EXECUTIVE SUMMARY

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

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

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

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

Cover photograph: Peter Caton.

ABOUT WHAT WORKS

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

Full report available at: https://whatworks.co.za/resources

THE AGA KHAN UNIVERSITY

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

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

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

Methodology

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

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

To be included, studies had to:

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

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

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

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

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

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

2 See Acknowledgements section for details of peer reviewers

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

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

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

TABLE 1: CLASSIFICATION OF INTERVENTION CATEGORIES BY EFFECTIVENESS

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

Limitations

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

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

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

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

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

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

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

Findings

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

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

TABLE 2: INTERVENTION EFFECTIVENESS FOR THE PREVENTION OF VAWG

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

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

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

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

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

Good evidence of effectiveness in reducing VAWG

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

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

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

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

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

Promising but insufficient evidence of effectiveness

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

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

Conflicting evidence

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

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

Good evidence of no effect

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

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

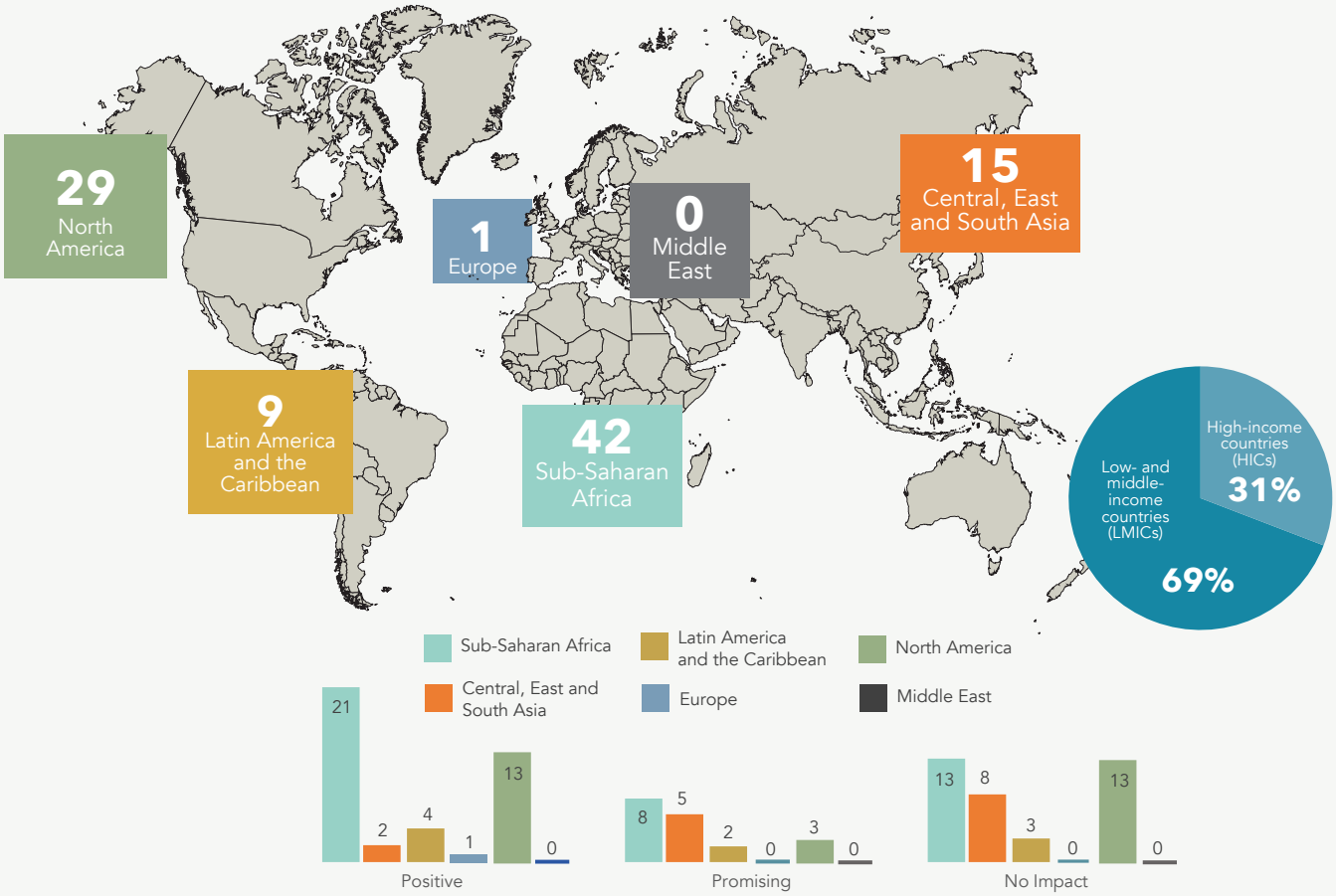
Insufficient evidence and no effect

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

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

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

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



KEY POPULATIONS

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

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

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

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

FOR DONORS:

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

Priorities include:

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

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

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

FOR PRACTITIONERS:

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

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

4. INNOVATE

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

FOR RESEARCHERS:

5. INCREASE THE RIGOUR OF RESEARCH METHODS

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

6. REPORT EVALUATION STUDIES USING STANDARDISED APPROACHES

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

7. MEASURE IMPACT ON MULTIPLE FORMS OF VAWG

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

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

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

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