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What works to prevent violence against women and girls evidence reviews

Paper 2:

Interventions to prevent violence against women and girls



WhatWorks
TO PREVENT VIOLENCE

Acronyms

ADHD	Attention Deficit Disorder
CSA	Child Sexual Abuse
DFID	UK Department for International Development
FSWs	Female Sex Workers
GBV	Gender-based Violence
HICs	High Income Countries
IPV	Intimate Partner Violence
LMIC	Low and Middle Income Countries
MASVAW	Men's Action for Stopping Violence Against Women
MSM	Men Who Have Sex with Men
ODD	Oppositional Defiant Disorder
RCT	Randomized Control Trial
STI	Sexually Transmitted Infection
TOC	Theory of Change
UN	United Nations
VAW	Violence Against Women
VAWG	Violence Against Women and Girls
VSLA	Village Savings and Loans Association
WHO	World Health Organization

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Acknowledgements

The authors would like to thank all members of the What Works Core Group who commented on drafts of this document. In particular, we would like to thank the peer reviewers who reviewed the paper and provided invaluable comments to improve it.

We acknowledge that the What Works programme and all related papers are funded by DFID however the views expressed do not necessarily reflect DFID's official policies.

1. Introduction

Violence against women and girls (VAWG) is one of the most widespread violations of human rights worldwide, affecting one-third of all women in their lifetime. It is the leading cause of death and disability of women of all ages and has many other health consequences. VAWG is a fundamental barrier to eradicating poverty and building peace.

To prevent VAWG, we need to address the underlying causes of the problem. Evidence shows that no single factor causes violence, nor is there a single pathway to perpetration. Violence emerges from the interplay of multiple interacting factors at different levels of the social 'ecology', as discussed below. These include genetic endowment, experiences of violence and abuse in childhood, relationship dynamics, household and community structures and social norms, the macro-level and global-level forces that shape prevailing norms, access to resources, gender roles and the relative power of men versus women. Interventions that have the potential to reduce rates of VAWG are, similarly, many and varied: they may target one or more risk factors and operate across single or multiple settings.

1.1 What Works global programme and evidence review

This paper is the second in a series of four evidence reviews that were produced by What Works to Prevent Violence against Women and Girls (What Works). What Works is a UK Department for International Development (DFID)-funded global programme that is investing an unprecedented £25 million over five years to assist with the prevention of VAWG. It supports primary prevention efforts across Africa, Asia, and the Middle East, which seek to understand and address the underlying causes of violence in order to stop it before it starts.

The papers were produced to assess the current state of research and the evidence base in order to inform the research agenda of the ensuing global program. The focus of What Works is to advance the field of primary prevention in particular, however this is understood to be closely aligned with response efforts. The papers therefore focus on prevention, although response mechanisms are also considered, particularly in Paper 3. The outline of the four papers is as follows:

Paper 1: State of the field of research on violence against women and girls

Paper 2: *Interventions to prevent violence against women and girls.*

Paper 3: Response mechanisms to prevent violence against women and girls.

Paper 4: Approaches to scale-up and assessing cost effectiveness of programmes to prevent violence against women and girls.

1.2 Scope and goals of the review

The purpose of the current paper is to examine the evidence base for the effectiveness of interventions to prevent VAWG. This rapid assessment, along with the other papers, is designed to:

- Inform the violence prevention research agenda and priorities for innovation; and
- Establish a baseline of the state of knowledge and evidence against which to assess the achievements of the What Works programme over the next five years.

1.3 Types of violence covered by the review

Violence against women and girls takes many different forms globally and is most likely to be perpetrated by someone known to the victim, such as a family member or intimate partner. Forms of VAWG are also distinguished according to the age or life stage during which it occurs, highlighting the specific risks and experiences of women and girls living under conditions of violence and insecurity (Solotaroff and Pande, 2014). Conceptualising the different forms that

VAWG can take is important for identifying the specific risks of violence faced by women and girls, the social norms and beliefs underpinning attitudes and practices surrounding violence, and for the informed design of preventative interventions and policies.

The What Works programme focuses on intimate partner violence (IPV), non-partner sexual violence, and child abuse; therefore this review, likewise, focuses on those types of violence, as defined in Table 1.

Table 1. Definitions of forms of VAWG addressed by existing studies

Child abuse or maltreatment	Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (WHO, 1999).
Child sexual abuse	Contacts or interactions between a child and an older or more knowledgeable child or adult ... when the child is being used as an object of gratification for an older child's or adult's sexual needs. These contacts or interactions are carried out against the child using force, trickery, bribes, threats or pressure (UNICEF, 2001).
Intimate partner violence	IPV refers to any behaviour in an intimate relationship that causes physical, sexual, or psychological harm, including aggression, sexual coercion, psychological abuse and controlling behaviour (WHO, 2005). An intimate partner or relationship is defined as a person with whom an individual has a close, personal relationship that may be characterized by emotional connectedness, regular contact or sexual behaviour, identification as a couple, and cohabitation. Intimate partners may include current or former spouses, boyfriends or girlfriends, dating partners, and ongoing sexual partners (Breiding et al., 2015).
Sexual violence - partner or non-partner	Any act in which one person uses force, coercion or psychological intimidation to force another to carry out a sexual act against his or her will or participate in unwanted sexual relations (WHO, 2004).

Source: *Table of forms of VAWG adapted from Solotaroff and Pande (2014).*

1.4 The social ecology model: Risk and protective factors

The dominant paradigm for understanding VAWG is the socio-ecological model, which posits that violence emerges from the interplay of multiple interacting factors at different levels of the social 'ecology' (Heise, 1998; Jewkes, Flood and Lang, 2014; Solotaroff and Pande, 2014). The social ecology model has been used to help illustrate the multiple risk and protective factors across individual, relationship, family, community, and societal levels. The model highlights the complex interplay of factors across and between these levels, and can therefore indicate key points for prevention and interventions (Heise, 1998). Significantly, this conceptualization of violence means that different combinations of factors interact to increase the likelihood of either perpetrating violence or being a victim. The social ecology model provides the framework for the examination of risk and protective factors contained within the What Works review papers. (For a full discussion of the model, please see Paper 1.)

1.5 Content and structure of report

In this paper, we examine interventions that specifically seek to reduce different types of VAWG as an outcome, and those that target key risk factors for violence perpetration and experiences. The paper does not present an exhaustive list of interventions, but focuses on the most common and promising intervention areas, grouped by entry point or platform.

We recognise that specific interventions do not necessarily fit neatly into pre-defined categories and that they may cut across multiple entry points and platforms. However, for the purposes of the report structure, the interventions are presented in four overlapping areas, based on: the socio-ecological model and the level at which the programme primarily tries to intervene or the level at which it is trying

to create change, i.e. working with and trying to change individuals, relationships, communities or institutions.

1. Interventions that primarily focus on intervening at the individual level:

- a. Economic empowerment interventions
- b. Social empowerment interventions for vulnerable groups
- c. Bystander interventions primarily engaging men and boys
- d. Interventions to tackle alcohol abuse, as key risk factors for VAWG

2. Interventions that primarily focus on intervening at the relationship or family level:

- a. Peer and relationship interventions
- b. Parenting interventions

3. Interventions that primarily focus on intervening at group or at community level:

- a. One-dimensional communication and advocacy campaigns
- b. Multi-component community mobilization campaigns
- c. Group education combined with community mobilization

4. Interventions that primarily focus on intervening at a structural or institutional level:

- a. Whole school and other holistic approaches
- b. School curriculum-based interventions (in combination with community outreach)
- c. Interventions to increase girls' school attendance (reduction in indirect costs; improvement of infrastructure)

The first half of the paper presents a summary of the evidence by broad intervention typology, including:

- A top line summary of: (i) types of evidence; and (ii) evidence of effectiveness of intervention;
- A description of the intervention type;
- A summary of the extent of the evidence found; and
- An assessment of what the evidence suggests as to the effectiveness of the intervention type in preventing VAWG.

We discuss the evidence with regard to impact on perpetration and experiences of violence, as well as on known risk factors for violence. The second half of the paper discusses the findings and presents: an overall summary of the strengths, gaps and limitations in the body of evidence; a synthesis of the overall findings; and a discussion of what this means for the prevention agenda. Finally, we present recommendations in terms of priorities for supporting innovation and conducting research.

An overall summary of this paper can be found at: www.whatworks.co.za

2. Methodology

2.1 Search process and inclusion criteria

We conducted a rapid review of the existing evidence on the impact of interventions that aim to prevent VAWG, or address key risk factors for such violence. The focus of the review was on IPV, non-partner sexual violence and child abuse.

This assessment has drawn extensively from existing systematic and comprehensive reviews. We conducted a keyword search in Google, Google Scholar and Pubmed. We also

searched for grey literature by visiting the websites of bilateral and multilateral donors, the United Nations (UN) and other international agencies, international Non-government Organization (NGOs), and research institutes. Our search strategy was reliant on published sources, but we also sent out emails to VAWG networks requesting any unpublished sources – although, this yielded only a few additional studies.

The review looked for evidence of direct impact (i.e. a reduction in VAWG), and if this was not available, it looked for evidence of impact on intermediate outcomes such as reduction in disempowerment and other relevant risk factors at individual, family, community or societal levels.

Our inclusion criteria consisted of the following:

- Completed reviews or individual studies (including RCTs, quasi-experimental studies, cohort evaluations, qualitative studies, pre-test and post-test designs, case studies, and opinions of respected experts);
- Studies focusing on interventions intended to prevent violence (primary prevention) or further violence (secondary prevention);
- Studies focusing on the effectiveness of interventions in either preventing/reducing further VAWG; and
- Studies from high-income, medium-income and low-income settings, and from development, humanitarian and conflict-affected contexts.

Overall, 244 individual studies were reviewed for this assessment, drawn in part from 24 systematic reviews and reviews of reviews. For details of all interventions and studies considered, please see Annex 2 (online link).

2.2 Assessment criteria

In order to provide a consistent rating of the evidence across the reviews, we adapted the evidence criteria from the Canadian Task Force on Preventative Health Care. We ensured that they were broad enough to ensure we covered different sectors and intervention types (i.e. not just health) and could capture: (i) types of

evidence; and (ii) evidence of effectiveness of intervention. These ratings are presented at the beginning of each section for that intervention type, and as defined in Table 2. Further, a detailed interpretation of the specific rating is discussed under each intervention type.

Table 2. Quality and classifications of evidence reviewed

QUALITY OF EVIDENCE ASSESSED	
I:	Evidence obtained from at least one properly randomized controlled trial (RCT).
II-1:	Evidence from well-designed controlled trials without randomization.
II-2:	Evidence from well-designed cohort (prospective or retrospective) or case-control.
II-3:	Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments could also be included in this category.
III:	Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

CLASSIFICATION OF RECOMMENDATIONS	
A.	There is good evidence to recommend the intervention for preventing VAWG.
B.	There is fair evidence to recommend the intervention for preventing VAWG.
C.	The existing evidence is conflicting and does not allow to make a recommendation for or against the intervention; however, other factors may influence decision-making.
D.	There is fair evidence to conclude that the intervention is not effective in preventing VAWG.
E.	There is good evidence to conclude that the intervention is not effective in preventing VAWG.
F.	There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

2.3 Limitations of the review

This rapid assessment of evidence is not designed to be a systematic review and is by no means all encompassing. There are a number of limitations to the review and the research evidence reviewed:

- This paper represents a summary and analysis of the evidence primarily from quantitative research published in peer-reviewed journals and organizational reports, which evaluate diverse interventions into VAWG from around the world. The evidence assessed here comes solely from those interventions and studies that were found in the processes of the review; it is therefore reliant upon the existence of published reviews and evaluations. We recognise that there may be many other promising interventions that are not included here as they have not yet been evaluated or had evaluations published.
- Many evaluations have not measured overall and sustained impact on the occurrence of VAWG.
- Where impact on the occurrence of VAWG is measured, it is important to note that measurement of short-term outcomes may over-estimate effect because to sustain impact over the long-term many interventions require effective systems beyond the control of the intervention.
- This review only includes a limited number of qualitative evaluations of interventions from NGOs and donor agencies, primarily because they are unpublished and difficult to access.
- The review is limited by the fact that we only drew upon literature published in English.
- Unfortunately, not all interventions relating to VAWG have been subjected to rigorous evaluation, and few studies effectively measure the impact on VAWG. We also

found that many of the evaluations were not rigorously designed: many lacked a specific and limited number of primary outcomes, a baseline, or rigorous data analysis. Substantive gaps in the evidence base, alongside a concentration of studies coming out of high income countries (HICs), have led to certain forms of violence and intervention types receiving more focus, for example bystander approaches coming out of the US, and microfinance programmes in developing countries. Moreover, a lack of long-term studies with large target groups can make it difficult to support generalizations on effectiveness and the drafting of recommendations. However, any limitations of the existing evidence base in no way suggests we should not act now. Limitations in the quality of the evaluations are discussed in detail in Section 4.

3. Review of evidence

The following table provides a summary of the interventions and evidence reviewed for this report.

Table 3. Summary of the number of interventions included in the review

Intervention focus	No. of interventions included in the review
3.1 Individual level	
3.1.1 Economic interventions	82
3.1.2 Social empowerment with vulnerable groups of women and girls	32
3.1.3 Bystander interventions	13
3.1.4 Addressing alcohol abuse	14
3.2 Relationship and family level	
3.2.1 Relationship-level interventions	3
3.2.2 Interventions with families: Parenting Interventions	28
3.3 Community level	
3.3.1 Communications and advocacy campaigns	4
3.3.2 Community mobilization and advocacy: Multi-component interventions	9
3.3.3 Group education (outside of school) combined with community mobilization	12
3.4 Institutional level	
3.4.1 Whole school and other holistic approaches	11
3.4.2 School curriculum-based interventions (in combination with community outreach)	29
3.4.3 Interventions to increase girls' school attendance (reduction in indirect costs; improvement of infrastructure)	7
Total	244

3.1 Individual-level interventions or those focused on individual level change

This section focuses on interventions that primarily target individuals or individual level change. Sometimes these intervention are implemented through groups, however they focus on changing the individual level risk factors for violence, such as alcohol abuse, and economic or social disempowerment.

3.1.1 Economic interventions

Types of evidence:	Evidence of effectiveness of intervention:
I. Evidence obtained from at least one properly randomised controlled trial.	B. There is fair evidence to recommend a combination of microfinance and gender transformative approaches, particularly amongst older women; however, there is less evidence for younger women, and limited evidence for economic approaches alone.

There is a substantial body of evidence that outlines the multiple ways in which poverty and a lack of economic autonomy for women intersects with and reinforces gender inequalities (Jewkes and Morrell, 2010). While not always directly increasing their risk for VAWG, it certainly places women in dependent relationships with men, who typically have higher social and economic power, making it more difficult for women to exit abusive and violent relationships (Hunter, 2010). Furthermore, the intersections of gender and poverty increase a range of risk factors that may play a role in increasing VAWG. Specifically: food insecurity has been linked to a range of HIV-risk behaviours (Weiser et al., 2007); while poverty has been linked to a reduction in condom use (Kamndaya et al., 2014) and women’s use of transactional sex as a way to access social and economic resources (Dunkle et al., 2004; Weiser et al., 2007).

Economic approaches targeting women and girls have been at the forefront of trying to address intersecting poverty and gender inequalities. While there has been increased focused on these approaches, there has also been recognition that: they focus on individual women; occur in contexts of widespread poverty; and do not transform economic systems (Kim and Watts, 2005).

While it is not always the primary goal of economic interventions, this section looks at the impact of economic interventions on VAWG prevention. The studies reviewed focused mainly on: microfinance or village savings and loans associations; increasing access to formal savings facilities, vocational or job training programs; and cash transfers targeted at women.

Description of the interventions:

Interventions to increase productive assets and build gender equality typically seek to: (i) build women's economic resources, particularly in terms of assets and income; and (ii) empower women or transform gender relationships in their lives through a variety of approaches. Combined, these approaches are seen to 'empower' women to resist male power and transform gender relationships. Older women, in general, receive either microfinance or Village Savings and Loans Association (VSLA) interventions. Younger women, primarily those out of school, tend to receive livelihood or vocational training; whilst young women tend to receive savings interventions.

Many interventions also include training regarding gender, communication skills, HIV and Gender-based Violence (GBV). A number of interventions include working with men through couples work, and a small number work with men as well as women as the main beneficiaries. A very small number include a community mobilization component, to change social norms related to gender at the community level, although the impact of this element on VAWG is generally poorly evaluated. Interventions vary significantly in length – the shortest is the Sisters for Life programme, which has ten one-hour sessions, delivered over a six-month period during the loan group meeting. The duration of these interventions is often based on the cycle of loans and savings, ranging from six months to two years of intervention.

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The dominant approaches to building economic resources found in the literature reviewed were:

- Microfinance or VSLA, which are group-based approaches to savings and lending to women normally excluded from formal banking/loan systems.
- Increasing access to formal savings facilities in the banking sector – often seen as a precursor to formal work/economic opportunities.
- Vocational or job training programmes that seek to build the skills and knowledge of participants to seek work more effectively, develop skills for informal sector work or develop alternative livelihood strategies.
- Cash transfers to women who care for children as a form of social protection. (There are many types of cash transfers, but they are not always targeted at women caring for children.)

Other types of economic empowerment interventions that could improve women and girls' economic standing include: approaches that use M4P and value chain development; trade and cross border work with women; formal employment and company codes; fair and ethical trade; and corporate social responsibility (CSR). These have not been looked at as part of our review, but for more information and case studies on these types of economic interventions, which could impact VAWG, see DFID's Guidance Note Part A (2015), Addressing Violence Against Women and Girls through DFID's Economic Development and Women's Economic Empowerment Programmes.

community level, although the impact of this element on VAWG is generally poorly evaluated. Interventions vary significantly in length – the shortest is the Sisters for Life programme, which has ten one-hour sessions, delivered over a six-month period during the loan group meeting. The duration of these interventions is often based on the cycle of loans and savings, ranging from six months to two years of intervention.

Other economic approaches that have been suggested as ways to reduce women's experience of VAWG or increase protective factors include transfers to women, including cash, vouchers and food transfers. They also include economic strengthening interventions alone, such as microfinance, as well as support to women who have microenterprises and who are providing not just financial services but also business support, training and access to markets. Cash transfers directed to carers may also have a long-term benefit for children targeted through these approaches.

Summary of evidence available:

The review found 75 individual and multi-country studies that included an economic component for the empowerment of women and girls. Ten studies were RCTs reporting VAWG as an impact. Of these: nine measured IPV in various forms (including sexual, physical and/or emotional); while one study (Bandiera et al., 2012) measured experiences of 'coerced sex', without a clear indication of whether the perpetrator was an intimate partner or not. An additional ten studies using non-randomized quantitative evaluations reported their impact on IPV. Others reported outcomes related to risk and protective factors, including: sexual debut, condom use at last sex, transactional sex, and measures of economic wellbeing.

There was a relatively limited evidence base on the particular forms of intervention that may be relevant for vulnerable groups of women

or girls in particular (for example, survivors of violence, MSM, women with disabilities or HIV/AIDS, female sex workers (FSWs), indigenous women or other minorities). Further, very few studies assessed the sustainability of intervention impacts; however, this has been done for two cash transfer studies, with the findings suggesting that the impacts were not sustained over longer timeframes.

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG – Economic-only interventions had very mixed results in terms of impact on perpetration or experiences of VAWG. While a number showed positive outcomes on IPV in a range of settings, others documented an intensification of IPV among women receiving transfers or women who were part of economic groups. These findings point towards the complex interaction between microfinance interventions and other social and economic factors, which may place women at risk of violence if they are not tackled directly. On the other hand, all four RCTs (that linked microfinance or other group-based approaches to economic strengthening and social empowerment interventions) showed a reduction in IPV amongst female participants, although the strength of these results varied. The IMAGE project, using women-only gender discussion groups and community mobilization approaches, showed a statistically significant 55 percent reduction in women's experience of physical and/or sexual IPV (Pronyk et al., 2006). Using a couples-based intervention and controlling for exposure, Gupta and colleagues (2013) showed a significant reduction in physical IPV for those attending over 75 percent of sessions. Evaluation of vocational/jobs training interventions also showed mixed results. Stepping Stones/Creating Futures used a pre-test/post-test design and showed: a reduction in women's experience of IPV; but no significant reduction in men's perpetration of violence (Jewkes et al., 2013).

While there remains mixed evidence regarding the impact of social protection programmes targeted at mothers, some suggest women experienced a decrease in IPV (Haushofer and Shapiro, 2013; Hidrobo, Peterman and Heise, 2013). Others, however, showed no impact, and one reported an increase in emotional forms of violence and controlling behaviour (Bobonis and Castro, 2010; Hidrobo and Fernald, 2013). This suggests that a range of contextual factors is critical in shaping intervention outcomes to achieve decreased rates of violence.

Impact on risk factors for VAWG – Microfinance and social interventions also show promise in shifting a range of behaviours that could potentially increase or decrease the risk of VAWG. These include: economic measures; gender and health measures, including condom use; negotiation of a partner’s HIV-related behaviour; sexual power; and number of partners. Other studies, which looked at savings and job training interventions combined

with social empowerment components, also showed a range of positive changes in risk factors for violence, such as increased condom use, and a reduction in the number of sexual partners (Hallman and Roca, 2011; Ssewamala et al., 2010). For example, one RCT in Zimbabwe showed significant improvement in transactional sex and condom use, but only a non-statistically significant reduction in IPV (Dunbar et al., under review). Broad-based social protection programmes (e.g. cash transfers that target mothers in order to benefit the child) showed: an increase in positive outcomes for protective factors only for girl children; and no impact on boy children.

Women’s and girl’s social empowerment has long formed a cornerstone of the violence prevention movement. This is based on the understanding that VAWG is fundamentally about gender inequality and women’s subordination. There is strong qualitative evidence that women’s disempowerment

3.1.2 Social empowerment of vulnerable groups

Types of evidence:	Evidence of effectiveness of intervention:
I: Evidence obtained from at least one properly randomised controlled trial.	F. There is insufficient evidence (in quantity or quality) to make a recommendation for all types of social empowerment, however some interventions show effectiveness in reducing violence.

and dependence on men make them both vulnerable to experiencing violence, and less able to challenge or leave situations of violence. Women’s and girl’s empowerment has been conceptualized in many ways, and is commonly recognized as a process, rather than a ‘state of being’. This section focuses

on social empowerment interventions that target vulnerable groups of women, including pregnant women and FSWs, who are often highly vulnerable to violence from many men, including clients, pimps, the police, as well as their partners.¹ Interventions include gender sensitization and transformative programming,

¹ 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).

which seek to enable women and girls to imagine their world differently and to realize that vision by changing the relations of power that have kept them in poverty, restricted their voice and deprived them of their autonomy. Focusing on girls and women as agents of their own empowerment, and recognising that such empowerment is interconnected with surrounding structures, activities within social empowerment interventions are often linked with other stakeholders, such as the family, community and institutions.

Description of the interventions:

Social empowerment interventions with vulnerable groups of women and girls (without any economic component)² often involve group work with women and girls from similar backgrounds meeting in clubs or community spaces. They often combine awareness-raising with skills building, either life skills (including matters relating to rights and violence prevention) or skills relating to leadership and collective organising, with the purpose of building the awareness of women and girls about: their rights; how to access services; how to protect themselves against violence.³ They can also include one-to-one support for particularly vulnerable individuals through home visits (typically by trained health professionals or non-professional mentors), providing training on issues regarding health, family roles, violence and services available.⁴

These interventions are sometimes complemented by work with the girls' or women's community or sexual partners, in order to disseminate messages through face-to-face meetings or media campaigns to build their support for women's empowerment (Beardon and Otero, 2013; Brady et al., 2007; Pande et al., 2006).

Examples of social empowerment programmes

- The **Oxfam Raising Her Voice** programme (2008-2013) was a broad ranging portfolio of 19 projects across 17 countries that worked in different ways and contexts to strengthen women's participation and voice in governance. It focused on networking, advocacy, training, and disseminating good practice, among other activities.
- The **Sonagachi project**, based in Calcutta, promotes the use of health services and STI treatment for FSWs to reduce HIV incidence. It includes multifaceted, multilevel interventions with FSWs as peer educators.
- The **Avahan programme**, funded by the Bill and Melinda Gates Foundation was an HIV/ AIDS programme in India that aimed to reduce HIV transmission in high-risk populations (notably FSWs, MSM, and transgenders, through prevention education and services such as condom promotion, STI management, behaviour change communication, community mobilization, and advocacy.

Female sex workers empowerment programmes include a broad range of initiatives, from warning FSWs about men who are known to be violent, to: self-defence classes; alternative livelihood activities; training on human rights and legislation; outreach activities to reduce stigma; training of police officers about FSWs' rights; and rapid response systems for FSWs facing violence.

² Economic empowerment interventions are discussed in section 3.3

³ The frequency of sessions varies, but tends to be between one to five times a week, over a period of from ten weeks to two-and-a-half years,

⁴ The number of home visits varied, but in the studies included in this research we found that there were: between six and thirteen home visits to pregnant at risk women over the course of a pregnancy or a year; ten to twelve sessions to women with mental disabilities (not including follow-up), for up to twelve weeks.

Summary of evidence available:

This review identified 30 studies on social empowerment initiatives with poor and vulnerable women and girls, which measured the impact of the intervention either specifically on violence reduction or on other related outcomes. A total of 26 studies were on interventions to support specifically vulnerable groups, 11 of which focused specifically on FSWs. This included: three RCTs on interventions with pregnant women at risk of IPV (Mejdoubi et al., 2013; Taft et al., 2011; Tawai et al., 2005); three quantitative non-RCT studies on interventions with women with mental disabilities (Khemka, 2000; Mittenberg et al., 1999); and one RCT on vulnerable drug users (Wechsberg et al., 2013). The other four studies were on interventions done with groups of poor or marginalized girls, including Oxfam's Raising Her Voice portfolio (Beardon and Otero, 2013; Heaner, 2012; Repila, 2013). Approximately half of the studies measured the impact of interventions on a reduction in VAWG, which was largely IPV, apart from the FSW studies, which also included abuse by clients and the police. Other outcomes measured included: impact of interventions on health related outcomes, particularly depression, physical and emotional well-being; skills in decision-making; stress management; knowledge of how to prevent abuse; drug abstinence; and greater autonomy.

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG

– Most of the studies reviewed that dealt with sex worker collectivization initiatives showed a positive impact on reducing violence and on participants' ability to manage client risk behaviours related to violence better. For example, studies of the Avahan HIV prevention programme in Karnataka showed that FSWs' membership of a collective group was associated with less experience of violence and police coercion, particularly in districts with

programmes of longer duration (Blanchard, 2013; Karnataka Health Promotion Trust, 2012). A study of the Ashodaya Samithi initiative in Mysore (Reza-Paul et al., 2012) found that, after a safe space was established for sex workers to meet, and with crisis management and advocacy initiated with different stakeholders: violence decreased by 84 percent over five years; police-perpetrated violence and violence by clients decreased substantially.

In terms of one-to-one support, studies found some evidence that intensive regular home visits by health care professionals or non-professional mentors to at-risk pregnant women resulted in a reduction in IPV, particularly where these visits: continued up to a year or more; were done before and after the pregnancy; and where the mother's partner was involved (Mejdoubi et al., 2013; Taft et al., 2011). A less intensive intervention, involving a short 30 minute empowerment training session and the provision of a card containing details of community resources for abused women, was also effective in reducing psychological abuse, but not sexual abuse (Tiwari et al., 2005). However, these studies were done in HICs and required extensive resources, making them difficult to replicate in low and middle income countries (LMICs). There is also some evidence to support leadership training, with one study showing that low-income Latin American immigrant and refugee women reported a decrease in incidents of coercive or violent behaviour by male partners (Gomez et al., 1999).

Impact on risk factors for VAWG – A number of studies also reported an impact on risk and protective factors for violence. Some collectivization interventions reported an impact on: women's self-esteem; acceptance of IPV; women's ability to challenge male behaviour and to resist unequal relations in the family (Brandl et al., 2003; Unterhalter et al., 2013); and women's knowledge of pregnancy

and STI symptoms, savings, self-confidence and social capital (Engebretsen, 2013). Each of these impacts can be seen as protective factors for VAWG in certain contexts. In Brazil, a study done on Fio da Alma (which established a drop-in centre to create a safe space for sex workers to access health services and information on rights and safety, and to mobilize for collective action) found that participants' ability to manage client risk behaviours related to alcohol, drugs and violence improved significantly following the intervention (Kerrigan et al., 2008).

A leadership training programme for adolescent girls in the Solomon Islands did not measure its impact on violence, but found positive outcomes in terms of protective factors, including an increase in women's leadership

skills, knowledge on women's right, and self-confidence (YWCA Solomon Islands, 2013). Interventions to prevent violence against women (VAW) that are directed at men have gained momentum in the last decade, with increased attention being given to measuring what works. Interventions with men are, firstly, based on the premise that they are the ones who perpetrate this violence. Secondly, constructions of masculinity - the social norms associated with manhood and the social organization of men's lives and relations - play a crucial role in shaping VAWG. Thirdly, men and boys have a positive role to play in helping to stop VAWG, and they will benefit personally and relationally from this (Flood, 2013; Jewkes, Flood and Lang, 2014).

3.1.3 Bystander interventions primarily targeting men and boys

Types of evidence:	Evidence of effectiveness of intervention:
I: Evidence obtained from at least one properly randomised controlled trial.	C. The existing evidence is conflicting and does not allow for recommendations to be made, either for or against the intervention. Also, most of the evidence is from North America and there remain limitations to the generalizability of these findings beyond Anglo-American populations.

Description of the interventions:

Bystander action refers to action taken by a person (or persons) not directly involved as subject(s) or perpetrator of VAW to identify, speak out about or seek to engage others in responding to violence. While some forms of bystander action are intended to intervene in actual violent incidents or actions, others are intended to challenge the social norms and attitudes that perpetuate violence in the community.

Bystander interventions are mainly implemented in schools and usually focus on changing individual and peer attitudes and behaviours (essentially in the US), mainly with groups of men, and more rarely with women or both sexes. They draw on existing influential relationships to elicit social norm change, particularly within groups of young men during an impressionable life stage. Bystander approaches can also be included in social marketing campaigns which aim to promote bystanders intervening in cases of

violence or abuse. They can be brief one-off or longer interventions, and can be implemented by teachers or trained educators. Bystander components may be integrated into holistic, community-based interventions, or they may be implemented as stand-alone interventions.

The stand-alone model is examined here:

Types of evidence available:

Ricardo (2011) reviewed 65 interventions (RCT and non-RCTs) that were designed to engage boys and young men, including some bystander interventions. In a recent review, Powell (2011) describe the origins, underlying theory and programme application of bystander approaches, including a rapid mapping of interventions and a review of some evaluations. The present assessment extracted 13 interventions from these reviews and additional searches. Interventions are highly concentrated in the US and only one intervention specifically targeted women. We identified seven RCTs; one control trial without randomization; two without control groups; two of unclear design. Six studies measured perpetration of sexual violence or IPV and the rest measured impact on knowledge, awareness and attitudes (towards gender roles, violence, and rape myth acceptance). In general, studies are characterized by measures of short-term outcomes (seven studies had a follow-up of less than seven months and only two had a 12-month follow-up).

There is currently no evidence available on bystander interventions in LMICs, although Safe Dates is being evaluated in South Africa at present. Further, Bell Bajao and Soul City have bystander elements, which aim to get people to intervene to stop violence; these are discussed in section 3.3.1. Therefore there remain limitations in the generalizability of these findings beyond Anglo-American populations (Radford, 2014).

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG – Despite the high number of bystander interventions that have been evaluated, only one RCT found positive outcomes in terms of IPV perpetration: Coaching Boys into Men (Miller et al., 2012). At a 12-month follow-up, this cluster RCT demonstrated a reduction in negative bystander intervention behaviour (fewer intervention athletes supporting the abusive behaviour of peers) and less abuse perpetration (with an estimated intervention effect of -0.15). This suggests that a brief programme with few resources, utilizing coaches as key influencers, may buffer against the initiation of dating violence perpetration during a critical developmental period for youth.

Examples of bystander interventions:

- **Coaching Boys into Men** targets coaches and high school male athletes from 16 American high schools. The intervention consists of a 60-minute training session for coaches, followed by brief weekly scripted discussions (10-15 minutes) with athletes.
- **Bringing in the Bystanders** is based on one 4.5-hour session conducted in groups with a team of one male and one female peer facilitator. Using an active learning environment, participants learn about the role of pro-social bystanders in communities and about sexual violence. They also learn and practise appropriate and safe bystander skills.

Impact on risk factors for VAWG – Most of the evaluation findings measured risk factors for violence perpetration, rather than perpetration itself, and the results are conflicting:

- None of the interventions retrieved found any positive change relating to attitudes towards gender roles;
- Rape myth acceptance decreased in two studies, but did not change in two others; and
- The main positive changes concerned: the ‘intention to intervene’, which was found to be positive in four studies; efficacy; and knowledge and awareness (recognition of abusive behaviour).

In Coaching Boys into Men, compared with control subjects, at three months, athletes exposed to full-intensity implementation of the intervention demonstrated improvement in intention to intervene and recognition of abusive behaviour, and positive bystander behaviour; but these outcomes were not sustained at the one-year follow-up. Bringing in the Bystander (Moynihan et al., 2010) provides some of the strongest evidence of impact on behaviour (Powell, 2011; Ricardo, 2011), but the impact on attitudes is still limited. Significant difference in bystander efficacy was found at two-month follow-up, but not for rape myth acceptance.

3.1.4 Tackling alcohol abuse

Types of evidence:	Evidence of effectiveness of intervention:
I: Evidence obtained from at least one properly randomised controlled trial in HICs.	B. Fair evidence from HICs that structural, group and self-help interventions are effective in reducing alcohol abuse and IPV (although insufficient evidence in LMICs)

Drinking, especially binge drinking by men, has been found to be a contributing factor to violence and to increase both the frequency and severity of partner abuse at the individual level. Other evidence suggests that women whose partners had been drinking preceding violent incidents are significantly more likely to be injured than women whose partners had not been drinking before the violent incident. A recent meta-analysis likewise demonstrated a clear association between IPV and women’s drinking - although the direction of the effect

is unclear (Devries et al., 2013). Longitudinal studies suggest that the relationship goes both ways, with women who drink being more likely to be victims and women who are abused being more likely to drink (Heise, 2011). The association between alcohol and VAW has both biological and cultural underpinnings. There is biological evidence to suggest that alcohol use leads to lowering of inhibition, hinders problem-solving ability, increases risk-taking behaviours, enhances emotional responses, and makes one less cognisant of consequences.

Additionally, alcohol consumption may 'give men permission' to express culturally-bound social norms that condone male dominance over women (Watts, 2012).

Description of interventions:

There are four categories of alcohol reduction interventions: 1) Brief interventions involving screening in primary care settings and using a brief intake questionnaire or enquiry during history taking; 2) Structural interventions that restrict access to alcohol by developing laws and policies to make alcohol more expensive and less available; 3) Community-based interventions that aim at changing the drinking environment through social norms campaigns, education in schools or public dialogue; and 4) Treatment and self-help support systems, such as Alcoholics Anonymous (AA) (Heise, 2011).

The multi-component interventions directed at men (such as the One Man Can campaign in South Africa or the Yaari Dosti campaign intervention in India) also have components aimed at reducing alcohol abuse; but the evaluation done on the One Man Can campaign did not measure outcomes related to alcohol abuse and the Yaari Dosti intervention is currently undergoing a RCT.

Summary of evidence available:

Although there is now a substantial evidence about the relative effectiveness of different strategies for reducing the rate of alcohol-related harm, most of it derives from HICs and cannot be transposed directly to LMIC settings (Benegal, 2009). However, some reviews identified and analyzed evidence coming from LMICs, such as Heise (2011) and Benegal (2009); the latter describes and proposes different packages of care for alcohol use disorders in LMICs, based on a mapping of existing interventions.

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG – There is fair evidence from HICs that structural alcohol reduction interventions may impact on the prevalence of IPV in the population. For example, a recent longitudinal study conducted in Australia found a significant association between alcohol outlet density and rate of domestic violence (Livingston et al., 2001). In Greenland, a coupon system that limited beer consumption to 72 beers per month decreased the number of domestic violence calls to police by 58 percent (Room et al., 2003). Based on an analysis of 112 studies, Wagenaar et al. (2009) showed that an increase in alcohol tax has an effect, with drinking reducing, including among youth and problem drinkers. The only intervention that measured the impact of price on IPV was conducted in the mid-1980s: it showed that a price increase in alcohol decreased the probability of IPV (Markowitz, 2000); however, given the age of

Examples of alcohol reduction interventions:

- The **RISHTA programme** in India explicitly integrates programming related to harmful alcohol use into the ongoing work on men's sexual and reproductive health, based on a combination of improved services, community drama and group reflection. Alcohol abuse was tackled through the use of street dramas and follow-up community meetings.
- The **Share Trial** is an intervention aimed at reducing IPV and HIV infection by targeting direct and indirect risk factors, including alcohol abuse, for both outcomes, through a multi-component approach that combines community-based education, advocacy and capacity building.

this study, it should be treated with caution. The Share Trial implemented in Uganda (with a sample of 5,339 people) also had a significant impact on women's experiences of physical and sexual IPV.

Impact on risk factors for VAWG – A systematic review of 22 controlled trials (Kaneer, 2007) showed the effectiveness of early identification and brief advice given to people with hazardous and harmful alcohol use, but who were not severely dependant. There is also evidence that more intensive interventions are not more effective than less intensive ones (Anderson, 2009).

The Phaphama programme in South Africa (Kalichman, 2009), which combined the Brief Intervention for Hazardous and Harmful Drinking with the HIV risk-reduction counselling model for STI patients, was evaluated through a RCT and showed a 65 percent reduction in unprotected sex for Phaphama participants. However, the effects were not sustained after six months, indicating the need for more intensive alcohol risk reduction intervention components and maintenance intervention strategies. The evaluation of the RISHTA programme (Schensul et al., 2010) in India found a significant drop in overall alcohol use in the study communities (there was no comparison community). Men in the panel study, who were drinkers at baseline but not at end-line, reported a reduction in risky activities with friends, more gender equitable attitudes and reduced extramarital sex. However, it found no reduction in alcohol use surrounding sex,⁵ considered here as a mediator between IPV and HIV.

The small group intervention Stepping Stones (in South Africa) achieved a significant reduction in problem drinking among men at 12 months. In addition, self-help groups for problem drinking could constitute a simple low-cost model of intervention in

LMICs, as implemented through religious organisations in Latin America. However, it is not possible to do an RCT of AA because it contradicts the organisational philosophy of a group that is open to all those who wish to change their lives. However, a study using propensity score matching to deal with selection bias saw a significant reduction in harmful drinking (Benegal, 2009; Heise, 2011). Psychotherapeutic interventions working with couples are promising, but their affordability and feasibility in LMICs is improbable, due to the shortage of skilled mental health professionals. Most detoxification interventions that have proven successful in HICs (such as residential treatment) would not be affordable to LMICs (Benegal, 2009; Heise, 2011). However, Benegal (2009) identified packages of care for alcohol abuse in LMICs that include: community-based treatment camps to support alcohol-dependant men detoxification; and interventions to help maintain sobriety, such as self-help groups or the use of drugs.

3.2 Relationship and family-level interventions

The majority of VAWG occurs at the relationship level, with IPV being the most common form of VAWG globally. Families are also often the site of VAWG, and an important entry-point for intervention. This section examines the impact (on preventing VAWG) of interventions that focus on working with couples to address relationship dynamics, and those that work within families to promote positive parenting practices.

⁵ The men who reduced their alcohol intake were more likely to be older, less educated, living with their wives, more likely to perpetrate violence and to exhibit less gender equitable attitudes, and more likely to engage in extramarital sex and risky activities with their male friends.

3.2.1 Relationship-level interventions

Types of evidence:	Evidence of effectiveness of intervention:
I: Evidence obtained from at least one properly randomised controlled trial.	B: There is fair evidence to recommend the intervention type for preventing VAWG.

A number of cross-sectional household studies have shown that women are at increased risk of IPV where relationship discord is higher. There is some evidence to suggest that some forms of violence within relationships can be attributed (in part) to poor communication and conflict resolution skills. There is also an established association between witnessing partner violence as a child and either perpetrating or experiencing it in adulthood, suggesting that VAWG may have elements of learnt behaviour or psychological trauma that need to be addressed. Further, IPV may be more likely when either partner supports attitudes or beliefs that condone violence within relationships or that support power inequalities between men and women. Interventions at the relationship level aim to address these risk factors.

Description of interventions:

In most cases, gender transformative strategies are implemented through workshops directed at men and women separately or together. These interventions “encourage critical awareness of gender roles and norms, promote the position of women, challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community” (Heise, 2011).

Summary of evidence available:

This assessment identified two large-scale RCTs focused on relationship and communication skills aimed at reducing IPV and HIV infection (Stepping Stones and Share) (Jewkes, 2008; Wagman, 2014). The Stepping Stones evaluation had a sample of 2,776, a two-year follow-up and measured perpetration and experiences of IPV. The SHARE evaluation had a sample of 5,339 (intervention) and 6,112 (control), with two follow-up visits immediately following the intervention; it measured women’s experiences of IPV but not perpetration (Jewkes, 2008; Wagman, 2014). We also draw upon: Skevington’s (2013) systematic review of Stepping Stones, using eight reports of seven studies (n = 14,630) from India, Gambia, South Africa, Ethiopia, Angola, Tanzania, Uganda and Fiji; and Heise’s (2011) review of the effectiveness of interventions aimed at changing individual, community and social norms, which were implemented in LMICs.

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG – The Stepping Stones evaluation from South Africa found a decrease of 38 percent in men’s reports of IPV perpetration at 24 months in the intervention group. However, there was no change in reports of women’s experiences of IPV or forced sex among women.

The SHARE evaluation found a decrease in women’s experiences of physical and sexual IPV (including spousal rape), but no change in men’s reported perpetration of these outcomes. One limitation, however, was that data on frequency and severity of IPV was not collected; thus, repeated abuse cannot be distinguished from isolated events nor severe and moderate forms of violence differentiated from minor abuse.

Impact on risk factors for VAWG – In addition to changes in violence, these interventions also reported a decrease in risk factors, such as problem drinking at 12 months (Stepping Stones). All of them also show an increase in protective factors, such as education and better communication skills within relationships. A review of the Stepping Stones interventions in seven countries revealed that of the five studies investigating gender equity, only one did not show any change.

Examples of relationship-level interventions:

- **Stepping Stones** is a small-group relationship intervention that has been implemented in dozens of countries worldwide. It includes 13 participatory training sessions with 50 hours of intervention over a 6-8 week period. It covers topics such as gender inequality and violence, violence against youth, life-cycles of violence, love, stigma, STI/HIV, condom use, self-esteem and substance abuse (among others).
- **Safe Homes And Respect for Everyone (SHARE)** is a community-based intervention conducted by Rakai Health Sciences Programme in Uganda. It includes: training workshops; capacity building of professionals regarding domestic violence, reproductive health, HIV/AIDS and women’s rights; community activism through village meetings, music, and dance; HIV/AIDS and reproductive health outreach; counselling services and the distribution of learning materials.

3.2.2 Parenting programmes

Types of evidence:	Evidence of effectiveness of intervention:
I: Evidence obtained from at least one properly randomised controlled trial.	B. There is fair evidence to recommend the intervention type for preventing VAWG.

Poor or harsh parenting is not only a critical risk factor for maltreatment worldwide, particularly in the early years, but it is also a risk factor for VAW. There is strong evidence from the US and other HICs of an association between poor parenting and later violent behaviour (including IPV). There is also direct evidence of an association between conduct disorders (such as aggression) and the risk of abusive, violent or criminal behaviour later in life. Finally, positive parenting can buffer the effects of community violence or other negative influences (Knerr, 2011). Addressing child abuse, harsh parenting and conduct disorder in children are key goals in and of themselves. They can also contribute to the prevention of other forms of VAWG. Parenting interventions aim to stem the cycle of abuse by which those who experience abuse as children are more at risk, in later years, for wife abuse, sexual aggression, and heightened violent crime (MacKloskey, 2011).

Description of interventions:

Parenting programmes generally target parents who have abused or neglected their children, or who are at risk of doing so. Such interventions aim to improve relationships between parents and their children, and teach parenting skills. A few are directly aimed at reducing conflict and abuse. They consist of home visits, but can also be community-based or implemented in health clinic settings. Activities common to many of the parenting interventions are: individual counselling or group discussion; role play; videotape modelling of positive parenting behaviours; educational communication materials that model or guide positive behaviours; and structured or guided play between mothers, fathers and their children (Knerr, 2011).

Summary of evidence available:

Two systematic reviews recently analyzed parenting interventions. Knerr (2011) analysed evidence from 12 RCTs or quasi-experiments involving 1,580 participants in nine LMICs. This review investigated the effectiveness of parenting interventions in terms of: reducing harsh or abusive parenting; increasing positive parenting practices, attitudes and knowledge; and improving parent-child relationships. MacKloskey (2011) reviewed 22 studies from HICs with a total of 5,160 parents in clinical trials and an additional 18,000 in a population-based trial. Mikton (2009) conducted a systematic review of reviews concerning child maltreatment, including parenting interventions and Heise (2011) reviewed the effectiveness of interventions implemented in LMICs, including parenting interventions. Finally, in 2013, WHO produced a Guidance Note, 'Preventing violence: Evaluating outcomes of parenting programmes' that reviews the effectiveness of parenting programmes. An additional review focuses on analysing the effectiveness of the widespread Triple P intervention (Wilson et al., 2012).

We extracted 34 interventions from these reviews and other searches. Only nine of the interventions came from LMICs (six home-visit programmes; one community-based programme; two programmes implemented in clinics). A high proportion of the evaluations were methodologically weak (Knerr, 2011; MacKloskey, 2011; Mikton, 2009). In Knerr's review (which focussed on LMICs) out of 12 studies, only three had a low risk of bias.⁶ The reliability and validity of the other studies' results are unclear. In particular, few of the trials employed reliable and validated direct observational instruments for assessing parenting behaviour. Measures of the impact on abuse are also limited. Most studies aimed at improving parenting and child development

⁶ Klein, in Ethiopia; Cooper, in South Africa; and Rahman, in Pakistan; only the latter two reported sample sizes based on a power calculation.

and only three studies done in LMICs measured the impact on reducing parent/child conflict or abuse (Aracena et al., 2009; Kagitcibasi et al., 2001; Oveisi et al., 2010).

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG – The results of parenting programmes are uncertain in terms of a reduction in child maltreatment itself, in part because such outcomes were not measured. Home-visit programmes appear to be the most researched type of programme and yet, only one programme conducted in 1998 has produced strong evidence of preventing child maltreatment in the USA. The Nurse Family Partnership (Olds et al., 1998.) showed that by the 15-year follow-up, rates of child abuse were reduced by 48 percent compared with the children in the control group. The programme has also shown positive results in three other RCTs across various samples and regions in the USA. Other interventions showed impact in HICs, but the evidence is not as strong. Four studies found a decrease in agency or hospital abuse reports among groups exposed to the intervention compared with control groups: two conducted in a clinic (Chaffin, et al., 2004; Prinz, et al., 2009); and two at home (Jouriles, et al., 2010; Olds, et al., 1997). Another four reported differences through self-reports using standardized instruments (conflict tactics scale) (Fergusson, 2005; Jouriles, 2005, Linares, 2006; Ovisi, 2010). In LMICs, the three studies that measured reduction on negative, harsh or abusive parenting had positive results.⁷ Transferability of home visiting programmes remains in questions due to cultural adaptation and the high cost, which may make them unaffordable for LMICS.⁸

Impact on risk factors for VAWG – The evidence suggests that parenting interventions can

Examples of parenting programmes:

- The **Nurse Family Partnership** includes nurse visits conducted with low-income first-time mothers during pregnancy and until the child is two years old.
- **Enriched Healthy Families** adds a component to the original Healthy Families intervention that addresses the mother's own cognitive abilities, her expressions of emotion with her child, and her success in labelling and identifying emotions.
- **Triple P** is a multifaceted model attempting change at different levels. It includes: behavioural interventions and workforce training; media coverage and communication strategies; and distribution of material to support parenting.
- The **Spokes Project** is a multi-component intervention that seeks to impact on early-onset antisocial behaviour by tackling four risk factors: ineffective parenting, conduct problems, attention deficit/hyperactivity disorder (ADHD) symptoms, and low reading ability. The Incredible Years programme methodology is used to address child behaviour, along with other methodologies to address the other risk factors.

reduce risk factors for child maltreatment by influencing parental attitudes and parenting skills. One intervention, conducted in South Africa (Cooper, 2009) with a sample of 449 mothers living in shacks, showed a small but significant effect of intervention on maternal sensitivity and maternal intrusiveness at six-month follow-up, compared to the control

⁷ Aracena (2009) is a home-visiting programme in Chile; Oveisi et al. (2010) is set in a clinic; Kagitcibasi (2001) is a community-based intervention in Turkey.

⁸ The estimated total cost of the Nurse Family Partnership is about US\$ 4,500 a year for each person taking part in the programme.

group. A home visiting programme conducted in Pakistan (Rahman, 2009) suggests significant effects on mother's knowledge and attitudes about child development at 12-month follow-up, compared to the control group. A programme aimed at fathers of children at risk and supporting their involvement to prevent maltreatment (Cowan, 2009), has modest findings but holds potential in that it challenges the gender stereotypes surrounding childcare. Multi-component interventions may be effective at reducing conduct disorder and later anti-social behaviour among children, risk factors for violence perpetration (Heise, 2011). An evaluation of the Spokes Project (Scott, 2010) reported a reduction in children's conduct problems including ODD and Attention Deficit Disorder (ADHD) symptoms reduced and reading age improved by six months.

On the other hand, there are mixed-results from some of the most widely adopted interventions in the US, including home visiting programmes Healthy Families (Dumont, 2008), Healthy Start (Duggan, 2004), and Triple P. Prinz (2009), who evaluated Triple P with a sample of 85,000 people, found preventative effects on substantiated cases of child maltreatment, child out-of-home placements, and child injuries from maltreatment. However, a systematic review and meta-analysis of 33 Triple P studies showed that mothers generally report that Triple P group interventions are better than no intervention, but questioned the validity of these results given the high risk of bias, poor reporting and potential conflicts of interest (Wilson et al, 2012). Further, the review did not find any convincing evidence that Triple P interventions work across the whole population or that any benefits are long-term and highlighted that the two studies involving an active control group showed no between-group differences.⁹

3.3 Community-level interventions

Historically VAWG has often been considered a private issue and been shrouded in secrecy and silence. In many societies and communities VAWG is also considered normal or acceptable under certain circumstances. Efforts to break the silence and challenge social norms that promote or tolerate violence are therefore one key component in addressing the problem. In recent years, there has been some recognition that changing individual attitudes may not be enough to end violence and greater emphasis has been placed on more comprehensive, multi-component efforts to change social norms. This section considers both media and communication campaigns, more comprehensive community mobilization interventions, and group education combined with community mobilisation.

⁹ Sanders (2012) contested the findings of Wilson. Additional recent Triple P evaluations include those of Morawska (2014), who evaluated the efficacy of a Triple P podcast series and found that parents in the intervention group improved significantly more than parents in the control group, on measures of child behaviour problems and parenting style: self-efficacy, and confidence, at a six-month follow-up.

3.3.1 Communications and advocacy campaigns

Types of evidence:	Evidence of effectiveness of intervention:
<p>II-2: Evidence obtained from four evaluations, but with no control groups.</p>	<p>F. There is insufficient evidence (in quantity or quality) to make a recommendation, however the evidence that exists suggests that single component awareness campaigns are ineffective in preventing VAWG.</p>

Description of interventions:

A wide array of interventions designed to prevent VAWG, which range in intensity and objectives, could be labelled communication campaigns. Awareness campaigns may aim to raise awareness or increase knowledge about a service, a law or about VAW as an issue in general. Advocacy campaigns often take the form of a regional or national coalition of individuals and organizations that are encouraged to take action to influence policy change under the banner of a common campaign identity (Heise, 2011), for example UNITE: the UN Secretary General’s Campaign to End Violence against Women. They often include media interventions, using television, radio, the internet, newspapers, magazines and other printed publications. They aim to increase knowledge, challenge attitudes and modify behaviour. Media interventions may also aim to alter social norms and values through public discussion and social interaction. Other campaign interventions take the form of ‘edutainment’ - integrating social messages into popular and high-quality entertainment media based on a thorough research process. Finally, social norms marketing is used to try to: change perceptions about attitudes and behaviour considered normal by the community; activate

positive social norms and discourage harmful ones (Palluck, 2010).

Summary of evidence available:

While communication campaigns have often been used as a strategy at global, regional and national level, rigorous evaluation of the effectiveness of these campaigns is scarce. This assessment identified four strong evaluations done on media and awareness raising campaigns - all randomized trials with no control group.¹⁰ The evaluations measured change in awareness, attitudes and norms, but none measured actual change in violent behaviour or change in rates of VAWG.

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG – To date, there is little evidence to indicate that simple awareness campaigns have an impact on the prevalence of VAWG. This is partly because existing evaluations have not measured violence as an outcome, and because it is difficult to attribute change to a media campaign. However, it is likely that single component communication campaigns are

¹⁰Soul City: a before and after survey; sentinel sites; qualitative interviews; and helpline data assessment (Usdin et al. 2005). Bell Bajao: two arms: one media only intervention and one with media and community mobilization activities (Heise, 2011). Search for Common Ground: mixed method, pre and post surveys for cinema viewers, focus group discussions and qualitative interviews (Holmes, 2013). Seven-month public health education campaign targeting domestic violence in a rural county in the US: a random telephone survey before and after the intervention (Gadomski, 2001).

seldom intensive enough or sufficiently theory-driven to transform norms or to change actual behaviour (Heise, 2011).

Impact on risk factors for VAWG – There is some evidence that awareness campaigns can lead to an increase in awareness and knowledge. For example, the evaluation of a public health education campaign in a US rural county found that domestic violence agency hotline calls in the intervention county doubled during the intervention period (Gadomski, 2001). There is mixed evidence with regard to the impact of ‘edutainment’ on attitudes related to domestic violence. There was a consistent association between exposure to Soul City and

support-seeking and support giving behaviour. However, the impact on norms and attitudes related to domestic violence was mixed and there was no influence on norms of the sexual harassment being inappropriate or on cultural acceptability of violence (Usdin et al., 2005).

Overall, greater intensity of intervention or exposure to messaging through more than one component appears to increase the effectiveness of campaign interventions. For example, the Bell Bajao evaluation found greater changes in individuals exposed to both media and on-the-ground training components of the intervention, as opposed to individuals exposed to only the media component.

3.3.2 Community mobilization (changing social norms): Multi-component interventions

Types of evidence:	Evidence of effectiveness of intervention:
I: Evidence obtained at least one properly randomised control trial.	B. There is fair evidence to recommend the intervention type for preventing VAWG.

Description of the interventions:

Community mobilization interventions usually attempt to empower women, engage with men and change gender stereotypes and norms at a community level. They can take the form of community workshops and peer training aimed at shifting attitudes and behaviour by interrogating prevalent norms. They are often accompanied by localized campaigns and community mobilization activities, including video, radio broadcasts or dramas. A growing number of interventions seek to have an influence at all the levels of the ecological framework and combine multiple methodologies. Multi-

component interventions often include specific empowerment components that aim to increase women’s self-confidence in relationships, negotiation and communication skills, and raise awareness about their rights (Jewkes, Flood and Lang, 2014). These social empowerment interventions share some similarities with women’s economic empowerment programmes, as discussed below. Some community mobilization interventions focus on changing men’s attitudes and behaviours, such as the Cambodian Men’s Network, Men’s Action for Stopping Violence Against Women (MASVAW) in India, and the One Man Can campaign in South Africa (which is currently being evaluated).

Summary of evidence available:

Through recent reviews (Heise, 2011; Holmes, 2013) and other searches, we identified four rigorous evaluations of multi-component social norm change interventions for inclusion in this assessment. This included: a multi-country quantitative and qualitative mixed method evaluation of the We Can Campaign in South Asia (India, Bangladesh, Nepal, Sri Lanka and Pakistan); a non-RCT in Bangladesh; and qualitative in-depth analysis of the change processes in different settings (Hughes, 2012; Raab, 2011; Rajan, 2010; William, 2011). Through this review we also identified a mixed method (quantitative and qualitative) evaluation of Somos Diferentes, Somos Iguales (SDSI) in Nicaragua (Solorzano, 2008), mixed method impact evaluation of a Raising Voices programme (not SASA!) in Uganda (Raising Voices, 2003) and findings from a pair-matched cluster randomized controlled trial in eight communities in Uganda of SASA! (Abramsky et al., 2014). The SASA! evaluation is the first study to assess the impact of a partner violence prevention intervention at community level, rather than with intervention recipients or their partners.

However, there remains a scarcity of rigorous impact evaluations, particularly those that demonstrate a reduction in the perpetration of violence. This is partially linked with the difficulty of evaluating multi-pronged interventions and campaigns. However, we also found that: many of the evaluations were not rigorously designed; many were lacking a specific and limited number of primary outcomes, baselines or rigorous data analysis.

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG – There is evidence that well-designed interventions aimed at changing social norms can impact upon perpetration or experience

Examples of community mobilization campaigns

- **SASA!** is a community mobilization intervention that was started by **Raising Voices** in Uganda. It seeks to change community attitudes, norms and behaviours that result in gender inequality, violence and increased HIV vulnerability for women. The interventions are designed to systematically work with a broad range of stakeholders within the community to promote a critical analysis and discussion of power and power inequalities.
- Oxfam's **We Can Campaign** across South Asia, aims to achieve a shift in social attitudes and beliefs that support VAW by achieving a collective stand by different sections of the community against VAW and a wide range of alliances actively addressing VAW. Change Makers are trained and then tasked with carrying forward the campaign's mandate and signing up more change makers, using events, workshops, print and video materials.
- The **Men's Action for Stopping Violence Against Women** (MASVAW) in India is an alliance or 'movement' of men and organizations working on gender issues. Through male members engaging with other men in their communities, cultural and advocacy campaigns, MASVAW raises awareness, inspires actions and recruits new network members.

of domestic violence. Findings from the SASA! evaluation found that past year physical IPV experienced by women was significantly lower in intervention communities versus control communities, although there was no significant decrease in sexual IPV (Abramsky et al., 2014).

The evaluation of another intervention by Raising Voices also demonstrated a decrease in all forms of IPV in the community (cited in Arango et al., 2014). A non-RCT trial of the We Can Campaign in Bangladesh found evidence to suggest that the campaign, where implemented with significant intensity, can reduce intra-marital violence, although primarily among the Change Makers - those trained by the programme - rather than in the general community (Hughes, 2012).

Impact on risk factors for VAWG – There is fair evidence to show that community mobilization campaigns have the potential to change risk factors for VAWG, particularly violence-condoning attitudes and beliefs; however, a linear relationship between attitude and behaviour has not yet been established.

For example, the evaluation of the One Man Can campaign (Hughes, 2012) showed that whilst change in attitude was limited, change in perpetration was quite substantial. Findings from the SASA! evaluation found that the social acceptance of IPV was significantly lower for women and among men in intervention communities. There was also a significant increase in attitudes supporting women having the right to refuse sex - among both women and men (Abramsky et al., 2014). A qualitative evaluation of MASVAW documents some changes in the behaviour of individual men, in couple relationships, and in community norms related to the acceptability of violence (cited in Dworkin et al., 2013); however, more research on such interventions is needed.

3.3.3 Group education (outside school) combined with community mobilization, primarily engaging men and boys

Types of evidence:	Evidence of effectiveness of intervention:
II-1: Evidence from well-designed controlled trials, without randomization.	B. There is fair evidence to recommend the intervention type for preventing VAWG.

Description of the interventions:

This section looks at interventions targeting men and combining group education and community mobilization only. The interventions identified are typically implemented in LMICS (Chile, South Africa, Brazil, India) and usually train small groups of boys and men (aged 15 to 18 and recruited through schools or communities) to mobilize others.¹¹ The training sessions are facilitated by trained facilitators or

peers, and implemented over a few days¹² or over six months.¹³ Group education methods are used, often based on existing curricula and material, such as Programme H or the White Ribbon Campaign Education and Action Kit. Typically, they cover topics such as: conceptual understanding of masculinity, gender, VAW, sexuality, and human rights; concepts of power in relationships; and men’s participation in domestic activities. Some curricula ask men to draft personalized plans for how to

¹¹ Between 150 and 260 men are trained in average.
¹² 4-5 days for the One Man Can campaign intervention in South Africa
¹³ 6 months for the Programme H.

make changes to their lifestyle. These trained boys and men then organise community events (such as football tournaments, lifestyle social marketing campaigns and community dialogues), reaching an average of 1,500 people, in order to raise awareness and engage other males against VAW.

Summary of evidence available:

Four reviews recently analyzed programmes engaging men; they have different foci but all included community mobilization and group education interventions (Barker, 2009; Dworkin, 2013; Flood, 2013; Ricardo, 2011). Eleven interventions were extracted for this analysis.¹⁴ This included: six control trials without randomization; three interventions without control groups; and three interventions that used a mix of routine data analysis, surveys with some participants and qualitative interviews. Ten measured attitude change (five using the Gender Equitable Men Scale); but only four studies measured perpetration of VAW (Instituto Promundo, 2012c; PATH, 2012; Pulerwitz, 2010; Verma, 2008), and two of those have methodological challenges (social desirability issues¹⁵ and the absence of a control group).

Existing reviews and impact evaluation findings point to several issues that limit the strength of the evidence. Changes in attitudes and behaviour are self-reported soon after the end of the intervention, which could result in social-desirability bias. Only short-term changes are measured, with a maximum follow-up of one year. Evaluations are mainly conducted with men participating in programme and not with the general population (except Instituto Promundo (2012c), which included a community-wide survey before and after to assess diffusion effects), and study participants are often self-selected and hence more likely

to change. This is in contrast to perpetrator programmes not reviewed here, which target more violence-prone men, who are often identified by restorative justice strategies (Jewkes, Flood and Lang, 2014).

Effectiveness of the intervention:

Interventions that combine group education with boys and men (sometimes in combination with women and girls) and adopt a gender transformative approach and intense community mobilization are promising (Barker, 2009; Dworkin, Treves-Kagan and Lippman, 2013; Heise, 2011).

The programmes directed at boys and men show an evolution in their content:

- From group education only to a combination of group education and community mobilisation;
- From working with single sex groups to working with both sexes, simultaneously or sequentially (Heise, 2011);
- Increased regional and global networking, in relation to particular campaigns focused on men and in terms of the emergence of regional and international networks and organisations (Flood, 2013); and
- Increased focus on shifting institutional relations through engagement with public policy (such as: for Partners for Prevention (P4P), based in the Asia-Pacific; or Sonke (gender justice) in South Africa) (Flood, 2013).

¹⁴ Breaking Gender Barriers, Kenya; Community Leadership Councils, India; Male Norms Initiative, Ethiopia; Facilitators Training, Chile; MASVAW, India; One Man Can, South Africa; Programme H, Brazil; Men as Partners, South Africa; Spokes Project Yaari Dosti, India.

¹⁵ Social desirability bias refers to the fact that in self-reports, people will often report inaccurately on sensitive topics, in order to present themselves in the best possible light. This may be particularly likely soon after the completion of an intervention.

Impact on perpetration or experience of VAWG – Overall, there is a limited number of evaluations measuring the effectiveness of such interventions on the prevention of VAWG. Pulerwitz (2010) evaluated the Ethiopia Male Norms Initiative (using the Programme H curriculum), and showed decreased IPV perpetration in both arms of the intervention (36 percent versus 16 per cent in the group education and community mobilization arm; 36 percent versus 18 per cent in the community education arm). An Instituto Promundo (2012c) study done in India, using Programme H, Stepping Stones and White Ribbon campaign methodologies, showed a decrease in IPV, but this was not significantly different to the control community. The evaluation of Yaara Dosti, a Programme H intervention in India, showed a decrease in IPV perpetration (including sexual violence) in the intervention group six months after the intervention. A 2012 PATH (2012) study done in Kenya showed a decrease in all types of violence perpetration, and a significant decrease in three types of violence perpetration 12 months after the intervention. However, the strength of these findings is limited by a high loss to follow up (from 1,357 people to 578 people) and the absence of a comparison group.

Impact on risk factors for VAWG – There is substantial evidence of the effectiveness of these types of interventions in improving men and boys' gender-related attitudes, which is a possible risk factor for perpetration. Of the ten studies measuring attitude changes, nine showed positive results and declines in gender inequitable attitudes. The only intervention that did not show positive attitude change (Promundo, 2012b) was conducted in health facilities and included a facilitators' training intervention for government health professionals. It is important to note, however, that the relationship between gender attitudes and violent behaviour is still unclear and requires further research.

Example of group education intervention:

Programme H seeks to engage young men and their communities in critical reflection about rigid norms related to manhood. It includes group educational activities, community campaigns, and an evaluation model (the GEM scale) for assessing the programme's impact on gender-related attitudes. Programme H was developed and validated in Latin America and the Caribbean (Bolivia, Colombia, Jamaica and Peru) and subsequently evaluated in Rio de Janeiro, Brazil. The methodology has also been adapted for use in the Balkans, India, Peru, Tanzania, Vietnam and other countries around the world.

3.4 Institutional-level interventions: Prevention in schools

School-based interventions aim to prevent violence in schools, and to use schools as an entry point for preventing VAWG, dating violence and sexual abuse. From a perspective of taking primary prevention to scale, school systems provide an opportunity to reach a large number of students, teachers and parents in a teaching-learning environment. Through the teaching of specific gender-themed curricula, schools are uniquely placed to influence and shape children's understanding of gender stereotypes and roles, and the prevention of VAWG.

In this section, we discuss a range of school-based interventions, including: 'whole school' or other holistic approaches; improving school water and sanitation infrastructure; (working with teachers to raise their awareness about violence and their skill in behaving in non-

violent ways; and working with students through curriculum-based awareness raising and skills-building interventions. They target either male or female peer groups separately, or male and female youth together, and address gender norms and attitudes before these become deeply ingrained in youth. Bystander programmes, which often take place in schools,

are discussed separately in section 3.1.3. As we did not find any evaluations on training teachers or older pupils to provide counselling services or providing counsellors in school that specifically measured a reduction of VAWG, these types of interventions are not included here.

3.4.1 Whole school and other holistic approaches

Types of evidence:	Evidence of effectiveness of intervention:
II-1: Evidence from well-designed controlled trials, without randomization.	F. There is insufficient evidence (in quantity and quality) to make a recommendation, however evaluations showed some positive results in terms of violence related risk factors.

Description of the interventions:

A ‘whole school’ approach, or holistic school-based intervention aims to make schools safer, more child-friendly and a better environment for children to learn, by engaging various stakeholders at the school level, as well as in the local community and in government, in a range of activities. By targeting several different levels at once, this approach aims to bring about systemic, sustainable change, so that change in individuals’ attitudes and behaviour are reinforced by supportive community and governmental response mechanisms and legal frameworks. Interventions typically include a combination of activities with the following key stakeholders or systems:

- **Teachers and other staff:** teacher training, including on gender responsive pedagogy; on specific violence prevention and healthy relationship curricula; developing codes of conduct and manuals to address school-

based violence; and creating or strengthening formal guidance and counselling services.

- **Pupils:** establishing girls’ or children’s clubs, and providing life skills and rights training.

Description of the interventions:

A ‘whole school’ approach, or holistic school-based intervention aims to make schools safer, more child-friendly and a better environment for children to learn, by engaging various stakeholders at the school level, as well as in the local community and in government, in a range of activities. By targeting several different levels at once, this approach aims to bring about systemic, sustainable change, so that change in individuals’ attitudes and behaviour are reinforced by supportive community and governmental response mechanisms and legal frameworks. Interventions typically include a combination of activities with the following key stakeholders or systems:

- **Teachers and other staff:** teacher training, including on gender responsive pedagogy; on specific violence prevention and healthy relationship curricula; developing codes of conduct and manuals to address school-based violence; and creating or strengthening formal guidance and counselling services.
- **Pupils:** establishing girls' or children's clubs, and providing life skills and rights training.
- **Reporting mechanisms:** setting up mechanisms in schools to allow for anonymous reporting of violence; allocating responsibility to particular staff or focal points to address reports of violence.
- **Parents and local community:** working with parent-teacher associations, local government and/or traditional leaders and school management committees to hold the school accountable and to change their own behaviour and attitudes to violence.
- **National level and government:** advocacy at the national level to raise awareness and promote advocacy for prevention and response to violence in schools.

Summary of evidence available:

This rapid review found ten studies on the whole school approach, i.e.: five multi-country or global portfolio evaluations; five individual studies from LMICs. Only one of these was an RCT, which is currently being implemented¹⁶; the rest are largely non-randomized quantitative or mixed method studies, two qualitative studies, and one where the methodology was unclear. We also identified three individual studies evaluating standalone interventions working with teachers to address VAWG, either by training existing teachers or by recruiting female classroom assistants

Examples of whole school approaches:

- The UNICEF **Child Friendly School** presents five principles that underpin a quality, child-friendly school: i) inclusiveness; ii) effective for learning; iii) healthy and protective of children; iv) gender sensitive; and v) involved with children, families and communities.
- The USAID **Safe Schools** model is an integrated set of interventions at the national, institutional, local and individual levels, including: national-level awareness raising activities with a range of stakeholders; a teachers' Code of Conduct; teacher training to recognise, prevent and respond to GBV; and community-level awareness-raising.
- ActionAid's **Transforming Education for Girls in Nigeria and Tanzania** (TEGINT) programme includes a combination of girls' clubs, teacher training, and support to school management mechanisms.

with a specific mandate to support students at risk of violence. These studies used a range of methods, including: RCT; quantitative; non-RCT; qualitative.

Only four of these studies measured the impact of the intervention specifically in terms of a reduction in violence in schools.¹⁷ These were all of the NGO interventions and one was an RCT, which has not been completed. However, all the studies measured risk or protective factors, including: pupil's knowledge of their rights and mechanisms to report violence and their perceptions of safety; teachers' understanding

¹⁶ This RCT is on the Raising Voices' Good Schools Toolkit in Uganda and is currently being conducted by the London School of Hygiene and Tropical Medicine.

¹⁷ These are two studies of Plan International interventions (Leach et al., 2013; Reilly, 2014), one of Save the Children's Rewrite the Future Global Evaluation Final Report (Save the Children, 2011), and the Raising Voices RCT, which is still underway (Devries et al., 2013).

and attitudes to violence; girls' enrolment, attendance and attainment; increased parental support to girls; and improved mental, sexual and reproductive health, including reduced pregnancy rates.

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG – In general, there is weak evidence on whether or not whole school approaches reduce violence, either generally within the school environment, or specifically against girls and women. Also, due to the multi-pronged nature of a whole school development approach, it is not easy to make clear attributions about a reduction in violence. Of the three completed studies that measure impact on reduction of violence, there is an indication that violence has been reduced. However, this largely relates to corporal punishment by teachers, rather than specific violence against girls or violence between pupils. Further, the studies are not particularly rigorous, incorporating un-triangulated data collected from student focus group discussions. One study found that corporal punishment had been reduced; however, this was attributed to the establishment of participatory school codes of conduct, rather than to a holistic whole school approach. Another found that whilst there had been a reduction in corporal punishment, this had been replaced by other forms of punishment (such as collecting water) and there did not appear to have been a reduction in sexual violence. The studies did not measure the long-term effects of interventions on children as they grow.

Impact on risk factors for VAWG – The identified evaluations showed some positive results in terms of other violence related outcomes. A 2009 evaluation of the UNICEF Child Friendly School global portfolio, including 150 child-friendly schools (as defined in the box 'Examples

of whole school approaches') in six countries, found: that students generally felt safer and more supported in child-friendly schools; and that; on average; female students had more positive feelings about safety than male students (UNICEF, 2009). A 2008 review of the USAID Safe Schools programme in Ghana and Malawi found positive shifts in knowledge and attitudes among teachers and students, and improved teachers' understanding of how to report school-related GBV (USAID and DevTech, 2008).

These whole school approaches also showed positive outcomes in terms of: improving school enrolment and attendance;¹⁸ improving girls' school performance;¹⁹ and improving girls' self-confidence and other capabilities. A few studies also noted an improvement in teacher and parent understanding of and attitudes to violence.

3.4.2 School curriculum-based interventions (in combination with community outreach)

Types of evidence:	Evidence of effectiveness of intervention:
I: Evidence obtained from at least one properly randomized controlled trial.	C. The existing evidence is conflicting and insufficient because most did not measure an impact on VAWG. This applies to interventions at all education levels.

Description of the interventions:

Stand-alone in-school interventions that specifically aim to increase students' knowledge about and attitudes towards violence usually include informational sessions delivered through students' curricula, school assemblies, or smaller group sessions. These sessions are sometimes complemented by life skills work, to build students' capacity to respond to violence through recognising what constitutes violence, including CSA, saying no, and reporting violence. Interventions at the primary and secondary level are sometimes curriculum-based, taking part within the regular classes. Whilst these are often one-off events, some projects use weekly lessons spaced over several weeks; the longest appears to be 15 weeks (Espelage, 2013). At post-secondary level, interventions tend to use universities to deliver a range of theatre, role-play, live educational workshops, televised educational workshops, and peer education interventions. This type of intervention originated in the US, and many of the individual studies reviewed by us are from the US.

Summary of evidence available:

Our search found: two systematic reviews, one on school-based education programmes

to prevent GBV; and one on child abuse maltreatment programmes, including in-school interventions (Mikton and Butchart, 2009; Zwi et al., 2007); plus 26 individual studies on curriculum based interventions, ten from tertiary institutions, and 16 from primary and secondary schools. The majority of the studies are from North America, with 21 of the 26 studies from the US and Canada. The remaining five were from Uganda, Taiwan, India, Tanzania and Malaysia. The Love Journey programme in Vietnam is currently undergoing evaluation.

Of the 26 studies: 20 were control trials, including seven RCTs and 13 non-RCTs; and four were other types of quantitative or mixed studies. Two appeared to have no control group; three used other types of methodologies, including one qualitative study and one longitudinal study; and one had no information on its methodology. Only four of the 26 studies measured the impact of interventions on violence reduction. In terms of broader outcomes, the majority of the studies measured: changes in knowledge about violence and attitudes towards it; and changes in self-protection skills and behaviour.

Only two of the studies (Achyut, 2011; Wurtele et al., 1986) tested different types of treatment interventions, combining education with

¹⁸ For example, among rural primary school girls in Nigeria in TEGINT.

¹⁹ Measured through test scores in Nigeria in TEGINT.

skills building. Moreover, it was often unclear how studies controlled for attrition - between the pre-test and intervention, or during the intervention, if it was more than a one-off session.

Effectiveness of the intervention:

Impact on perpetration or experience of VAWG – This assessment found that there is little evidence of actual change in levels of violence as a result of these interventions. In

Examples of school curriculum approaches:

Gender Equity Movement in Schools (GEMS) in India (coordinated by ICRW) and **Love Journey** in Vietnam (coordinated by Paz y Desarrollo) use a combination of the cognitive-affective approach and life skills, undertaken in institutional settings, to bring about transformative and sustained change in attitude towards violence prevention. The curriculum (adapted for different settings) engages boys and girls between the ages of 11-14 in collective critical self-reflection through group education activities, enabling them to recognize and challenge inequitable gender norms and the use of violence in their everyday lives. Group reflection reciprocates and reinforces the processes of individual change among students. This is coupled with school-level campaigns and orientation workshops with teachers, parents and the local community. In Vietnam, in-school counsellors also augment the intervention.

the few cases where school-based or college-based studies measured the impact on rates of violence, the results were always insignificant, non-existent, or mixed (Achyut, 2011). One RCT

(Breitenbecher, 2001) in the US (a 90-minute sexual assault educational session focusing on psychological barriers to resistance) found that it was unsuccessful in reducing sexual assault. Another non-RCT in India (Achyut et al., 2011) found a reduction in school based violence perpetrated by boys in the campaign arm of the trial - but not amongst participants in the group education activities arm. The one exception where a clear reduction in violence was measured was the Second Steps programme (Espelage, 2013) - a 15-week violence prevention curriculum in American middle schools, which resulted in: a substantial reduction (42 percent) in self-reported physical aggression in schools; but no significant change in verbal aggression, bullying, homophobic teasing, or sexual violence.

Impact on risk factors for VAWG – Mikton and Butchart (2009) concluded that studies showed significant improvement in children's knowledge and protective behaviours, but that these need to be monitored beyond 3-12 months, to ensure that they are indeed sustainable changes. In their review of promising school-based GBV prevention interventions, Leach and colleagues (2013) found that few of the interventions being implemented in developing country contexts have been evaluated formally, in terms of longer-term attitude change or behaviour change. The findings from the first phase of GEMS found that girls and boys who participated in the school-based curriculum and campaign activities were more likely to develop gender-equitable attitudes toward gender roles and norms. On the other hand, studies in the US and Malaysia have found that attitudes toward dating violence and inappropriate touching by relatives are difficult to shift (Fay and Medway, 2007; Weatherly et al., 2007). A study from the US (Drake et al., 2003) found that children had a harder time understanding emotional abuse than other kinds of abuse.

3.4.3 Interventions to increase girls' school attendance

Types of evidence:	Evidence of effectiveness of intervention:
I. Evidence obtained from at least two properly randomized controlled trials on the link between WASH, provision of menstruation pads and economic interventions and school attendance, but not on links to violence reduction.	F. There is insufficient evidence (in quantity and quality) to make a recommendation for any of the sub-areas.

Description of interventions:

This section looks at interventions that aim to address barriers to girls accessing school and gaining an education (which are frequently used in education programming) and their impact on reducing VAWG. These include interventions to reduce the direct and indirect costs of schooling, by: providing school uniforms, scholarships, removal of school; providing non-conditional cash transfers, or incentivising school attendance or progression through conditional cash transfers, or providing school meals on attendance.

Other school attendance interventions include those to improve the school environment through: building or improving water, sanitation and hygiene (WASH) facilities, where toilet areas are seen as inadequate and as sites where VAWG can take place; as well as the provision of space next to the toilets to change and wash menstrual pads.

Summary of evidence available:

This review did not identify any studies that specifically explored the impact of school-based economic incentive or infrastructure improvement interventions on VAWG. We only found intervention evaluations measuring an

impact on educational outcomes including girls' attendance, drop-out and progression. Specifically, we identified three RCTs, two quantitative studies, and two secondary data analyses looking at interventions designed to reduce the direct cost of schooling. In addition, we found one RCT, two quantitative non-RCT studies, and four secondary analyses on conditional economic incentives, plus one systematic review of 35 studies comparing conditional and non-conditional cash transfers to improve educational outcomes in Africa, Latin America and South-East Asia.

In terms of infrastructure and WASH studies, despite the research showing girls' concerns about violence taking place around WASH spaces, we found no individual studies on the link between infrastructure provision and VAWG in schools. We did, however, find a systematic review, plus four individual studies (including two robust RCTs), and two qualitative studies analysing the impact of sex-specific toilets and the provision of menstrual pads on girls' school attendance.

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG – Neither the economic nor infrastructure/WASH studies measured the direct impact

of interventions on VAWG. As such, there is insufficient evidence on the impact of these approaches as they relate to VAWG.

Impact on risk factors for VAWG – A number of studies suggest that there are positive outcomes for both conditional (CCT) and unconditional cash transfers (UCT) on school enrolment for girls and boys (Baird et al., 2013; Karim, 2014). There is considerable debate about the relative importance of conditionality in cash transfer programmes, and it appears that it is the strict enforcement of conditions that is important. However, there remain questions about costs related to high levels of monitoring and enforcement of the conditions. Reducing the cost of schooling also has positive outcomes on school attendance and drop out (Barrera-Osorio, 2008; Cho et al., 2011; Hallfors et al., 2011). A smaller number of studies link improvement in school attendance or drop out to wider gender-related measures, including impact on STIs and early/child marriage, which may have relevance to reducing IPV in the short-term or long-term. Two of the strongest studies we found in terms of study design (the Zomba cash transfer programme (Baird et al., 2012), and the Reducing HIV in Adolescents (RHIVA) trial in South Africa (Karim, 2014)) both show a reduction in STIs.²⁰ In a number of studies where school attendance and child marriage were measured, more mixed results were seen. Evaluations of interventions done in Ethiopia (Erulkar and Muthengi, 2009) and Zimbabwe (Hallfors et al., 2011), which used economic incentive packages to increase school attendance, found that child marriage was delayed, while school attendance increased.²¹ However, two studies done in Bangladesh, both using microcredit and other strategies to increase school attendance, saw increases in marriage rates amongst participants (Amin and Suran, 2005; Shahnaz and Karim, 2008). These contrasting findings

may be due to the different social pressures regarding early marriage. However, as early marriage is a potential risk factor for IPV, these studies also point to complex outcomes in such interventions.

We found little evidence that the provision of WASH facilities increased girls' attendance at school. Birdthistle and colleagues, (2011) and Unterhalter and colleagues (2013) found that there is insufficient evidence of the impact of the provision of separate toilets for girls on their primary and secondary enrolment and attendance. One RCT in Kenya (Freeman et al., 2012) found no overall effect of school WASH improvements on students' attendance; however, there were some modest improvements in female students' attendance in schools in areas not affected by post-election violence. Unterhalter and colleagues (2013) found limited evidence of impact of that the provision of menstrual supplies on girls' participation in schools. This was further supported by another RCT (Oster and Thornton, 2011) of an intervention that provided sanitary cups to female students in Nepal, which found no impact of access to the menstrual cup on school attendance.

²⁰ While the Zomba trial suggests a number of potential ways this may have happened, including girls changing sexual partners for younger men, the RHIVA trial presents a mixed picture, with little clear evidence currently reported on why HSV2 may have changed.

²¹ CCTs in Ethiopia and a feeding programme in Zimbabwe.

4. Discussion and Recommendations

4.1 Overall strengths, gaps and limitations in the body of evidence

There has been an impressive increase in the evidence base for violence prevention interventions in the last ten years. We now have several well conducted RCTs in LMICs showing some success in preventing VAWG in programmatic timeframes. The evidence base is continually expanding and there are many rigorous impact evaluations of programmes in the pipeline. However, there are still many gaps and limitations in the evidence base.

Limited rigorous evidence from LMICs and comparison across studies is difficult:

Most rigorous evaluations of interventions to prevent VAWG are from the US and other HICs and there has been little testing done on how these programmes might be adapted or applied in low-income and middle-income settings. We also found: that many of the evaluations were not rigorously designed; many were lacking a specific and limited number of primary outcomes, baselines, or rigorous data analysis. Many of the studies had small sample sizes, which may result in null findings reported due to underpowered studies, rather than due to a definite absence of intervention effect. Further, across the studies identified, there is a wide range of methods and outcome measures used, as well as different timeframes, so it is difficult to make accurate comparisons.

Small sample sizes and few interventions with large target groups:

Further, most evaluations included in this assessment are on interventions that target relatively small groups of people. While these

are important first steps in developing the evidence base we need to know much more in terms of which interventions are scalable. VAWG is a hugely pervasive issue that requires large-scale solutions. In this regard, there appears to be a large gap in the evidence on interventions that target large groups of people, for example at the workplace, and other institutions.

Some intervention types have received more attention than others:

Overall, this review did not identify any intervention types that have what could be considered a very strong evidence base to recommend them, highlighting the need for more research across the board. Nevertheless, some intervention areas have received more attention than others. For example, school-based interventions, microfinance interventions, relationship-level interventions and parenting interventions have a larger evidence base. On the other hand, complex and multi-component interventions to transform masculinities or change social norms are sorely under-researched.

There is also relatively limited evidence on the particular forms of intervention that may be relevant, especially for vulnerable groups of women and girls, men and boys (for example lesbian and transgender women, those living with disability, those living with HIV and various religious and ethnic minorities).

Few studies measure impact on VAWG:

Many evaluations of violence prevention interventions fail to measure rates of VAWG as an outcome, making an assessment of their effectiveness difficult. Across evaluations, indicators of VAWG and related risk factors vary widely in nature and in data collection method, making comparisons across settings difficult.

This is likely due (in part) to the fact that measuring the incidence and prevalence of violence is challenging (as discussed in Paper 1). However great methodological strides have been made in this area in recent years and greater effort needs to be made to measure VAWG in rigorous and consistent ways that enable comparisons to be made across evaluations.

Key evidence gaps:

- Limited evidence from LMICs.
- Particularly limited evidence on some intervention types, i.e. transforming masculinities and social norm change.
- Limited evidence on interventions especially relevant for vulnerable groups.
- The majority of evaluations do not measure violence as an outcome.
- The majority of evaluations assess the impact on direct recipients of the intervention and not at a community or population level.
- Indicators vary widely in nature and in data collection, making comparison difficult.
- Limited synthesis (across interventions) of key pathways through which interventions may be achieving their impacts.
- Short follow-up means we understand little about how change is sustained.
- For multi-component interventions, it is difficult to attribute outcomes to various intervention components.
- Limited evidence on scalability of interventions.

There is overreliance on the use of attitude measures as proxies for behaviours:

Some evaluations show changes in risk and protective factors related to VAWG, for

example attitudes towards violence. They should not be a replacement for measures of VAWG. However they are still useful because achieving secondary outcomes such as increased well-being, decision-making capacity and knowledge or attitudes related to VAWG demonstrate incremental movements in the right direction (Beardon and Otero, 2013).

Nevertheless, there is an over-reliance on the use of attitude measures as proxies for behaviours and this assumption of linear progression from attitude change to behaviour change is not fully convincing.

Few studies measure impact on VAWG at the community or population level:

Even when an evaluation has measured a direct impact on violence, it has been almost exclusively among direct intervention recipients or their partners. Very few evaluations have measured an impact on VAWG at the community level or population level. The field of violence prevention needs to identify approaches to prevent violence at a community level, not just at the individual level.

There is limited evidence on intervention intensity and sustainability:

A number of the study findings suggest that in order for violence prevention interventions to be effective they need to be of sufficient duration and intensity. For example, the GEMS school-based intervention in India (see the case study box in section 3.4.2) found a greater impact on boys' attitudes after two years compared with one year. However, in many cases it is not clear what is optimal in terms of balancing cost-effectiveness and impact. For example, one-to-one interventions with pregnant women in HICs showed a marked reduction in IPV, but they require a lot of resources that may not be available in LMICs. It would be worth exploring

whether or not a reduced package of support or the use of trained volunteers (rather than healthcare professionals) might also lead to a reduction in IPV for at risk pregnant women as well as other vulnerable groups.

In addition, the vast majority of studies are characterized by a short follow-up and measures of short-term outcomes. Therefore we do not yet understand much about whether change is sustained or indeed how it is sustained if it is. Some studies that did assess sustainability, for example two cash transfer studies, found that the impacts were not sustained over longer timeframes.

There is a lack of synthesis on key pathways to achieving impact:

Some studies have been successful in increasing our understanding of change processes and identifying mediators of change. However, for the most part, there has been relatively limited synthesis across interventions of what may be the key pathways through which different interventions may be achieving their impact. For example, the conflicting evidence on the impact of microfinance programmes on women's experience of violence suggests that the pathways of change are context specific. It remains unclear if pathways for change relate to reduced levels of economic stress in the household, social capital and the establishment of new social norms regarding violence, empowerment effects, or to other things. As another example, studies found collectivization or group-based initiatives effective in reducing violence targeted at vulnerable groups such as FSWs. However, it is not clear from the studies what it is about the collective action by a vulnerable group that can lead to a reduction in violence. For example, is it the growing self-awareness of individuals, or a perceived common goal and support from the group combined with awareness raising with the local community and perpetrators that

together leads to violence reduction? Are there particular vulnerable groups who benefit most from collective action in terms of a reduction in VAWG?

It is difficult to attribute outcomes between intervention components in multi-component interventions:

Whilst many studies suggest that it is important to take a holistic approach to prevention (for example, a whole school approach), it is difficult to attribute outcomes to specific intervention components for these forms of intervention. For example, how much do girls' clubs contribute to violence reduction, compared to a teachers' code of conduct? While all components may be necessary and serve to reinforce each other, in order to assess cost-effective prevention it would be useful to better understand what minimum package of components are required in order to ensure the greatest impact on VAWG. More sophisticated research is needed to understand if all parts of multi-component interventions are necessary, or if individual components are sufficient on their own.

4.2 Summary of the evidence

Overall, this assessment found that while **many intervention evaluations show an impact on risk factors** related to violence (such as attitudes, school attendance, sexual practices, alcohol use, harsh parenting and others), evaluations that demonstrate a significant **impact on women's experiences or men's perpetration of VAWG are still relatively rare**. This is in part because, as discussed above, many evaluations fail to measure VAWG as an outcome. In other cases, when VAWG is measured, we failed to find a change in rates of violence. This may be because interventions lack the intensity required to lead to changes in VAWG, or because interventions do not fully understand or address the pathway from

a risk factor to experiences or perpetration of violence. This suggests that interventions need to have a more rigorous theory of change (TOC) in order to prove most successful.

Of concern is the fact that **there are some areas of intervention that are receiving substantial investment, but where there is limited evidence of effect.** For example, there is significant interest amongst the aid community and national governments of reducing the cost of girls' education through economic incentives and also in improving school infrastructure, including WASH facilities to increase girls' attendance at school. These are generally demand driven, as girls, parents and communities often see these as some of the main barriers to girls' education (Kerr-Wilson, 2014; Khan, 2014). Both these types of interventions, however, make the assumption that by removing specific barriers to girls' attendance they will enrol in school and learn. Some WASH interventions also make the specific assumptions that provision of these facilities will automatically lead to violence reduction. However, without investing in other areas (such as increasing numbers of teachers, improving the quality of teaching, addressing social norms, attitudes and behaviours that lead to gender inequality and VAWG), there is no guarantee that girls will learn or be protected from violence through these interventions alone. Bystander interventions and some types of parenting interventions also did not show any robust evidence of impact on VAWG, but are being rolled out widely. We suggest that it is as important for donors and programmers to pay attention to negative evaluation findings to refine prevention priorities, as it is to look at positive results.

Even where interventions did demonstrate an impact on VAWG, the findings were often inconsistent. For example, **we are yet to see an intervention that has effectively reduced both men's perpetration and women's**

experiences of violence at the same time, with evaluations tending to report a change in one, but not in the other. Furthermore, where evaluations have measured the impact on different types of violence, we often see evidence of an impact on physical violence, but not on sexual violence, or visa versa. This is supported by the literature outlined in Paper 1, which shows that there are some unique drivers of sexual and physical violence. Clearly, **prevention interventions have not yet been fully optimized** and further work is required to improve our approaches, understand and address different pathways to violence and measure the impact of interventions on different types of violence.

In general, the assessment found that **multi-component interventions that engage with multiple stakeholders tend to be more effective in preventing VAWG than single-component ones.** Media campaigns were more effective when combined with locally targeted outreach efforts and training workshops. Livelihood programmes alone had significantly less impact than interventions that combined economic interventions with gender training. Two studies showed that combining in-school awareness raising and skill building works better than either approach on its own. The relative success of multi-component interventions makes sense in light of what we know about VAW: that there is no single cause, but multiple drivers across multiple levels of the social ecology (discussed in Working Group Paper 1). Harmful masculinities, for example, are embodied and reproduced across all levels of society. It is therefore logical that interventions that address multiple risk factors for violence, influence various stakeholders, and seek change across several settings, show the most promise. Some studies also showed the potential benefit of integrating violence prevention into existing platforms, such as microfinance and education, which could allow scalability.

The assessment also reveals that **gender transformative approaches are more effective** than interventions that simply target attitude and behaviour change. This is true for parenting programmes and addressing gender socialization and men's roles in care giving; economic interventions that also aim to transform gender relationships. In addition, whilst current evaluation evidence on interventions with boys and men is limited, evidence points to greater effectiveness by those interventions classified as gender transformative or those focused on addressing masculinities (Dworkin et al., 2013). Such interventions explicitly address the norms, behaviours, and relations associated with ideals of manhood, rather than just specific behaviours or attitudes. On the other hand, interventions that focus on changing infrastructure or providing services, such as WASH facilities in schools, without addressing the gender and power dynamics that underlie violence, appear to have little impact.

There is emerging evidence that **interventions that work with both men and women are more effective than single-sex interventions**. Typically, intervention types have been segregated into those targeting women's empowerment and those working with men and boys. For example, the majority of economic interventions primarily target women, which is not surprising given that women experience the overwhelming majority of IPV, which is linked to their social and economic dependency on men. The majority of bystander interventions, on the other hand, target boys and men. However, there is evidence to suggest that this separation is not conducive to long-term social change. As such, group education interventions have evolved from working with single sex groups to working with both sexes simultaneously or sequentially. And there are compelling arguments for including poor, economically marginalized men in economic interventions,

especially when these are linked with gender-transformative components.

A number of evaluations across intervention types strongly suggest that **some element of face-to-face engagement is necessary to achieve lasting social and behavioural change**, and that skill building elements are also important. For example, the Bell Bajao campaign reached millions of people through radio, television and social media, but its community outreach component was key to its success.

Table 4 presents a summary of the evidence for different types of interventions designed to prevent VAWG. Darker colours represent stronger evidence, i.e. fair evidence compared with insufficient evidence. Green suggests that the interventions have been shown to be effective in preventing VAWG; blue suggests they are promising, in that they have been found to have an impact on risk factors, but not on outcomes of violence directly. Orange means the evidence is conflicting, that is, some evaluations show that they are effective and others show that they are not. Red illustrates that the interventions have been found to be ineffective in preventing VAWG (although they may be effective in achieving other important goals not related to VAWG).

Table 4: Summary of evidence for different types of interventions to prevent VAWG

Impact of intervention	EFFECTIVE (Impact on VAWG)	<ul style="list-style-type: none"> • Microfinance and gender transformative approaches • Relationship-level interventions • Group education with community outreach (men/boys) • Community mobilization – changing social norms 	<ul style="list-style-type: none"> • Social empowerment interventions with vulnerable groups • Alcohol reduction programmes (limited evidence from LMICs)
	PROMISING (Impact on risk factors only)	<ul style="list-style-type: none"> • Parenting programmes 	<ul style="list-style-type: none"> • Whole-school interventions
	CONFLICTING	<ul style="list-style-type: none"> • Bystander interventions 	<ul style="list-style-type: none"> • School curriculum-based interventions
	INEFFECTIVE		<ul style="list-style-type: none"> • Single component communication campaigns • WASH interventions in schools
		FAIR EVIDENCE	INSUFFICIENT EVIDENCE

Fair evidence for

Despite the limitations in the evidence base, overall this rapid review concludes that in terms of preventing VAWG there is **fair evidence** to recommend: relationship-level interventions such as Stepping Stones; microfinance combined with gender-transformative approaches, such as IMAGE; community mobilization interventions to change social norms, such as SASA!; interventions that primarily target boys and men through group education combined with community mobilization; and parenting programmes.

Overall, there is strong evidence of the effectiveness of relationship-level interventions grounded in gender theory to reduce rates of IPV, however, more is needed to understand what leads to a decrease in violence perpetration for wider prevention. It has been proven that one-off workshops, when not grounded in change theories, are not effective. When looking at interventions that are solidly grounded in gender theory, there is no consensus on the number of sessions required to achieve positive outcomes, but there seems to be an emerging consensus that both single-sex and mixed-sex discussions are necessary to effect changes within couples (Flood, 2013).

The current evidence suggests that community-based social norms interventions are most effective when combined with workshops. The evaluation of the SASA! intervention model illustrates the strength of multi-level, community diffusion strategies, for violence prevention through community responses to violence and personal change within relationships (Abramsky et al., 2014). However, given the dearth of evaluations, it remains unclear: what the mediators of change within communities are and how they work; how shifts in attitudes and social norms relate to changes in behaviour; how sustainable changes are over time; and what inputs are needed for such sustainability. More rigorous evaluations are needed, including longitudinal studies, and greater effort is required to evaluate multi-component interventions in a sophisticated and comprehensive way.

With regards to interventions that primarily target boys and men through group education combined with community mobilization, Dworkin et al point out that such interventions “may reach more individuals with more efficient use of resources, and help to sustain long term transformation in gender norms compared to current programming by introducing change in entire communities” (2013: 2860-1). More research is needed into the effectiveness of such interventions, utilizing large target groups of both sexes over longer periods. It remains uncertain which components of community mobilization strategies most affect sustainable behaviour and social norm change.

Overall, the impact of building women’s productive assets, as a strategy to reduce their experience of VAWG, typically shows promise, but is limited by: few studies having VAWG as a measured outcome; weak research designs. There is stronger evidence that interventions that sought to tackle economic and social factors simultaneously had consistently

stronger positive outcomes than interventions that focused on economic factors alone.

Insufficient evidence

Currently, there is **insufficient evidence** to recommend single component communication campaigns as a means of preventing VAWG, but the evidence that does exist suggests that they are not intensive enough to prevent VAWG. Alcohol reduction programmes show promise in HICs, but more evidence is required from LMICs; and it appears that such interventions should be combined with broader prevention initiatives in order to be of most use in the prevention of VAWG.

There is insufficient evidence on school-based interventions, mainly because they have not measured VAWG as an outcome sufficiently, but they show promise in reducing risk factors for violence. Whole of school approaches appear to have the most promise and whilst few robust experimental studies exist on the ‘whole school approach’, evaluations have identified some key findings and examples of good practice, including the importance of:

- Having clear policies in place to address violence in schools;
- Promoting training and open discussion among school staff and management; and
- Basing work on grounded, context-specific research (particularly qualitative studies) and involving young people in this research (where possible).

More research is needed to understand the best delivery method of school-based curriculum; however, in general, our review found that the more effective interventions were those that: combine education with skills training; include more than a one-off activity; and are longer-term (for example two years compared to one).

Conflicting evidence

Finally, there is **conflicting evidence** on bystander programmes and school curriculum programmes, which does not allow us to make a recommendation for or against these interventions in terms of prevention. Bystander interventions are a promising intervention to improve intention to intervene in the moment or after witnessing a specific violent incident occurring. In particular, the influence of coaches, religious or community leaders, or other 'classic' male role models (such as sports stars) is related to the fact that they provide a familiar frame of reference and engagement between men (Jewkes, Flood and Lang, 2014). However, these approaches are yet to confirm an impact on violence perpetration or to prove any impact on individual attitudes or in transforming peer and social norms. Further, in drawing on existing hegemonic forms of masculinity, such approaches may fail to counter the association of masculinity with power and domination (Jewkes, Flood and Lang, 2014). Powell (2011) suggests that bystander strategies will be most effective when they exist as one component of a broader approach or of a multi-level programme in one setting. Further longitudinal research and rigorous analysis are required to build the evidence base for bystander strategies.

Recommendations for violence prevention and the global research agenda

Based on this review, we make the following recommendations for funding, programming and for the global research agenda:

- **Innovate:** This review only assesses evidence from existing evaluations of prevention programmes. This means that there may be many promising prevention programmes being implemented that have not been evaluated. Therefore, we cannot rely only on what we currently know; the field must continue to innovate, try new strategies and push boundaries.
- **Use consistent research methods:** More consistent and rigorous methods for evaluation of violence prevention programmes should be developed and implemented, in order to ensure comparability across studies and interventions.
- **Measure impact on VAWG:** Evaluation of violence prevention interventions must measure the impact of the intervention on rates of VAWG - not just on related risk factors.
- **Have and test a clear TOC:** Violence prevention interventions should have a clear TOC that is based on a thorough understanding of the context. Evaluations of such programmes should be based on testing that specific theory of change.
- **Promote and evaluate multi-component interventions:** Where possible, prevention programmes should employ multi-methods, target multiple risk factors, work with multiple stakeholders or work across multiple settings. Interventions that work in a particular setting or institution should take a holistic approach across a certain setting, for example a whole school approach, or a whole family approach. To test such multi-component programmes, more sophisticated research should be developed to understand if all parts of multi-component interventions are necessary, or if individual components are sufficient on their own.

- **Measure community level impact:** More interventions should aim to have a broad impact on community level violence, rather than just on individual behaviour (of those undergoing the intervention). Similarly, evaluations should measure the community level and population level impact on violence.
- **Assess costs and scalability:** Given the dimensions of the problem, any intervention to prevent VAWG needs to be implementable and scalable in LMICs. There is a great need for more research to understand what interventions are scalable, how they can be scaled and if they can be implemented affordably.
- **Implement and evaluate programmes for different populations:** More interventions targeting vulnerable populations, ethnically diverse populations and older populations, should be developed and evaluated. While the focus of prevention should be on impacting the largest number of people, more research is needed to understand the types of interventions that would be most relevant for different population groups, including particularly vulnerable groups of women and girls.
- **Research pathways to change:** More research should be conducted on the key pathways through which different interventions may be achieving their impacts.

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