with caution.

The other evaluation of the **IMPower** curriculum in rural Malawi included both primary school girls with a mean age of 15 and secondary school girls with a mean age of 19. Schools were randomised to receive the intervention, and participants were recruited. The study showed a significant reduction, reported in intervention schools, on the school incident rate of sexual assault (Decker et al., 2018). Design limitations included loss of schools after randomisation, short follow-up (10 months), an inability to link individual students across time points, and teacher-led survey administration which may have biased responses.

32 Previous studies of this intervention in Kenya include (Baiocchi et al., 2016; Sarnquist et al., 2014; Sinclair et al., 2013)

3.6 Interventions in antenatal and postnatal settings

The time during the antenatal and postnatal period provides an opportunity to intervene with women around IPV, as women often encounter the health system in this period. Pregnancy and the first weeks after a birth can also be a critical time to intervene, as violence may increase because of increased stress in the family. Experience of violence during pregnancy can increase adverse pregnancy outcomes, including low birth weight, miscarriages, and maternal mortality (Hill et al., 2016).

Description of the interventions

Antenatal and postnatal interventions broadly fall into two types of intervention, both of which have been almost exclusively implemented in high-income countries. The first are psycho-behavioural approaches (which the literature often refers to as 'advocacy' or 'empowerment' interventions). These support women to reflect on their lives and develop concrete strategies, including safety plans, to minimise risk. Interventions focus on counselling around safety planning and may also provide legal and financial advice, and facilitate access to other services (e.g., emergency housing/shelters). In addition, some interventions provide Cognitive Behavioural Therapy (CBT), as a more structured intervention.

Psycho-behavioural (advocacy) interventions range substantially in length and location. McFarlane et al (2006) had a single 20-minute nurse-led counselling session for women experiencing IPV. Similarly, in Hong Kong, a 30-minute session was offered by nurses (Tiwari et al., 2005), while Kiely et al (2010) had a minimum of four sessions (maximum of eight) in the antenatal period, and an additional two sessions, post-partum, and this included CBT. Interventions are typically delivered to women who are experiencing IPV or are at high risk.

The second approach is nurse-visitation programmes during the antenatal and postnatal periods. These are distinctive not only because of their location (home visits), but also because they are typically much longer. Nurse-visitation programmes cover topics beyond IPV, including child nutrition, family functioning and general wellbeing. Safety planning and referral were also components of these interventions. For instance, the **Domestic Violence Enhanced Home Visitation Programme (DOVE)** in the US consisted of six sessions (each 15 to 35 minutes) focused on IPV and safety planning (Sharps et al., 2016). Mejdoubi et al (2013) report on a nurse visitation programme that consisted of ten nurse home visits during pregnancy, and 20 visits a year, for up to two years.

SUMMARY OF EVIDENCE AVAILABLE		
8 interventions	**8 interventions from global evidence review:** DOVE (US), VoorZorg (Netherlands); Nurse Home Visitation (US); Healthy Starts (Hawaii, US); NIH-DC Initiative to Reduce Infant Mortality in Minority Populations (US); Brief Counselling (Hong Kong); Brief, Counselling, and Outreach (US); Nurse Case Management (US)	
	0 Africa	**0 Central and South Asia**
8 RCT / quasi-experimental studies	**2 with positive impacts on VAWG:** VoorZorg, a long home-visitation programme by nurses in the Netherlands (Mejdoubi et al 2013); CBT integrated into antenatal care in the US (Kiely et al., 2010) **2 with promising impacts on VAWG:** Home visitation by nurses in the US (Olds et al., 2004); brief counselling in Hong Kong (Tiwari et al., 2005) **4 with no impact on VAWG:** Two brief counselling interventions in the US (McFarlane et al., 2006; 2010); Healthy Starts home visitation in Hawaii (Bair-Merritt et al., 2010); DOVE home-visitation programmes by nurses in the US (Sharps et al., 2017)	
1 evidence review	A review of IPV interventions during pregnancy (Van Parys et al., 2014)	
0 with adolescent focus	**0 in conflict/humanitarian**	**0 with disability focus**
OVERALL FINDINGS		
Promising: An intervention using cognitive behavioural therapy over multiple sessions showed promising findings at reducing IPV in this period. There is good evidence that brief counselling and safety interventions have no impact. There is conflicting evidence on the effectiveness of home-visitation programmes. These interventions have almost exclusively been implemented in high-income countries.		

Effectiveness of the interventions

The evidence for antenatal and postnatal interventions falls into three main categories. There is promising but insufficient evidence that CBT interventions can reduce women's experiences of IPV. There is conflicting evidence of the effectiveness of home-visitation programmes with pregnant women and new mothers for reducing women's experiences of IPV. Other brief psycho-educational (advocacy) interventions have not shown similar effects. These interventions have almost exclusively been delivered in high-income countries, and as such, their applicability to low- and middle-income countries needs to be considered.

We identified four brief interventions in healthcare settings, as well as one systematic review that included psycho-behavioural interventions. Although all four studies were RCTs, the numbers of women enrolled in them were often quite small.

There was one large RCT of a longer intervention integrating CBT into the psycho-behavioural approach in the US, and this showed a substantial reduction in physical IPV (Kiely et al., 2010). The intervention was intensive, as it was delivered by master's students and was up to 10 sessions in length (a maximum of eight prenatal, two postnatal). The research was well conducted, with a low risk of bias.

In Hong Kong, a brief psychoeducational intervention of 30 minutes of counselling on safety, choices and problem-solving, and a brochure, showed a small reduction in 'minor' physical IPV experience, but no reductions in severe IPV or sexual IPV experience (Tiwari et al., 2005). Only 23 participants in the intervention arm had experienced any physical IPV at baseline, so caution is needed in interpreting the results, as small differences in reports could lead to large changes in effect sizes.

Two studies by McFarlane (2000; 2006), both relying on brief interventions delivered by nurses, showed no impact on women's experiences of IPV in the US.

We identified four home-visitation programmes, one of which showed positive impact on IPV while a second showed promise. In the Netherlands, the **VoorZorg** intervention worked with trained nurses to provide extensive support to women in the antenatal period, and for two years in the postnatal period (Mejdoubi et all, 2013), with a focus on improved maternal and child health. Sessions included emotional regulation, communication and safe choices for the child (Mejdoubi et al., 2013). At 32 weeks of pregnancy there were significant reductions in physical IPV reported, and postnatally, at 24 months, there was a significant reduction in physical IPV (being shoved and hit) (Mejdoubi et al., 2013).

One home-visitation programme showed promise. Olds et al (2004) recruited women from antenatal clinics in the US and offered home visits for two years, delivering a broad programme around child health and nutrition, and improved family functioning. There were two intervention arms – a nurse-led arm, and a para-professional arm[33] – and one control arm. The intervention's impact on IPV ('domestic violence') was not reported in the first paper, but a paper reporting findings two years after the end of the intervention found that there had been a significant impact on reducing physical IPV in the nurse-led arm, but not in the para-professional arm (Olds et al., 2004). Multiple outcomes were reported, which increased the likelihood that this was a chance finding. In addition, the nine-year follow-up (seven years after the intervention ended), found no overall reduction in women's experience of physical IPV (Olds et al., 2007).

Two home-visitation interventions showed no effect. In Hawaii, Bair-Merritt et al (2010) evaluated the **Healthy Start Program**, which was intended to include weekly visits at home for three years. However, because there was a high drop-out rate, an average of only 13.5 visits were delivered in the first year. Postpartum visits from para-professionals included nutrition advice and family functioning as well as components related to IPV. Follow-up of women was conducted using a randomised control trial over nine years. The incidence of physical or sexual IPV episodes (events) was not significantly lower in the intervention arm. The **Domestic Violence Enhanced Home Visitation Program (DOVE)**, followed women up over 24 months, and did not show overall evidence of any effect of the intervention (Sharps et al., 2015).

33 A paraprofessional is someone delegated with a particular aspect of a professional task, but not licensed to practice as a fully qualified professional, in this context a nurse

3.7 Working with men and boys only

Interventions with men and boys to prevent VAWG are based on the premise that they are the ones who perpetrate this violence and should thus be central to its prevention. This position has not been without controversy. The counter view is that because women bear the brunt of experience of VAWG, a 'nothing about us without us' position problematises the notion of VAWG interventions that do not benefit women as victim/survivors.

The starting point of interventions that work with men and boys is generally a recognition that constructions of masculinity – the social norms, roles, expectations and identities associated with manhood – play a crucial role in shaping men's use of violence against women. This is combined with the observation that non-violent men and boys have a positive role to play in helping to stop VAWG, and benefit from doing so (Flood, 2013; Jewkes, Flood, & Lang, 2015).

In this section, we consider interventions that work exclusively with men and boys, whereas, in most of the other sections, the interventions described work with men and boys as well as women and girls.

Description of the interventions

Interventions that work solely with men and boys to prevent perpetration of VAWG and engage men as allies of women in VAWG prevention have taken several forms. Some draw on participatory group-education approaches and discussion around concepts of masculinity and inequitable gender attitudes and behaviours. Others draw on other health behaviour-change approaches, particularly Bandura's social cognitive theory, which focuses on changing attitudes towards specific behaviours. Examples include **Yaari Dosti** (Box 12) and the group and community intervention in Ethiopia described below, which both share a common root in Promundo's **Program H**, which was developed for use in Brazil. The original Program H is not discussed further here as it has not been evaluated with a RCT or quasi-experimental study.

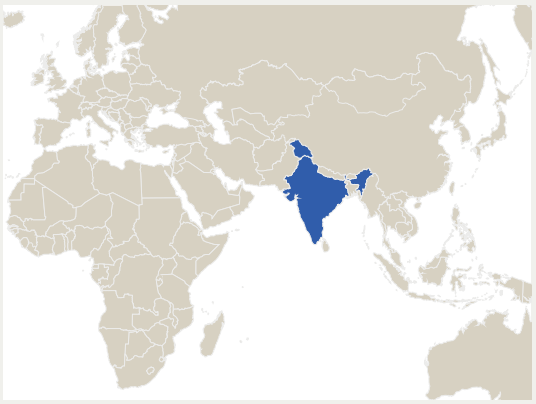
Bystander interventions are rather different to the approach described above, and have been mainly implemented in US college or sports team settings, with young men (18 to 22). These have focused on recognising that men can be allies in preventing sexual assault, and on concerns that interventions are too focused on men as perpetrators. Bystander interventions are theorised to work through i) supporting bystanders to recognise instances that could potentially lead to sexual violence; ii) supporting bystanders to intervene in situations (such as when they see a friend trying to get a partner intoxicated so they can have sex); iii) dispelling myths around rape; iv) supporting reflection on gender norms and attitudes. It is theorised that bystander interventions will reduce people's own perpetration of sexual and physical violence and encourage them to intervene in situations that could lead to sexual violence. The intervention's focus on opinion leaders in any setting – including high-school sports team members – is based on the assumption that opinion leaders can change attitudes about gender equality and the acceptability of the use of violence.

Many of the early bystander interventions were very short. For instance, **Bringing in the Bystander** is typically a 90-minute session, although sessions can be as short as 24 minutes. Longer interventions have also been developed. **Coaching Boys into Men** involves

Box 12: Examples of interventions working with men and boys only

Yaari Dosti works with young men aged 15 to 29 in India. Based on Promundo's Programme H - Working with Young Men Series, it promotes positive aspects of masculinity, encourages men's participation in sexual and reproductive health, promotes respect for sexual diversity and improves the understanding of the body and sexuality. It is a manualised intervention, working with groups of young men around four key themes: (1) gender; (2) sexuality and reproductive health; (3) violence; and (4) HIV and AIDS prevention.

Yaari Dosti was evaluated in a three-arm study with a group-education-only arm and a group-education plus social-marketing campaign arm with drama, posters and comics, and a control arm. There were three communities in the urban setting and two in the rural setting. At endline, significant decreases in physical and/or sexual violence against a wife or other woman or main sexual partner were reported in the intervention arms, compared to the control arm (Verma et al., 2008).



repeated contact with coaches who receive a one-hour training and cue cards that encouraged them to have 10- to 15-minute discussions with high school athletes about dating violence and bystander intervention, over an 11-week period (Miller et al., 2013). Interventions tend to be implemented by teachers, trained educators or sports coaches (Kettrey & Marx, 2019). More recently, bystander interventions have also used video and online delivery, as well as poster campaigns (Salazar et al., 2014).

Many interventions with men and boys look at other outcomes beyond VAWG prevention, including changes in gender norms and attitudes, a willingness to intervene in potentially risky situations, and rape myths. However, these outcomes are not about the primary prevention of violence, and as such are excluded in the review. Campaigns focused on awareness-raising around men's use of violence and the role men have to play in ending violence against women – such as the global **White Ribbon Campaign**, and the **Men's Action for Stopping Violence Against Women (MASVAW)** campaign in India – are not expected to impact individual men's behaviour on their own, but provide a rallying point for more in-depth work by civil society organisations (see Section 3.3.1 – Social Marketing Campaigns and Edutainment).

SUMMARY OF EVIDENCE AVAILABLE

6 interventions

6 interventions from global evidence review: Men's Discussion Groups (Côte d'Ivoire); a group and community intervention (Ethiopia); Yaari-Dosti (India); Phaphama Men (South Africa); Bringing in the Bystander (US); Coaching Boys into Men (US and India, under Parivartan)

3 Africa	2 Central and South Asia

7 RCT / quasi-experimental studies

1 with positive impact on VAWG: Coaching Boys into Men among high-school athletes (Miller et al., 2013)

4 with promising impact on VAWG: Men's discussions groups in Côte d'Ivoire (Hossain et al., 2014); interactive group education and community mobilisation and engagement activities ('Ethiopian male norms initiative') with young men in Ethiopia (Pulerwitz et al., 2015); group education sessions and a lifestyle social marketing campaign ('Yaari Dosti') with young men aged 15 to 29, in India (Verma et al., 2008); an integrated HIV/GBV intervention ('Phaphama Men') in South Africa (Kalichman et al., 2009)

2 with no impact on VAWG: Parivartan, a form of Coaching Boys into Men adapted for cricket teams in urban middle schools in India (Miller et al., 2014); Bringing in the Bystander (Elias-Lambert and Black, 2016)

3 evidence reviews

1 review of intervention effectiveness for work with men and boys (Jewkes et al., 2015) – this study reviews the evidence on working with men and boys more generally, not just men and boys only interventions

2 systematic reviews of bystander interventions in US college: 5/14 studies assessed sexual violence perpetration, (Kettery and Marx, 2019; Katz and Moore, 2013) 12 evaluations included sexual violence perpetration

4 with adolescent focus	1 in conflict/humanitarian	0 with disability focus
(Pulerwitz et al., 2015; Verma et al., 2008; Miller et al., 2013; Miller et al., 2014)	(Hossain et al., 2014)	

OVERALL FINDINGS

Conflicting evidence on the effectiveness of interventions working exclusively with men and boys, with some evidence that more intensive intervention approaches, over sustained periods, show positive impacts on reducing perpetration of VAWG.

There is good evidence that brief bystander interventions are ineffective in preventing the perpetration of violence. Shorter, single- or two-session interventions show no evidence of impact.

There are not many evaluations in this category because, acknowledging that gender is relational and women and girls are primarily affected by VAWG, many of the interventions that work with men and boys also work with women and girls. Interventions working with women and girls and men and boys have been shown to be highly successful. Working with men and boys in structured interventions may also be important as part of a wider, multi-component approach that also works with women and girls.

Effectiveness of the interventions

Overall evidence that working with men and boys alone may be a useful approach for VAWG prevention is conflicting, but there is a need for more rigorous evaluation of well-designed, well-implemented interventions. Shorter single or two-session interventions show no evidence of impact. There are not many evaluations in this category because gender is relational, and women and girls are primarily affected by VAWG, many of the interventions that work with men and boys also work with women and girls. Overall, interventions that work with both men and women have been more effective and some have been shown to be highly successful in reducing self-reported perpetration of IPV). Given that questions have been raised around the ethical problems of only working with men and boys on VAWG prevention, we would argue that interventions on VAWG should be designed to include women and girls.

Both quasi-experimental evaluations of adaptations of **Program H** in India and Ethiopia had some positive findings, which suggests they had an impact on reducing VAWG. Both measured outcomes six-months post-baseline. In Ethiopia, the intervention engaged men age 15 to 24. In one community men received combined community outreach (with newsletters, leaflets and drama), over six months, with eight two- to three-hour sessions of group-based education delivered over four months. In a second community only outreach was offered (Pulerwitz et al., 2015). There was also a control community. Participants in both intervention arms reported perpetrating less IPV in the past six months at endline, but this was not conventionally statistically significant. There was significant residual bias, because only a few of the participants had partners (which resulted in small sample sizes), sites were not randomised, and there were significant differences on important variables between the arms at baseline that were not adjusted for, including the baseline prevalence of violence perpetration, in the main analysis. In addition, follow-up was short and there was only one community per arm, which signals the need for caution in interpreting the findings.

In India, **Yaari Dosti** was evaluated in a three-arm study with a group-education-only arm and a group-education plus social-marketing campaign arm with drama, posters and comics, and a control arm. There were three communities in the urban setting and two in the rural setting. At endline, significant decreases in physical and/or sexual violence against a wife or other woman or main sexual partner were reported in the intervention arms, compared to the control arm (Verma et al., 2008). The analysis did not show if there was additional benefit of the social marketing campaign to the group education. Again, the quasi-experimental nature of the study, the low number of communities and the substantial differences between arms on key variables such as marriage, necessitate caution in interpreting the findings.

In South Africa, the **Phaphama Men** five-session intervention was evaluated with a quasi-experimental study conducted in two communities, with one randomised to each of two arms of the trial and follow up at six months (Kalichman et al., 2009). A single item was used to assess perpetration of physical IPV. At six months, men in the intervention reported less physical IPV perpetration (Kalichman et al., 2009). However, the results were driven by changes in the control arm where the level of past-month violence tripled (from 19 to 61%) between the one-month and six- month follow-ups, compared with a 50% increase in the intervention arm (from 23 to 31%) and should thus be treated with caution.

An RCT in 12 communities of Cote d'Ivoire (Hossain et al., 2014) looked at the impact of a 16-week group-discussion intervention with men from conflict-affected communities. The study was randomised and the men's female partners were interviewed, which reduced the potential bias of self-reporting by men; follow-up was at 12 months. There was a substantial, but statistically non-significant reduction in women's experience of IPV at endline (Hossain et al., 2014).

A number of evaluations have assessed the impact of bystander interventions. Of the two separate studies that evaluated versions of **Coaching Boys into Men**, one found evidence of impact on VAWG. The first study, which was conducted among US high school students in Grades 9 to 11, examined the impact on male athletes of using coaches to discuss bystander behaviours and perpetration of dating violence. The initial outcome (three months post-intervention) showed no impact on dating violence (Miller et al, 2012) and was included in the systematic review by Kettery and Marx (2019). A subsequent follow-up at 12 months post-baseline showed a significant reduction in dating abuse (physical, sexual or emotional) perpetrated by the students in the past three months (Miller et al, 2013). It is unclear whether this was being driven by a reduction in all types, or one type of violence, because the scale had only one item on physical IPV, and two items on sexual IPV perpetration (and seven psychological IPV items). A second evaluation adapted **Coaching Boys into Men** for use in India and was called **Parivartan** (Miller et al., 2014). This was delivered to male athletes, aged 10 to 16 from 27 schools, and evaluated in a quasi-experimental study with 19 schools in a comparison arm. The intervention showed no significant reduction in sexual violence perpetration at 12-month follow-up (Miller et al., 2014).

Two systematic reviews on the impact of brief bystander interventions were conducted recently. One focused exclusively on studies among US school and college students, and identified 14 independent studies, 12 RCTs and two quasi-experimental studies (Kettrey & Marx, 2019), but only five included perpetration of sexual violence, and all of them worked with men only (Kettrey & Marx, 2019). The meta-analysis showed no impact on sexual violence perpetration (Kettrey & Marx, 2019), a finding much the same as that of an earlier meta-analysis by Katz and Moore (2013). This conclusion seems to have been driven by the fairly large number of very brief bystander interventions; it appears that including a bystander element in longer and more robust interventions may result in less self-reported VAWG perpetration (see **Green Dot** in School-based Interventions, Section 3.4.1). An additional study, falling outside the reviews, was an evaluation of **Bringing in the Bystander** a brief bystander intervention, in a quasi-experimental randomised trial, which showed no impact (Elias-Lambert & Black, 2016).

Photo: Anisa Sabiri

3.8 Interventions to tackle alcohol and/or other substance abuse

Global evidence points to harmful use of alcohol and drugs as risk factors for IPV perpetration and experience. A recent meta-analysis of 22 studies found that among men, harmful use of alcohol was associated with past-year IPV perpetration (Machisa, Hatcher, Christofides, & Jewkes, 2019). Men who perpetrated IPV were often found to have engaged in harmful alcohol use preceding the event (Thompson & Kingree, 2006) and harmful alcohol use was associated with increasing frequency and severity of partner violence, which includes femicide. Women who reported that their partner drank before a violent incident were significantly more likely to be injured (Foran & O'Leary, 2008). Harmful use of alcohol by women also increased their risk of being a victim of violence, usually because of decreased physical capacity and compromised decision-making ability. Women who experience IPV were also more likely to drink alcohol to harmful levels (Heise, 2011).

Description of interventions

Interventions that are primarily focused on reducing harmful alcohol use have been shown to be effective in doing so (O'Donnell et al., 2013) but less is known about how they impact on women's experience or men's perpetration of VAWG (essentially secondary outcomes). Five broad types of alcohol interventions that included VAWG as an outcome have been evaluated:

Brief interventions that usually seek to detect and intervene with those who have substance abuse disorders, or as a supplement to universal and/or tailored prevention approaches.

- **CBT-based couples' interventions,** with a therapeutic approach that involves accentuating a person's awareness of positive and negative thoughts and behaviour, with the aim of effective problem-solving.
- **Community-based interventions** aimed at modifying the drinking environment through social norms campaigns, often through education in schools or public dialogues.
- **Treatment and self-help support systems**, such as Alcoholics Anonymous (AA).
- **Structural interventions** (taxation, policy and pricing) (Heise, 2011; Wilson, Graham, & Taft, 2014).

In this review, we found 11 studies that looked at substance-use interventions as a pathway to reducing VAWG, and these covered brief interventions, couple-based interventions (including those with those elements of CBT), web-based programmes and other treatment-based interventions.

Box 13: Examples of interventions to reduce alcohol/drug use

The **Violence and Alcohol Treatment (VATU)** intervention in Zambia is a transdiagnostic intervention that aims to reduce poor mental health symptoms (trauma, depression, anxiety), IPV, and substance abuse. It builds off the **Common Elements Treatment Approach (CETA)** and was delivered to couples who were known to be experiencing IPV (in individual sessions) over 6 to 12 weekly sessions by lay counsellors. Each session runs for 60-120 minutes and covers a number of elements, including safety and violence prevention, substance use reduction, problem-solving, and talking about traumatic memories. Each treatment plan is individualised and decided on by the clinical team (counsellor and supervisor), with clients "completing" once the clients' clinical symptoms have reduced.

VATU was evaluated by What Works in a two arm RCT with 248 couples, who had been identified for having high substance use and violence in their relationship. It had positive outcomes for reducing both physical and sexual violence against women. **VATU** also successfully reduced hazardous alcohol use among both men and women (Murray et al., 2019). The results suggest that effects were largely sustained to 24 months, post-baseline.

SUMMARY OF EVIDENCE AVAILABLE

8 interventions

7 interventions from a global evidence review: Couples' Health CoOp (South Africa); Women's Health CoOp (South Africa); web-based combined sexual-assault risk and alcohol-use reduction programme (US); Integrated Violence Prevention Treatment (US); RHANI Wives (India), Brief Motivational Interviewing (US); Parent-Based Intervention (PBI) for college women (US)

1 What Works intervention: Violence and Alcohol Treatment (VATU) (Zambia)

3 Africa	1 Central and South Asia

9 RCT / quasi-experimental studies

6 with positive impact on VAWG: A web-based programme for college women aged 18 to 20 who engaged in heavy episodic drinking, in the US (Gilmore, Lewis, & George, 2015); Couples Co-op, a group-based intervention for men with harmful alcohol use and their female partners, in South Africa (Minnis et al., 2015); Women's Health CoOp for women who use drugs and alcohol (Weschberg et al., 2011); brief motivational interviewing at a US college on alcohol-involved sexual victimisation experiences among college women (Clinton-Sherrod et al, 2011) and a Parent-Based Intervention (PBI) preventing college women's sexual victimisation (Testa et al., 2010); Violence and Alcohol Treatment (VATU) in Zambia (Murray et al., 2019)

1 with promising impacts on VAWG: Reducing HIV among Non-Infected Wives (RHANI) programme – married women whose husbands were heavy drinkers and/or perpetrated IPV (Saggurti et al., 2014)

2 with no impact on VAWG: Motivational interviewing and therapy for men and women in treatment for substance-use disorders in the US (Chermack et al., 2017); Women's Health CoOp for women for drug-using women (Wechsberg et al., 2013)

3 evidence reviews

1 review of intervention effectiveness for work with men and boys (Jewkes et al., 2015) – this study reviews the evidence on working with men and boys more generally, not just men and boys only interventions

2 systematic reviews of bystander interventions in US college: 5/14 studies assessed sexual violence perpetration, (Kettery and Marx, 2019; Katz and Moore, 2013) 12 evaluations included sexual violence perpetration

3 with adolescent focus (Clinton-Sherrod et al., 2011; Testa et al., 2010; Gilmore, Lewis, & George, 2015)	0 in conflict/ humanitarian	0 with disability focus

OVERALL FINDINGS

Effective: There is good evidence for the effectiveness of alcohol- and substance-abuse interventions in reducing VAWG outcomes, particularly interventions that work with couples.

Effectiveness of the interventions

Overall, there is good evidence for the effectiveness of interventions addressing harmful alcohol use and substance abuse in reducing VAWG, with six RCTs or quasi-experimental evaluations that showed reductions in IPV. The evidence further suggests that working with couples around issues of alcohol and violence may be particularly beneficial.

In the US, a web-based intervention combined sexual-assault risk reduction and alcohol-use risk reduction **(SARR)** for college women (18 to 20) who self-reported that they were heavy episodic drinkers. This reduced their experiences of sexual assault (incapacitated rapes, sexual assault incidence and severity), after three months (Gilmore et al., 2015). However, these findings should be interpreted with caution as the study had very few women in each arm (a sample size of only 207 women for five different conditions), and the number of sexual assaults in the three months is not reported.

A second US-based study assessed the impact of the **Brief Motivational Interviewing** intervention, which delivered a brief alcohol intervention among first year female college students, who self-reported being heavy episodic drinkers (Clinton-Sherrod et al, 2011). Women were randomly assigned to one of four arms: Motivational Interviewing (MI), MI with feedback (MIFB), feedback alone, and a control. There was a significant reduction in sexual assault experienced in the MIFB arm. The study findings should, however, be interpreted with caution, as the study had only one measure of pressured or forced sex in the context of alcohol-related incapacity, which does not capture other sexual violence, and due to the study's short follow- up, there is no evidence of a sustained effect.

One RCT in the US tested the effectiveness of a **Parent-Based Intervention (PBI)** to reduce the incidence of women being raped after using alcohol among first-year college students (Testa et al., 2010). The intervention was designed to increase communication between mother and daughter, both in general and about alcohol use. It targeted female graduating high school seniors and their mothers from the community and randomly assigned them to one of four conditions: Alcohol PBI (n = 305), Enhanced Alcohol + Sex PBI (n = 218), Control (n = 288) or Unmeasured Control (n = 167). Mothers in the intervention group were given a manual and asked to discuss its contents with their daughters before college matriculation. The evaluation found that the standard and enhanced PBIs were both associated with lower incidence of daughters being raped after using alcohol in the first year of college, compared to the control group. Some caution is needed in interpreting these findings as intervention effects were modest and the intervention showed no effect on heavy episodic drinking.

What Works evaluated the **Violence and Alcohol Treatment (VATU)** intervention, which used the **Combined Elements Transdiagnostic Approach (CETA)** intervention (Box 11), which draws on elements of CBT to reduce harmful alcohol and other substance use and IPV. The study enrolled 248 couples in Zambia, with high levels of IPV and harmful alcohol use. At 12 months, those in the intervention reported significantly less alcohol use and IPV experience (women) and perpetration (men) (Murray et al., 2019).

Three RCTs evaluated versions of the **Women's Health Co-operative** intervention, implemented in South Africa. The first assessed the impact of the **Women's Health Co-op (WHC)** on women who used high levels of alcohol (Wechsberg et al., 2011). The evaluation found a significant reduction in women's experiences of sexual violence from an intimate partner (Wechsberg et al., 2011). This evaluation also included sex workers whose outcomes are described in Section 3.9. A second RCT assessed the **WHC** among drug-using women who commonly experienced IPV (Wechsberg et al., 2013). It was shown to have a biologically proven impact on drug use but no impact on IPV experience at 12 months (Wechsberg et al., 2013). A third RCT compared WHC for women alone with two variations that included their male partners – the **Couples Health CoOp [CHC]**, where sessions were for couples together and the gender-disaggregated sessions of the **Men's Health CoOp/Women's Health CoOp [MHC/WHC]** (Minnis et al., 2015). Compared to the **WHC** alone, women in both the **CHC** and the **MHC/WHC** reported significantly less violence six months post-baseline (Minnis et al., 2015). Women and men also reported significantly less harmful alcohol use (Wechsberg et al., 2016).

Findings from the **RHANI Wives' study** in India found promising impacts on reducing VAWG. Significant reductions were found in marital conflict, IPV and sexual coercion among intervention participants (Saggurti et al., 2014). However, some caution is needed as the study had low levels of reported IPV and the outcome measures used for the study included only single questions in the survey instrument (Saggurti et al., 2014), which increases the risk of under-reporting violence.

An RCT evaluated the **Integrated Violence Prevention Treatment (IVPT)** intervention in the US which targeted men and women in treatment for substance-use disorders. The intervention used a motivational interviewing session plus five therapy sessions (Chermack et al., 2017). The evaluation found that the IVPT group showed a significant decline in alcohol use but there was no impact on women's experience of IPV.

In studies reported elsewhere in the review, variations of the **Stepping Stones** trial, a gender transformative intervention, showed consistent results in reducing alcohol use and men's perpetration of IPV in more generalised populations (**Stepping Stones** [Jewkes et al., 2008], Section 3.4.1; **Stepping Stones and Creating Futures** [Gibbs et al., 2019a]; Section 3.1.3).

3.9 Interventions with female sex workers

Female sex workers (FSWs) are highly vulnerable to violence from a range of men, including clients, pimps, the police, as well as their intimate partners.[34]

Description of the interventions

Two broad types of approaches have been used to reduce violence against FSWs. The first approach – sex-worker collectivisation and empowerment programmes – are multi-level, structural interventions. They can include components such as sex-worker collectivisation, alternative livelihood activities, training on human rights and legislation, outreach activities to reduce stigma, training of police officers about the rights of FSWs and sensitisation or destigmatisation regarding FSWs, and rapid response systems for FSWs facing violence. They are often implemented by health or women's rights NGOs, or by organisations established by FSWs, which through collective action advocate for improvements to FSWs living and working conditions (Gurnani et al., 2011). These interventions are typically delivered across large areas (e.g., rural communities, cities etc.). The assumption is that sex-worker collectivisation and empowerment will reduce violence against FSW by bringing together individual FSWs and supporting them to collectively work towards achieving their right to live and work in an environment free of violence. Sex workers from the LGBTQI+ community face additional intersecting vulnerabilities around violence; studies do not specifically note whether they are included in interventions and/or analysis.

The second type of interventions for FSWs have been shorter, more 'contained' interventions. These have ranged from two 50-minute sessions (**Women's Health CoOp**, Wechberg et al., 2011) to six sessions lasting 20 minutes each (L'Engle et al, 2014). They have also focused on specific social empowerment issues, such as harmful alcohol- and drug-use reduction and HIV risks. These approaches are premised on the idea that FSW are better able to protect themselves from violence if they are sober.

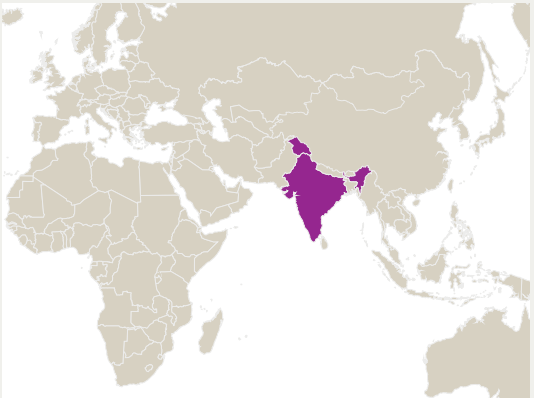
Both types of intervention have sought to address the violence FSWs experience from clients, police and others, and violence from intimate partners (recognising that some intimate partners have been clients).

Box 14: Examples of programmes working with female sex workers

The Karnataka Health Promotion Trust (KHTP) based in Karnataka, India, has implemented several interventions with female sex workers (FSWs). They have been involved in FSW empowerment programmes, most recently in implementing the **India AIDS Initiative (AVAHAN)** programme which combined sex-worker collectivisation, including outreach by peer sex workers, condom promotion and provision and HIV-testing and treatment. In addition, KHPT worked to collectivise sex workers to think critically about their position, and rights, and to campaign and work together to achieve these. They also worked to establish response mechanisms to violence experienced by FSWs, including a 24-hour helpline and legal responses. The intervention is described in detail by Gurnani et al (2011).

The programme was evaluated through a repeat cross- sectional study with random samples of FSWs (Beattie et al., 2015). Over the period of implementation, the evaluation found that sex workers experienced significantly less violence from clients and police officers.

The approach has been adapted and implemented in Kenya, focused on key populations (including FSWs and injecting drug users, and men who have sex with men) (Bhattacharjee et al., 2018).



34 Preliminary survey evaluations of violence among FSWs in India found that between 11% and 26% had been beaten or raped in the past year (WHO, UNAIDS, 2010).

SUMMARY OF EVIDENCE AVAILABLE		
5 interventions*	**4 interventions from global evidence review:** WHO's Brief Intervention for Hazardous and Harmful Drinking (Kenya); Avahan (India); HIVSSR (HIV/STI risk reduction) (Mongolia); Women's Health Co-Op (South Africa) **1 What Works intervention:** Samvedana Plus	
	2 Africa	**3 Central and South Asia**
6 RCT/quasi-experimental studies	**4 with positive impacts on VAWG:** A brief intervention to reduce alcohol use among female sex workers in Mombasa, Kenya (L'Engle et al., 2014); Women's Health Co-Op for Sex workers in South Africa (Wechsberg et al., 2011); two evaluations of AVAHAN community collectivisation in India (Beattie et al., 2015; Reza-Paul et al., 2012) **2 with no impact on VAWG:** Samvedana Plus (India) intervention with FSWs and their intimate partners (Javalkar et al., 2019); HIVSSR and microfinance with FSWs in Mongolia (Tsai et al., 2016)	
2 pre-post tests	**2 with positive impacts on VAWG:** Two evaluations of AVAHAN community collectivisation in India (Beattie et al., 2015; Reza-Paul et al., 2012).	
0 with adolescent focus	**0 in conflict/humanitarian**	**0 with disability focus**

OVERALL FINDINGS

Effective: Interventions with female sex workers, particularly collectivisation/empowerment programmes delivered over long periods, and short interventions seeking to reduce substance use, are effective in reducing violence from clients, police and others. There is promising but insufficient evidence of impact of combined harmful substance use and IPV prevention programming in reducing IPV.

Effectiveness of the interventions

FSW collectivisation or empowerment programmes are promising in their ability to reduce female sex workers' experiences of violence from clients, police and others, and alcohol-focused short interventions are effective at reducing violence from clients. Further research is required to replicate these findings in multiple settings (particularly sex-worker collectivisation approaches) and with longer follow-up periods for the alcohol-focused short interventions. There is promising evidence of impact of combined substance abuse and IPV prevention programming in reducing IPV.

Two repeat cross-sectional studies without a control assessed the impact of sex-worker collectivisation approaches. Both evaluations were carried out in Karnataka State, India, and the interventions were delivered by Karnataka Health Promotion Trust (KHPT). The most rigorous evaluation was a repeat cross-sectional study, with three different rounds of data collection, the first from August 2005 to July 2006, and the final round from September 2010 to August 2011, using population-based random sampling, for different sex-worker populations (Beattie et al., 2015). Across these waves there were significant reductions in being raped in the past year, and being beaten in the past year by a client (Beattie et al., 2015). Similarly, using ongoing monitoring data from an earlier study in one city in Karnataka, where facilitators recorded the number of self-reported experiences of violence over the period of the intervention delivery, the number of FSWs reporting violence also declined (Reza-Paul et al., 2012). Both studies have significant potential bias, with no control arm to compare natural trends in these experiences. In addition, the Reza-Paul et al (2012) study has potential for significant social desirability in reporting. However, given that these interventions work at large scale, and constructing a control group is therefore challenging, they probably constitute the best quality evidence that can be provided.

Four RCTs evaluated shorter interventions. Two of these interventions focused on alcohol and substance use. The first was in Kenya and used an adapted brief alcohol intervention of six sessions, delivered once a month to FSWs who were moderate-risk alcohol drinkers (as defined by the Alcohol Use Disorders Identification Test [AUDIT]), and had attended an HIV drop-in centre (L'Engle et al., 2014). They found that after six months of follow-up, drinking frequency and binge drinking immediately reduced post-intervention and at six months post-intervention, as did sexual violence from a client (L'Engle et al., 2014). In addition, physical and verbal abuse from clients had decreased six months after the intervention, but there was no impact on IPV (Parcesepe et al., 2016).

In South Africa, the **Women's Health CoOp (WHC)** addressing substance use and violence and promoting condom use and drawing up a personal plan, provided two 50-minute sessions to individual sex workers. Six-months post-intervention there were reductions in biochemically verified drug use, and physical violence from an intimate partner, and there was evidence of reduced sexual abuse from an intimate partner ($p=0.08$) (Wechsberg et al., 2011). This was encouraging, but some caution is needed as longer term sustainability of the impact is not known.

The third RCT evaluated the addition of a microfinance intervention to an HIV-risk reduction intervention for FSWs in Mongolia, where the study control arm had only the HIV intervention (Tsai et al., 2016). Six months post-baseline, there was no difference between arms in client violence (Tsai et al., 2016).

The *What Works* evaluation of the **Samvedana Plus** intervention in Karnataka State, India, assessed whether a participatory intervention could reduce FSW experience of violence from intimate partners (as opposed to clients). This participatory intervention had 12 to 24 hours of group sessions for sex workers, as well as a community intervention that drew on **AVAHAN** (see Box 14) and group sessions to which male partners were invited. However, because the male partners' attendance was very poor, the intervention could not be delivered as planned. The RCT findings showed no difference in IPV experience, although there was decreased acceptance of IPV, and greater solidarity around IPV among sex workers. However, the intervention had significant delivery and research challenges (Javalkar et al., 2019).

Overall, large-scale sex-worker collectivisation interventions are promising in reducing violence perpetrated by clients. There is also evidence that substance-use-focused interventions may reduce violence; two trials showed this, including one that demonstrated protection from IPV. Challenges in these evaluations include short follow-up (e.g., six months), or only being evaluated using repeat cross-sectional studies, which limits interpretability. There is promising evidence of impact of combined substance abuse and IPV-prevention programming in reducing IPV.

Photo: Equal Access

SECTION 4
Discussion

4.1 What is the evidence base for interventions to prevent VAWG?

There has been a large increase in the number of high-quality evaluations of interventions that seek to prevent VAWG, since *What Works* published its initial evidence review in 2014 (Fulu, Kerr-Wilson and Lang, 2014). *What Works* has been central to the production of knowledge around the effectiveness of interventions to prevent VAWG. This growth in evidence has meant that in this updated review, we have focused only on studies that 1) assess the impact of interventions on VAWG as an outcome and 2) have used more rigorous evaluation methods (see Section 2 on methodology). The growth in the number of well-evaluated interventions to prevent VAWG means that for some types of interventions there are a good number of well-conducted trials, with consistent findings across different settings.

In our classification of intervention approaches as effective, promising, conflicting or no effect in preventing VAWG, a significant challenge lay in the heterogeneity of intervention design in any one category, as well as limited knowledge of how interventions were implemented. Another review by *What Works* (Jewkes et al., 2020) identifies attention to detail in both these areas, and in congruence with best practice, as critically influencing the likelihood of success or failure.

Nonetheless, we now have some evidence about what works to prevent VAWG, what is promising, what is conflicting and what is ineffective (Table 7).

The overall effectiveness of intervention categories is as follows and is based on the criteria outlined in Tables 1 and 5. **Blue** suggests interventions are effective in preventing the perpetration and/or experience of VAWG. There are at least two high or moderate quality impact evaluations that have found statistically significant reductions in physical IPV, sexual IPV or non-partner sexual violence (or peer violence in LMICs). However, this does not mean that all interventions reviewed in the section are necessarily positive but rather that the evidence suggests that well-designed, well-implemented interventions do work to prevent VAWG. **Green** interventions are promising in terms of their potential to prevent VAWG; they either show positive changes in the direction of effect with a finding that is not significant, or one well-conducted RCT that shows positive outcomes but no confirmatory trial. **Orange** means the evidence is conflicting: primarily they have few studies, with some showing positive change and others not showing impact. **Grey** means interventions are ineffective in preventing VAWG in their current form (although they may be effective in achieving other important goals).

TABLE 7: INTERVENTION EFFECTIVENESS FOR THE PREVENTION OF VAWG

Classification	Intervention Type
Effective, when well designed and executed	• Economic transfer programmes. • Combined economic and social empowerment programmes targeting women. • Parenting programmes to prevent IPV and child maltreatment. • Community activism to shift harmful gender attitudes, role and social norms. • School-based interventions to prevent dating or sexual violence. • School-based interventions for peer violence. • Interventions that work with individuals and/or couples to reduce their alcohol and/or substance abuse (with or without other prevention elements). • Couples' interventions (focused on transforming gender relations within the couple, or addressing alcohol and violence in relationships). • Interventions with female sex workers to reduce violence by clients, police or strangers (i.e., non-intimate partners) through empowerment/collectivisation or alcohol and substance use reduction.
Promising, but requires further research	• Cognitive behaviour therapy (CBT) based interventions with pregnant women. • Self-defence interventions to prevent sexual violence for women at college. • Economic and social empowerment programmes targeting men. • Interventions with female sex workers to reduce violence by non-paying intimate partners.
Conflicting evidence	• Self-defence interventions to prevent sexual violence for girls at primary and secondary schools. • Working with men and boys alone. • Home visitation programmes in the antenatal and postnatal period to prevent IPV.
No effect	• Good evidence that as standalone interventions these do not reduce levels of VAWG: – Microfinance, savings and livelihood programmes. – Brief bystander interventions. – Brief counselling and safety planning for pregnant women. • Insufficient evidence* but unlikely to work as standalone interventions to reduce levels of VAWG: – Social marketing campaigns and edutainment. – Digital technologies for VAWG prevention.

*Insufficient evidence means we were unable to find RCT/quasi-experimental studies for these intervention categories.

Good evidence of effectiveness in reducing VAWG

Nine intervention approaches have good evidence that they are effective in reducing VAWG if they are developed and implemented according to good practice guidelines. These are:

- **Economic transfer programmes.** Cash or food transfers, often in the form of national social-protection programmes, particularly when combined with social components (group discussions, or other conditionalities), are effective in preventing women's experiences of IPV. Questions remain about how best to deliver these, including whether to target women, heads of households, or men, and whether social components are critical to maximise VAWG outcomes. There is also limited evidence from conflict-affected populations and on whether outcomes are sustained once the transfers stop.

- **Combined economic- and social-empowerment interventions for women.** There is good evidence that interventions that combine economic empowerment and social empowerment approaches can prevent VAWG. Within this approach, shorter interventions (often up to one year) appear to have a greater effect for older women, while for adolescent girls and young women, longer, multi-component interventions appear more effective. In addition, reflecting the wider practice base, short interventions (e.g., less than five sessions), or those not adequately drawing on theories of gender and power, appear less effective (see Box 1). Most evaluations are from Africa; there are very few in conflict-affected populations.

- **Parenting programmes to prevent IPV and child maltreatment.** Two RCTs and a quasi-experimental study showed that well-designed parenting programmes, working with parents with younger children, can reduce IPV and child maltreatment. The evaluated interventions were all intensive interventions that were built off theories of gender and power. Gaps around their ability to work in conflict-affected settings and across multiple settings remain.

- **Community activism to shift harmful gender attitudes, role and social norms.** These types of interventions are different from the other interventions as they seek to have an impact at the population level rather than with those directly exposed to an intervention. There are now a series of rigorous impact evaluations, including *What Works* studies in Ghana and the DRC, which show that well-designed, well-implemented interventions working with community activists over long periods can reduce women's experiences of IPV. However, community activism interventions to change social norms do not always work. It is important to allow sufficient intensity and implementation time (18 to 24 months or longer) and carefully develop or adapt interventions for any given setting. There are also questions about the extent to which these approaches are feasible in conflict-affected populations, or in those experiencing high levels of trauma and poverty. All effective intervention evaluations were conducted in Africa; detailed study and analysis of whether these can be adapted to other settings is critical, particularly as these results show that it is possible to have an impact on a whole population, even if this is hard to do well.

- **School-based interventions to prevent dating or sexual violence.** With four RCTs with positive findings, there is good evidence that school-based interventions can prevent dating violence. The more effective and promising interventions had longer programmes delivered by highly trained facilitators or teachers, used participatory learning approaches, including critical reflection and skills building, and were based on theories of gender and power. They were also evaluated with long-term follow-up. Many of the interventions which were not successful were short interventions, with more didactic styles. More research is needed to develop interventions for more effective use in classrooms, especially in LMIC settings, and to ensure impact on both girls and boys.

- **School-based interventions to reduce peer violence.** There is good evidence from Africa and Central and South Asia that peer violence can be prevented through the right interventions, even in fragile settings, and that results can be sustained. Two rigorous RCTs of two separate interventions found that interventions reduced peer violence (Devries et al., 2015 and Karmaliani et al, 2019), while three RCTs that found no reduction in VAWG were of the same intervention (GEMS) in three different contexts. The effective interventions all used participatory methods and built skills, and addressed violence prevention through a gender lens.

- **Interventions that work with individuals and/or couples to reduce their alcohol and/or substance abuse.** There is good evidence that interventions that work with individuals and/or couples to reduce their alcohol and/or substance abuse are effective in reducing IPV and non-partner sexual violence and that they may be particularly effective when working with couples.

- **Couples' interventions** (conducted among couples in the general population who may or may not have experienced IPV) are effective in reducing women's experiences of IPV. Approaches may include well-designed interventions focused on transforming gender relations within the couple, for example, the *What Works* intervention **Indashyikirwa**, which worked intensively with couples around gender, decision-making and

relationships.[35] In addition, **VATU** in Zambia showed that working intensively with couples around problem-solving reduced alcohol use and violence, and may be important when couples have multiple, overlapping challenges. There is less evidence that couples' interventions work if they are too short, or where the 'couple' status is concealed or ambiguous, which was the case with the *What Works* project with female sex workers in India.

- **Interventions with female sex workers on violence by clients, police or others.** Interventions with female sex workers, particularly collectivisation or empowerment programmes delivered over long periods, and short interventions that seek to reduce substance use, are effective in reducing violence from clients, police and others. One intervention has shown promise in preventing female sex workers' experiences of violence from intimate partners.

Promising but insufficient evidence of effectiveness

Four intervention approaches are promising but have insufficient evidence (i.e., only one robust RCT) for the prevention of VAWG.

- **Cognitive Behavioural Therapy (CBT) interventions with pregnant women.** There is one large, well-evaluated intervention which demonstrates that CBT in the antenatal and postnatal period can reduce women's experiences of IPV (Kiely et al, 2010). This study provides promising evidence that a more intensive approach to intervening one-on-one with women during this period can work, and as such, further studies are required to replicate this finding.
- **Self-defence interventions to prevent sexual violence for women at college.** One very well-evaluated intervention (EAAA) has demonstrated significant reductions in sexual assault at 12 months and reductions in sexual-assault risk at 18 months. Other studies in this category, though often promising in terms of findings, have methodological weaknesses. Despite this, the one strong RCT highlights that well-conceptualised self-defence training interventions are a promising approach for college-age women. This evidence also highlights that more intensive interventions work more successfully than shorter interventions. There is a need to consider their applicability to contexts outside of North America, and in non-college populations.
- **Economic and social empowerment programmes targeting men.** One well-evaluated approach – Stepping Stones and Creating Futures – showed that men's perpetration of VAWG was significantly reduced 24 months after baseline but in the evaluation, women (not men's partners) did not report any reduction in VAWG. In many contexts, poverty is a key driver of men's perpetration of VAWG, and working around livelihoods may provide a space for men to work on other aspects of their lives.
- **Interventions with female sex workers to reduce violence by non-paying intimate partners.** One study demonstrated that an alcohol- and drug-reduction intervention with female sex workers can reduce their experiences of physical IPV from non-paying partners. However, this study had small sample sizes and short follow-up periods. Further studies are required to understand if this approach can work. Working directly with the intimate partners of female sex workers may prove very challenging, particularly when these partners are hidden and relationships are not acknowledged.

Conflicting evidence

For three intervention categories the evidence is conflicting about their impact on VAWG.

- **Self-defence interventions (for schoolchildren).** There is conflicting evidence about whether self-defence interventions for adolescent girls are effective. The studies have differing findings and methodological limitations. Self-defence approaches for schoolgirls should therefore be treated with caution.
- **Working with men and boys alone.** Overall, there is conflicting evidence on interventions working with men and boys, with one RCT showing positive impact, four, promising findings, and two with no impact. There is some evidence that more intensive intervention approaches, over sustained periods, show positive impacts on reducing VAWG. Shorter, single or two-session interventions, show no evidence of impact. There are not a great number of evaluations in this category because, acknowledging that gender is relational, and women and girls are primarily affected by VAWG, many interventions that work with men and boys also work with women and girls. Some of these have been shown to be successful in reducing men's perpetration (e.g., Stepping Stones).
- **Home-visitation programmes in the antenatal and postnatal period, to prevent IPV.** There is conflicting evidence about whether home-visitation programmes can work to reduce VAWG, with two studies showing positive findings on reducing physical IPV, and two showing no impact. These interventions are often led by nurses, over relatively long periods. Currently, the evidence base for this approach to intervention is only from high-income countries, and there are questions about the extent to which these approaches are applicable in low- and middle-income country settings.

35 Pilot studies in *What Works* also highlighted that couples' or family-centred programming is potentially of particular benefit when combined with economic and gender empowerment interventions (for example Zindagii Shoista in Tajikistan and Sammanit Jeevan in Nepal).

Good evidence of no effect

Currently, there is good evidence to conclude that the following are ineffective for preventing VAWG:

- **Microfinance, savings and livelihood interventions.** On their own these have not been shown to reduce physical or sexual IPV as has been shown in three RCTs. This reflects the findings of the RESPECT framework (WHO, 2019), which similarly cautioned against such approaches for VAWG prevention. However, they do impact on protective factors for VAWG, and if delivered as part of a multi-sectoral intervention that also tackles gender inequitable norms, may be appropriate. However, microfinance, savings and livelihood interventions delivered on their own should not be implemented as a route to reduce VAWG.
- **Brief bystander interventions.** Short one- or two-session bystander interventions primarily targeting men have not demonstrated impacts on men's perpetration of IPV, or non-partner rape. This has been demonstrated in two systematic reviews. They have been primarily developed and implemented in North America among college-age populations. Newer versions of these approaches, which are more intensive and developed off stronger theoretical approaches to behaviour change, may hold more promise.
- **Brief counselling and safety planning for pregnant women.** A series of very short (often one or two sessions), typically nurse-led interventions for pregnant women have not demonstrated any significant effects on reducing women's experiences of IPV. In addition, they have been implemented primarily in high-income settings, and their applicability in low-income settings is questionable.

Insufficient evidence and no effect

Two intervention approaches have limited evidence and thus far show no effect for the prevention of VAWG, and there are concerns that as standalone interventions, they are unlikely to be effective.

- **Social marketing campaigns and digital technologies for VAWG prevention.** Despite their potential to reach large numbers of people, these approaches have not been shown to change violent behaviour, although they may raise issues and influence attitudes. They are most likely to be useful as part of multi-component interventions that include elements with robust design and implementation (see Jewkes et al., 2020).

4.2 Study settings

In total, we identified 104 studies, of which 96 were RCTs or quasi-experimental evaluations. Among the 104 studies, 69% were from LMICs and 31% from HICs. 41% were from sub-Saharan Africa. However, they were primarily from South Africa (13% of the total number), and Uganda (8% of the total number). There were also a large percentage (29%) from North America.

Even among studies conducted in LMICs there was considerable geographical imbalance. Most evaluations were undertaken in Africa (41%), and there were only 20 evaluations from Central, South and East Asia, nine from Latin America and the Caribbean and only one from the Middle East (although this may have also been because our searches were in English). *What Works* has undertaken five evaluations within Central and South Asia, and has significantly increased the limited evidence base in this setting. The focus on RCTs and quasi-experimental studies may convey a misleading impression of the amount of research undertaken in Africa, as many of the African studies were quasi-experimental and generally of a lower standard than the RCTs in other settings.

4.3 Gaps in effective programming amongst marginalised groups

There remains a lack of effective and well-evaluated interventions to prevent VAWG among several marginalised groups, specifically, adolescent girls in out-of-school-settings, conflict-affected populations, women and girls living with disabilities, and LGBTQI+ persons – all populations that experience disproportionately high rates of violence.

In total, there were 42 evaluations of interventions primarily focused on adolescent girls. However, the vast majority of these are interventions that target adolescent girls in schools or college settings. There were almost no evaluations looking at interventions outside of education settings, which is often where they are more vulnerable to VAWG.

There were only ten evaluations of interventions among conflict-affected populations. Women and girls living in conflict-affected settings experience high rates of multiple forms of VAWG, including non-partner sexual violence and IPV; these high rates of violence can be sustained long after the end of formal hostilities (Hossain, Zimmerman & Watts, 2014; Jewkes et al., 2017). There is limited evidence on which interventions are effective to prevent VAWG in this population (Murphy et al., 2019). It is unclear whether the lack

of effective interventions is because conflict-affected populations, who have high rates of trauma, poor mental health and poverty, require different, or more intensive, interventions and support than other populations, or whether the challenges of implementation in these populations (for similar reasons) underpin the lack of effect of interventions. Understanding how to translate successful approaches in non-conflict-affected populations to these populations is a critical next step in intervention work.

We identified no interventions specifically working to reduce violence among women and girls living with disabilities. Women and girls living with disabilities face increased levels of all forms of violence, and from a broad range of perpetrators, compared with women and girls without disabilities. Understanding how interventions include women with disabilities, their barriers to participation, and how to tailor and adapt interventions to ensure they are disability specific, is a critical set of next steps. We did not examine the literature on VAWG prevention among LGBTQI+ persons, and acknowledge the heterosexual bias of this review.

4.4 Overall gaps and limitations in the body of evidence

4.4.1 METHODOLOGICAL CHALLENGES

There were significant methodological challenges within published studies, even in RCTs, including small sample sizes, different ways of measuring VAWG, particularly IPV, different follow-up periods, and weaknesses in reporting results, which all created challenges in comparison of studies. The quasi-experimental studies ranged from very rigorously designed, to evaluations which appeared to have evolved haphazardly. In addition, the lack of qualitative reporting on intervention implementation and process evaluations, also made interpretation challenging. Studies, particularly cluster RCTs were often underpowered to show meaningful effects; SASA!, (Abramsky et al., 2014), for example, showed large reductions in IPV experienced by women, but because of the small number of clusters (8), reductions were not statistically significant, which led to challenges in interpreting this evidence.

Studies also had multiple ways of measuring VAWG, particularly physical and sexual IPV. In some studies, one question was used to assess whether a woman

Photo: Peter Caton

had experienced IPV. Single-question measures of IPV often fail to capture the true prevalence of IPV in populations, and lead to potential measurement errors driving significant intervention findings. A lack of standardised measures of IPV also limits comparability of intervention outcomes. *What Works* has sought to establish a standardised set of IPV measures, based on the WHO's Domestic Violence study scales (WHO, 2005) as adapted for the research with men in the UN multi-country study on Men and Violence in Asia and the Pacific (Fulu et al, 2013), to enable comparability across studies. The *What Works* IPV measure includes five physical and three sexual items, which are all behaviourally specific, with the outcomes coded consistently across the *What Works* body of studies, enabling some comparability.

Finally, studies had multiple different follow-up periods. With follow-ups that range from one, three or six months post-intervention, there is a risk that short-term effects are observed (these often attenuate over time with changes that may be driven by social desirability bias) rather than actual behaviour change. Studies with longer follow-up periods of 12 or 24 months reduce the chances of social desirability bias and provide a better assessment of actual behaviour change.

The primary focus of evaluated interventions was on the prevention of physical and/or sexual IPV, or non-partner rape. However, fewer studies reported on other forms of IPV, such as emotional and economic IPV, despite emerging evidence that these are independently associated with poor health outcomes. In addition, few studies focused on the intervention's impacts on non-partner sexual violence, apart from interventions working with female sex workers, and self-defence interventions. Women experience multiple forms of violence and sexual harassment, and expansion in measuring these and determining whether interventions work to reduce these is critical.

The approach to data analysis also varied considerably. Here, some of the studies did not use conventional best practice. For example, some used individual level analysis for cluster RCTs with very few clusters, or analyses that did not adjust for key baseline covariates, including the outcome variable. Some of the studies reported very large numbers of associations, without prior planning, and any adjustment of their p-values for reporting. Some of the studies did not provide full details of report findings, effect sizes and a measure of confidence. This made interpretation of findings very challenging across the different studies.

4.4.2. INTERVENTION HETEROGENEITY

A major challenge in the evidence review was that within intervention categories there was often great heterogeneity of what the interventions delivered, making comparison and synthesis challenging. For instance, within the couples' intervention category, studies included the *What Works* trial, **Indashyikirwa**, an intensive intervention, with 21 three-hour sessions, drawing on a previous promising IPV-prevention curriculum, with substantive piloting and close supervision and training of facilitators, layered over a VSLA programme. This intervention showed significant reductions in IPV perpetration and experience. In contrast, the **Partner Project,** which had four sessions of 90 to 120 minutes each, with content including HIV-related issues as well as gender and relationship material, showed no effect. While these interventions both use couples as a modality to address VAWG, their comparability is very limited. Similar challenges were seen in all sections of the review. Given the growing knowledge about what makes effective programming (Jewkes et al., 2020), there is a need to interpret some of the conclusions cautiously.

Photo: Actionworks Nepal

SECTION 5

Recommendations for violence prevention and the global research agenda

Based on this global evidence review on VAWG prevention, recommendations for funding, programming and research are as follows:

FOR DONORS:

1. INCREASE INVESTMENT IN EVIDENCE-BASED PREVENTION PROGRAMMING AND EVALUATION

Priorities include:

- Evidence-based interventions in new or challenging settings, populations, or a combination of both, that reflect best-practice in violence prevention programming (see Box 1) and evaluations thereof.
- Adaptation and careful scale-up up and evaluation of interventions that were effective within trial evaluations, to evaluate their impact at scale, in the original setting or in new contexts.
- Evaluations of intervention approaches that show promise in preventing VAWG, but where evidence is insufficient (i.e. where there are only one or two evaluations in low- to middle-income countries), to better understand whether these approaches are effective at preventing VAWG in multiple settings and how they could most effectively be used.
- Evaluations of well-designed and well-implemented interventions for vulnerable populations, including, but not limited to adolescent girls in out-of-school-settings, conflict-affected populations, women and girls living with disabilities, female sex workers and LGBTQI+ persons.
- Interventions in different social and cultural contexts, be this conflict-affected populations, facing particular challenges and needs, or global regions where evidence is limited, such as Asia, the Middle East, and North Africa.
- Expanded investment in VAWG response services, which are a critical element of effective prevention.

2. STOP FUNDING APPROACHES PROVEN NOT TO WORK TO PREVENT VAWG

- Some intervention domains and approaches to intervention design and implementation do not work as standalone approaches to the prevention of VAWG. VAWG-prevention resources should not be used to fund standalone awareness-raising campaigns, brief bystander interventions, brief counselling and safety planning for pregnant women or standalone microfinance, savings and livelihoods interventions, as the evidence base shows that they are ineffective in preventing VAWG. They may be considered, however, as part of multi-component approaches.

FOR PRACTITIONERS:

3. ADAPT AND SCALE UP EFFECTIVE PROGRAMMES TO DIFFERENT POPULATIONS AND CONTEXTS

- Support the adaptation of programmes shown to be effective in one context in new populations and contexts, and assess their impact when adapted and taken to scale through high quality programme monitoring and evaluation.

  It is also important to support the documentation of adaptation processes to learn how effective adaptation and scale-up occurs. VAWG-prevention practitioners and researchers are still learning about different approaches to scale-up, and this work needs to be undertaken iteratively and carefully evaluated. This should not be to the exclusion of robustly evaluating new, locally developed prevention models that are promising but have not yet been evaluated.

4. INNOVATE

- Some approaches have a limited evidence base and require further investigation, for example, digital interventions and workplace-based interventions for VAWG prevention. These areas need further innovation, building on evidence of best practice in intervention design (see Box 1), and rigorous formative and operational research.

FOR RESEARCHERS:

5. INCREASE THE RIGOUR OF RESEARCH METHODS

- *What Works* has shown the value of using a standardised set of outcome indicators, with multiple questions on violence and robust research methods, particularly with 18- to 24-month follow-ups, in establishing medium- to long-term impact and reducing concerns about social desirability bias in reporting.

6. REPORT EVALUATION STUDIES USING STANDARDISED APPROACHES

- Consistent and comparable reporting on trials, using standardised approaches, enables comparisons by other researchers, policy makers, activists and development workers. Using the Consolidated Standards of Reporting Trials (CONSORT) guidelines provides a robust approach to providing the information needed for interpretation and repeatability of studies.

7. MEASURE IMPACT ON MULTIPLE FORMS OF VAWG

- The evidence base needs to expand outwards to understand not only what works to prevent physical and/or sexual IPV but also to measure impact on multiple forms of VAWG (i.e., psychological/emotional and economic IPV, sexual harassment, and non-partner sexual violence).

8. MEASURE THE EFFECTIVENESS OF INTERVENTIONS AMONG WOMEN FACING MULTIPLE FORMS OF DISCRIMINATION

- The evidence base on effective interventions for women and girls who face multiple and intersecting forms of discrimination (e.g., based on disability, age, sexuality, gender identity and ethnicity), is almost non-existent. Collecting this data and disaggregating intervention effects along these lines is critical to understand whether interventions are as effective for the most excluded groups and help strengthen inclusive VAWG prevention efforts in the future.

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WORKING WITH MEN AND BOYS

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DISCUSSION AND RECOMMENDATIONS

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Recommendations for violence prevention and the global research agenda

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Annex B: Detailed summary table of studies in each section of the review

Intervention focus	Total individual studies included in the review	RCTs (and quasi-experimental studies) with positive VAWG impact	RCTs (and quasi-experimental studies) promising impact on VAWG	RCTs (and quasi-experimental studies) with no VAWG impact	What Works studies with this type of intervention as a primary intervention type + if Pre-Post Study
3.1 Economic interventions					
3.1.1 Economic transfers	13 (1 WW)	7 (Pettifor et al, 2018; Hidrobo et al, 2016; Roy et al, 2018; Haushofer and Shapiro, 2016; Perova, 2010; Bobonis et al, 2013; Camacho and Rodriquez, n.d)	2 (Angelucci, 2008; Heath et al., 2018)	3 (Roy et al, 2018; Bobonis and Castro, 2010; Hidrobo and Fernald, 2013)	1 Cash Transfer study (Syria) – 1 Pre-Post (Falb et al., 2019) No VAWG Impact
3.1.2 Microfinance, savings or livelihoods Interventions	3	0	0	3 (Green et al, 2015; Glass et al, 2017; Ismayilova et al., 2018)	
3.1.3 Combined economic and social empowerment interventions	18 (5 WW)	5 (Proynk et al., 2006; Bandiera et al., 2018; Austrian et al, 2018; Sarnquist et al., 2018; Kapiga et al., 2019)	4 (Gupta et al., 2013; Dunbar et al., 2014;; Gibbs et al., 2019a; Gibbs et al., 2019b)	7 (Austrian & Muthengi, 2013; Green et al., 2015; Austrian et al., 2018; Ismayilova et al., 2018; Aguero and Frisancho, 2018: Iyengar and Ferrari, 2011; Naved et al., 2019)	5 Stepping Stones + Creating Futures (South Africa); Sammanit Jeevan (Nepal); Zindajil Shoista (Tajikistan); Women for Women International (Afghanistan); HERRespect (Bangladesh) 2 Pre-Post (Mastonshoeva et al., 2019) Positive; (Shai et al., 2019) Promising
3.2 Relationship and family level					
3.2.1 Couples interventions	10 (4 WW)	6 (Jones et al, 2013; Minnis et al., 2015; Feinberg, 2016; Doyle et al., 2018; Dunkle et al., 2019; Murray et al., 2019)	1 (Raj et al, 2016)	3 (Jones et al, 2014; Clark et al., 2019; Javalkar et al., 2019);	4 Indashyikirwa (Rwanda); Change Starts at Home (Nepal); CETA/ VATU (Zambia); Samvedana Plus (India)
3.2.2 Parenting programmes to prevent IPV + child maltreatment	3	2 (Doyle et al., 2018; Feinberg, 2016)	1 (Ashburn et al., 2017)	0	
3.3. Community level Interventions					
3.3.1 Social marketing campaigns and edutainment	1 (Mennicke et al., 2018)	0	0	0	
3.3.2 Digital technology for decision-support and behaviour change	0	0	0	0	
3.3.3 Community activism to shift harmful gender attitudes, roles and social norms that tolerate violence against women	9 (5 WW)	3 (Wagman et al, 2015; Abramsky et al, 2014; Ogum-Alangea, D et al 2019)	0	5 (Pettifor et al, 2018; Hughes, 2012; Christofides et al, 2019; Clark et al., 2019; Chatterji et al, 2019)	5 CHANGE (South Africa); COMBAT RRS (Ghana); Transforming Masculinities (DRC); Indashyikirwa (Rwanda); Change Starts At Home (Nepal); 1 Pre-Post (Le Roux et al., 2019) – Positive

* All 114 studies, including the ten that feature in more than one section

Africa	Central and South Asia	Adolescent	Conflict / Humanitarian	Disability	Evidence (Good / Insufficient)	Effectiveness (Effective, Promising/ Conflicting, No effect/ Harmful)
3	1	1 (Pettifor et al, 2018)	2 (Falb et al, 2019; Hidrobo et al, 2016)	0	GOOD	EFFECTIVE
3	0	0	2 (Green et al, 2015; Glass et al, 2017)	0	GOOD	NO EFFECT
13	3	5 (Dunbar et al., 2014;Bandiera et al., 2018; Austrian, Soler-Hampejsek, Maluccio, Mumah, & Abuya, 2018; Austrian & Muthengi, 2013; Austrian et al., 2018)	3 (Gupta et al, 2013; Green et al, 2015, Gibbs et al, 2019)	0	GOOD INSUFFICIENT EVIDENCE	EFFECTIVE (for economic and social empowerment programmes targeting women) PROMISING (for economic and social empowerment programmes targeting men)
6	3	0	0	0	GOOD	EFFECTIVE
2	0	1 (Ashburn et al., 2017)	0	0	GOOD	EFFECTIVE
0	0	1 (Mennicke et al., 2018)	0	0	INSUFFICIENT	NO EFFECT
0	0	0	0	0	INSUFFICIENT	NO EFFECT
7	2	0	1 (Le Roux et al., 2019)	0	GOOD	EFFECTIVE

Intervention focus	Total individual studies included in the review	RCTs (and quasi-experimental studies) with positive VAWG impact	RCTs (and quasi-experimental studies) promising impact on VAWG	RCTs (and quasi-experimental studies) with no VAWG impact	What Works studies with this type of intervention as a primary intervention type + if Pre-Post Study
3.4 School-based interventions					
3.4.1 School-based interventions to prevent dating or sexual violence	13	5 (Wolfe et al., 2009; Mathews et al., 2016; Jewkes et al., 2008; Coker et al., 2017; Coker et al., 2016)	2 (Sosa-Rubi et al, 2017; Taylor et al, 2015)	6 (Miller et al., 2015; Foshee et al., 2004; Jaycox et al., 2006; Taylor et al., 2010; Espelage et al., 2013; Connolly et al., 2015)	
3.4.2 School-based interventions to prevent peer violence with a gender component	6 (2 WW)	2 (Devries et al., 2015); Karmaliani et al., 2019)	0	3 (GEMS in India, Bangladesh + Vietnam (Achyut et al., 2017)	2 Play Based, Life-Skills Programme (Pakistan), Peace Education (HTAC) 1 Pre-Post (Corboz et al., 2019) - Positive
3.5 Self-defence interventions					
	8 (1 WW)	3 (Senn et al 2015/2017; Decker et al, 2018; Hollander, 2014)	3 (Orchowski et al., 2008; and Gidcyz et al, 2001 on sub-group; Senn et al., 2011)	2 (Gidycz et al, 2006; Baiocchi et al, *forthcoming*)	1 IMPower (Ujamaa) (Kenya)
3.6 Interventions in antenatal and post-natal setting					
	8	2 (Mejdoubi et al 2013; Kiely et al., 2010);	2 (Tiwari et al., 2005; Olds et al., 2004)	4 (McFarlene et al., 2006; 2010; Sharps et al., 2017; Bair-Merritt et al, 2010;)	
3.7 Working with men and boys only					
	7	1 (Miller et al., 2013)	4 (Hossain et al., 2014; Pulerwitz et al., 2015; Verma et al., 2008; Kalichman et al., 2009)	2 (Miller et al., 2014; Elias-Lambert and Black, 2016)	
3.8 Interventions that work with individuals and/or couples to reduce their alcohol and substance abuse					
	9 (1 WW)	6 (Gilmore et al, 2015; Minnis et al., 2015; Clinton et al, 2011; Testa et al, 2010; Wechsburg et al., 2011, Murray et al., 2019)	1 (Saggurti et al., 2014)	2 (Chermack et al., 2017; Wechsberg et al., 2013)	1 Common Elements Treatment Approach (CETA) (Zambia)
3.9 Interventions with female sex workers					
	6 (1 WW)	4 (L'Engle et al., 2014; Wechsberg et al., 2011; Beattie et al., 2015; Reza-Paul et al., 2012)	0	2 (Tsai et al., 2016; Javalkar et al., 2019)	1 Samvedana Plus (India)
TOTAL					
114 studies of which 10 studies appear in more than one category.* 104 separate studies (20 WW of which four are counted in two categories.** 16 separate WW interventions)		52 (47 separate studies)	19 (19 separate studies)	43 (38 separate studies)	20 studies of 16 interventions
12 Evidence Reviews:	Arango et al., 2014; Ellsberg et al., 2015; Ellsberg et al., 2018; Buller et al., 2018; Gibbs et al., 2017; Karakurt et al , 2016; Lester, Lawren				

* These are Green et al, 2015; Ismayilova et al., 2018; Roy et al., 2018; Pettifor et al., 2018; Clark et al., 2019; Doyle et al., 2018; Feinberg, 2016; Minnis et al., 2015; Murray et al., 2019; Javalkar et al., 2019

** These are Samvedana Plus (Javalkar et al., 2019); Indashyikirwa (Dunkle et al., 2019; and Chatterji, 2019); Change Starts at Home (Clark et al., 2019); and, CETA/ VATU (Murray et al., 2019)

	Africa	Central and South Asia	Adolescent	Conflict / Humanitarian	Disability	Evidence (Good / Insufficient)	Effectiveness (Effective, Promising/ Conflicting, No effect/ Harmful)
	2	0	13 (All)	0	0	GOOD	EFFECTIVE
	1	5	6 (All)	1	0	GOOD	EFFECTIVE
	2	0	8 (All)	0	0	GOOD	PROMISING (for women at college) CONFLICTING (for girls at primary and secondary schools)
	0	0	0	0	0	INSUFFICIENT GOOD	PROMISING (for CBT based interventions with pregnant women) CONFLICTING (for Home visitation programmes in the ante-natal and post-natal period to prevent IPV NO EFFECT (for Brief counselling and safety planning for pregnant women)
	3	2	4 (Pulerwitz et al., 2015; Verma et al., 2008; Miller et al., 2013; Miller et al., 2014)	1 (Hossain et al., 2014)	0	GOOD	CONFLICTING (for working with men and boys alone) NO EFFECT (Brief bystander interventions)
	3	1	3	0	0	GOOD	EFFECTIVE
	2	4	0	0	0	GOOD (on client, police or others violence) INSUFFICIENT (on non-client partner violence)	EFFECTIVE (on client, police or others violence) NO EFFECT (on non-client partner violence)
	49	23	42	10	0		

ce, & Ward, 2017; Parkes et al., 2016; Van Parys et al., 2014; Jewkes et al., 2015; Kettery and Marx, 2019; Katz and Moore, 2013

Annex C: Search Terms[36]

VAWG terms	AND	Evaluation terms	AND	Themes
violence abuse harass* "intimate partner violence" "violence against women" VAW* GBV assault "gender-based violence" "IPV" "domestic violence" Rape "sexual assault" "sexual coercion" "child abuse" "child maltreatment" "child sexual abuse"		evaluation prevention intervention review "impact assessment" "randomised controlled trial" "impact evaluation" effectiveness quasi-experimental qualitative Randomised and Randomized Comprehensive review Systematic review		**Economic interventions:** economic "cash transfer" microfinance "skills development" "job creation" "income generating" "social protection" "saving and loans" VLSA livelihood workplace factory training
				Relationship and family-level interventions "relationship skills" couples parenting family
				Awareness raising and changing social norms: Communications social norm* change radio digital online app mass media advocacy edutainment "community mobilisation/mobilization" gender + norm* "group education" drama
				Self defence: "self-defence"/"self-defense" risk reduction
				Prevention in schools: school "whole school" curriculum "girls' education" "community outreach" "life skills"
				Working with men and boys: boys/men and boys masculinities and masculinity bystander Alcohol: alcohol drugs substance
				Female sex workers: Sex worker/sex work prostitution
				Other: mentoring "rights training" "SRH training" "girls' clubs" "women's groups"/collectivisation gender* multi-component youth programmes

Annex D: Interventions

Reference	Intervention	Country	Region	VAWG Impact	Section	Adolescent	Conflict
Abramsky et al., 2014	SASA! – community mobilisation	Uganda	SSA	Positive	Community activism		
Achyut et al., 2017	GEMS	India, Bangladesh, Vietnam	South Asia	No impact	Schools – peer violence	Adolescent	
Agüero and Frisancho, 2018	Peruvian adaptation of IMAGE	Peru	LAC	No impact	Economic- and social-empowerment interventions		
Angelucci, 2008	Opportunidaes – women receive transfer	Mexico	LAC	Promising	Economic transfer		
Ashburn et al., 2017	REAL Fathers	Uganda	SSA	Positive	Parenting	Adolescent	
Austrian and Muthengi, 2013	Safe and Smart Savings Products for Vulnerable Adolescent Girls (SSSPVAG) combining savings, financial education and safe spaces for adolescent girls	Uganda and Kenya	SSA	Positive	Economic- and social-empowerment interventions	Adolescent	
Austrian et al., 2018	Adolescent Girls Empowerment Program combining safe spaces, health vouchers, and savings	Uganda and Kenya	SSA	No impact	Economic- and social-empowerment interventions	Adolescent	
Austrian, Soler-Hampejsek, Maluccio, Mumah, and Abuya, 2018	Adolescent Girls Initiative combining schooling, cash transfers, violence prevention at community level, group discussions for adolescents	Kenya	SSA	Positive	Economic- and social-empowerment interventions	Adolescent	
Baiocchi et al., *forthcoming*; Decker et al., 2018	Interactive empowerment self-defence training (IMPower) + SoS for boys	Kenya and Malawi	SSA	No impact	Self-defence	Adolescent	
Bair-Merritt et al., 2010	Healthy Starts home-visitation	Hawaii/ USA	North America	Positive	Antenatal and postnatal		
Bandiera et al., 2018	Multi-faceted women's empowerment combining microfinance, vocational training and life skills for adolescent girls	Uganda	SSA	Positive	Economic- and social-empowerment interventions	Adolescent	
Beattie et al., 2015; Reza-Paul et al., 2012	AVAHAN community collectivisation	India	South Asia	Positive	Female sex workers		
Bobonis and Castro, 2010; Bobonis, Gonzales-Brenes and Castro, 2013	Opportunidaes	Mexico	LAC	No impact	Economic transfer		
Camacho and Rodriquez, n.d.	Familias en Acción conditional cash transfer	Columbia	LAC	Positive	Economic transfer		
Chatterji et al., 2019	Indashyikirwa community-mobilisation component	Rwanda	SSA	No impact	Community activism		

Reference	Intervention	Country	Region	VAWG Impact	Section	Adolescent	Conflict
Chermack et al., 2017	Motivational interviewing session plus five therapy sessions for men and women in treatment for substance-use disorders	US	North America	No impact	Alcohol		
Christofides et al., 2019; Pettifor et al., 2018	CHANGE and community mobilisation both based on the One Man Can campaign	South Africa	SSA	No impact	Community activism		
Clark et al., 2019	Change Starts at Home – couples	Nepal	South Asia	No impact	Couples		
Clark et al., 2019	Change Starts at Home - Community	Nepal	South Asia	No impact	Community activism		
Clinton-Sherrod et al., 2011	Brief intervention on alcohol-related sexual victimisation experiences among college women	US	North America	Positive	Alcohol	Adolescent	
Coker et al., 2016; Coker et al., 2017	Green Dot bystander training in high schools and colleges	US	North America	Positive	Schools –dating	Adolescent	
Connolly et al., 2015	Two-session programme for middle-school	Canada	North America	No impact	Schools –dating	Adolescent	
Corboz et al., 2019	Peace Education	Afghanistan	Central Asia	Positive	Schools – peer violence	Adolescent	Conflict
Devries et al., 2015	Good School Toolkit	Uganda	SSA	Positive	Schools – peer violence	Adolescent	
Doyle et al., 2018	Bandebereho – participatory, small group sessions of critical reflection and dialogue with expectant/current fathers and their female partners	Rwanda	SSA	Positive	Parenting and couples		
Dunbar et al., 2014	SHAZ! – combining vocational training and life-skills for adolescent girls	Zimbabwe	SSA	Promising	Economic- and social-empowerment interventions	Adolescent	
Dunkle et al., 2019	Indashyikirwa couples	Rwanda	SSA	Positive	Couples		
Elias-Lambert and Black, 2016	Bringing in the Bystander	US	North America	No impact	Men and Boys		
Espelage et al., 2013	15-lesson Second Step curriculum	US	North America	No impact	Schools – dating	Adolescent	
Falb et al., 2019	Cash Transfer	Syria	Middle East	No impact	Economic transfer		Conflict
Feinberg, 2016	Couple-focused intervention at transition to parenthood	US	North America	Positive	Couples and parenting		
Foshee et al., 2004	Safe Dates – 10-week curriculum with poster contest and play	US	North America	No impact	Schools – dating	Adolescent	
Gibbs et al., 2019a	Livelihoods training and gender-transformative intervention with young people – men: self-reported perpetration only	South Africa	SSA	Promising	Economic- and social-empowerment interventions		
Gibbs et al., 2019b	Women for Women International evaluating a one-year economic and social empowerment intervention for women	Afghanistan	Central Asia	Promising	Economic- and social-empowerment interventions		Conflict
Gidcyz et al., 2001; Gidcyz et al., 2006; Orchowski et al., 2008	Ohio University Sexual Assault Risk Reduction Programme	US	North America	Promising	Self-defence	Adolescent	

Reference	Intervention	Country	Region	VAWG Impact	Section	Adolescent	Conflict
Gilmore, Lewis and George, 2015	Web-based programme for college women age 18-20 engaged in heavy episodic drinking	US	North America	Positive	Alcohol	Adolescent	
Glass, Perrin, Kohli, Campbell, and Remy, 2017	Pigs for Peace – a livestock productive asset-transfer programme	DRC	SSA	No impact	Microfinance, savings or livelihood only		Conflict
Green et al., 2015	Wings Plus, a microenterprise and short gender discussion	Uganda	SSA	No impact	Economic- and social-empowerment interventions		
Green, Blattman, Jamison, and Annan, 2015	business and microloans intervention	Uganda	SSA	No impact	Microfinance, savings or livelihood only		Conflict
Gupta et al., 2013	Reduction of Gender-Based Violence Against Women combining gender dialogue and savings group	Ivory Coast	SSA	Promising	Economic- and social-empowerment interventions		Conflict
Haushofer and Shapiro, 2016	Give Directly, a cash transfer	Kenya	SSA	Positive	Economic transfer		
Heath et al., 2018	Jigisémèjiri, for polygamous households	Mali	SSA	Promising	Economic transfer		
Hidrobo and Fernald, 2013/15	Cash transfer	Ecuador	LAC	No impact	Economic Transfer		
Hidrobo, Peterman and Heise, 2016	World Food Programme – cash, voucher and food transfer and nutrition discussion in northern Ecuador for conflict-affected refugees	Ecuador	LAC	Positive	Economic Transfer		Conflict
Hollander, 2014	University self-defence classes	US	North America	Positive	Self-defence	Adolescent	
Hossain et al., 2014	Men's discussion groups	Cote D'Ivoire	SSA	Promising	Men and Boys		
Hughes, 2012	We Can Campaign	Bangladesh	South Asia	No impact	Community Activism		
Ismayilova et al., 2018	Trickle-Up, a comprehensive livelihoods intervention for women	Burkina Faso	SSA	No impact	Microfinance, savings or livelihood only		
Ismayilova et al., 2018	Trickle-Up Plus: combining economic strengthening and family coaching	Burkina Faso	SSA	No impact	Economic- and social-empowerment interventions		
Iyengar and Ferrari, 2011	VSLA and couples' discussion	Burundi	SSA	No impact	Economic- and social-empowerment interventions		
Javalkar et al., 2019	Samvedana Plus: engaging sex workers and their intimate partners	India	South Asia	No impact	Couples and female sex workers		
Jaycox et al., 2006	Three-lesson curriculum on domestic violence and the law	US	North America	No impact	Schools –dating	Adolescent	
Jewkes et al., 2008	South African adaptation of Stepping Stones	South Africa	SSA	Positive	Schools –dating	Adolescent	
Jones et al., 2013	The Partner Project and Partner Plus couples-based intervention on prevention of mother-to-child transmission of HIV	South Africa	SSA	Positive and No Impact	Couples		
Kalichman et al., 2009	An integrated HIV/GBV intervention ('Phaphama Men')	South Africa	SSA	Promising	Men and boys		

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Kapiga et al., 2019	Maisha a microfinance and gender transformative intervention for women	Tanzania	SSA	Positive	Economic- and social-empowerment interventions		
Karmaliani et al., 2019	Play based, life skills programme	Pakistan	South Asia	Positive	Schools – peer violence	Adolescent	
Kiely et al., 2010	Combined CBT and advocacy for NIH-DC intervention	US	North America	Positive	Antenatal and postnatal		
L'Engle et al., 2014	A brief intervention to reduce alcohol use among female sex workers in Mombasa, Kenya	Kenya	SSA	Positive	Female sex workers		
Le Roux et al., 2019	Transforming Masculinities	DRC	SSA	Positive	Community activism		Conflict
Mastonshoeva et al., 2019	Zindagii Shoista – combining group discussions and micro-grants within households	Tajikistan	Central Asia	Positive	Economic- and social-empowerment interventions		
Mathews et al., 2016	PREPARE – multi-component, after-school HIV-prevention intervention	South Africa	SSA	Positive	Schools – dating	Adolescent	
McFarlene et al., 2006; McFarlene et al., 2010	Brief counselling intervention	US	North America	No impact	Antenatal and postnatal		
Mejdoubi et al., 2013	VoorZorg, a long home-visitation programme by nurses	Netherlands	Europe	Positive	Antenatal and postnatal		
Mennicke et al., 2018	Social marketing campaign in colleges	US	North America	Positive	Social marketing	Adolescent	
Miller et al., 2013	Coaching Boys into Men programme for high-school athletes	US	North America	Positive	Men and boys	Adolescent	
Miller et al., 2014	Parivartan – a form of Coaching Boys into Men – adapted for cricket teams in urban middle-schools	India	South Asia	No impact	Men and boys	Adolescent	
Miller et al., 2015	Start Strong - healthy teen relationships initiative for middle school students	US	North America	No impact	Schools – dating	Adolescent	
Murray et al., 2019	CETA/ VATU	Zambia	SSA	Positive	Alcohol		
Naved et al., 2019	HERrespect: group-based sessions with workers and managers in garment factories	Bangladesh	SSA	No impact	Economic- and social-empowerment interventions		
Ogum-Alangea, D et al., 2019	COMBAT RRS	Ghana	SSA	Positive	Community activism		
Olds et al., 2004	Home visitation by nurses	US	North America	Positive	Antenatal and postnatal		
Perova, 2010	Juntos, a conditional cash transfer	Peru	LAC	Positive	Economic transfer		
Pettifor et al., 2018	HPTN068, a conditional cash transfer for schooling	South Africa	SSA	Positive	Economic transfer	Adolescent	
Proynk et al., 2006	IMAGE combining microfinance and gender training for women	South Africa	SSA	Positive	Economic- and social-empowerment interventions		
Pulerwitz et al., 2015	Interactive group education and community mobilisation and engagement activities ('Ethiopian male norms initiative') with young men	Ethiopia	SSA	Promising	Men and boys	Adolescent	

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Raj et al., 2016	CHARM – a gender-equity and family-planning intervention for young married men and couples age 18-30	India	South Asia	Promising	Couples		
Roy et al., 2018	Transfer Modality Research Initiative, a cash transfer and nutrition discussion	Bangladesh	South Asia	Positive	Economic transfer		
Roy et al., 2018	Cash transfer only	Bangladesh	South Asia	No impact	Economic transfer		
Saggurti et al., 2014	Reducing HIV among Non-Infected Wives (RHANI) programme for married women whose husbands were heavy drinkers and/or perpetrated IPV	India	South Asia	Promising	Alcohol		
Sarnquist et al., 2018	Mashinani: micro-loans, business training and psycho-social support sessions	Kenya	SSA	Positive	Economic- and social-empowerment interventions		
Senn et al., 2015/2017; Senn et al., 2011	EAAA + AAA	Canada	North America	Positive	Self-defence	Adolescent	
Shai et al., 2019	Sammanit Jeevan in Nepal combining group discussions and micro-grants within households	Nepal	South Asia	Promising	Economic- and social-empowerment interventions		
Sharps et al., 2017	DOVE: home-visitation programmes by nurses	US	North America	Promising	Antenatal and postnatal		
Sosa-Rubi et al., 2017	Amor…pero del Bueno (True Love)	Mexico	LAC	Promising	Schools – dating	Adolescent	
Taylor et al., 2015	Shifting Boundaries: teen dating violence-prevention programme for middle-school students	US	North America	Promising	Schools – dating	Adolescent	
Taylor et al., 2010	Five-week curriculum with interactive classes and a five-week curriculum on justice and law	US	North America	No impact	Schools – dating	Adolescent	
Testa et al., 2010	Parent-Based Intervention (PBI) preventing college women's sexual victimisation	US	North America	Positive	Alcohol		
Tiwari et al., 2005	Empowerment counselling	Hong Kong	East Asia	Promising	Antenatal and postnatal		
Tsai et al., 2016	HIVSSR and microfinance with FSWs	Mongolia	East Asia	No impact	Female sex workers		
Verma et al., 2008	Group education sessions and a lifestyle social-marketing campaign ('Yaari Dosti') with young men age 15-29	India	South Asia	Promising	Men and boys	Adolescent	
Wagman et al., 2015	Safe Homes and Respect for Everyone [SHARE] Project	Uganda	SSA	Positive	Community activism		
Wechsberg et al., 2011	Women's Health Coop	South Africa	SSA	Positive	Female sex workers		
Wechsberg et al., 2013; Minnis et al., 2015	Couples Health CoOp [CHC]) and a gender-separate intervention (Men's Health CoOp/Women's Health CoOp [MHC/WHC]	South Africa	SSA	Positive	Alcohol and couples		
Wolfe et al., 2009	(Fourth R) with skills training for dating relationships	Canada	North America	Positive	Schools – dating	Adolescent	

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