What works to prevent violence against women and girls?
Evidence Review of interventions to prevent violence against women and girls

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Acronyms

ADHD	Attention Deficit Disorder
CSA	Child Sexual Abuse
FSWs	Female Sex Workers
GBV	Gender-Based Violence
HICs	High Income Countries
IPV	Intimate Partner Violence
LMIC	Low and Middle Income Countries
MSM	Men who have Sex with Men
ODD	Oppositional Defiant Disorder
RCT	Randomized Control Trail
STI	Sexually Transmitted Infection
VAW	Violence Against Women
VAWG	Violence Against Women and Girls

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1. Introduction

Violence against women and girls (VAWG) is one of the most widespread abuses 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. Violence against women and girls is a fundamental barrier to eradicating poverty and building peace. Even the most conservative estimates measure national costs of violence against women and girls in the billions of dollars.

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'. These include genetic endowment, developmental history, personality profile, relationships dynamics, household and community structures, and the macro- and global level forces that shape prevailing norms, access to resources, and the relative standing 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.

The purpose of this paper is to examine the evidence base for the effectiveness of interventions to prevent violence against women and girls. This rapid assessment, along with the other working group papers, is designed to:

- inform the development of the *What Works* 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.

In this paper we examine interventions that seek to specifically reduce different types of violence against women and girls as an outcome, and those that target key risk factors for violence perpetration and experiences. It is not an exhaustive list of interventions, but focuses on the most common and promising intervention areas, grouped by entry points or platforms.

First, this review considers interventions attempting to raise awareness and change social norms, particularly around the acceptability of violence. Within this broad category we consider one dimensional communication and advocacy campaigns and multi-component community mobilization campaigns. Secondly, we examine social and economic empowerment interventions. These have the potential to prevent violence given the strong qualitative evidence that women's economic and social disempowerment and economic dependence on men both make them vulnerable to experiencing violence, and less able to challenge or leave violent situations. Recognising that men are the primary perpetrators of violence and key partners in creating change, prevention interventions have increasingly focused on engaging men and boys, along with women and girls often through school, peer or relationship interventions. These are the focus of section three. There is strong evidence on the association between adverse childhood experiences and later experiences or perpetration of VAWG, thus early childhood interventions are an important prevention area discussed in section four. Finally we present interventions operating at the individual level to tackle alcohol abuse and depression, as key risk factors for VAWG.

The first half of the paper presents a summary of the evidence by broad intervention typology including 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 violence against women and girls. 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, presenting 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.

2. Methodology

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

This assessment has drawn extensively from existing systematic and comprehensive reviews (see Annex 1 for all reviews consulted). 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, UN and other international agencies, international NGOs, and research institutes. Our search strategy was reliant on published sources, but we also send out emails to VAWG networks requesting any unpublished sources – however, this yielded only a few additional studies. This assessment is not designed to be a systematic review and is by no means all-encompassing. In particular we recognise that the assessment does not include many of the qualitative evaluations of interventions, primarily because they were unpublished and difficult to access.

The review looked for evidence of impact on both long-term impact (e.g. reduction in VAWG), and if this is not available evidence of impact on intermediate outcomes such as reduction in disempowerment and other relevant risk factors at individual, family, community or societal level.

Our inclusion criteria consisted of the following:

- *Completed* reviews or individual studies (including RCTs, quasi-experimental studies, cohort evaluations, qualitative studies, pre- 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

- Studies from high-, medium- and low-income, and from development, humanitarian and conflict-affected contexts

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

For the evidence ratings, we adapted the evidence criteria from the Canadian Task Force on Preventative Health Care, ensuring that they were broad enough to cover different sectors and intervention types (i.e. not just health) and would 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, defined as follows.

Quality of evidence assessment	Classification of Recommendations
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II–1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II–2: Evidence from well-designed cohort (prospective or retrospective) or case-control	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making

II–3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	E. There is good evidence to recommend against the clinical preventive action
	F. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

3. Summary of Evidence

3.1 Raising awareness and changing social norms

Historically VAWG has often been considered a private issue and been shrouded in 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 a recognition that changing individual attitudes may not be enough to end violence and a greater emphasis has been placed on more comprehensive, multi-component efforts to change social norms. This section considers both media and communications campaigns and more comprehensive community mobilization interventions.

3.1.1 Communications and advocacy campaigns

Types of Evidence:
I: Evidence obtained from four evaluations but no control groups

Evidence of effectiveness of the interventions:
F. There is insufficient evidence (in quantity or quality) to make a recommendation.

Description of the interventions:

A wide array of interventions to prevent violence against women and girls could be labelled communications campaigns, and they range in intensity and objectives. Awareness campaigns may aim to raise awareness or increase knowledge about a service, a law or about violence against women as an issue in general. Advocacy campaigns often take the form of regional or national coalitions of individuals and organisations that are encouraged to take action to influence policy changes 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

Examples of communications and advocacy campaigns

- *Search for a Common Ground's* DRC programme includes a community-based awareness raising intervention for refugees aimed to change attitudes and knowledge and provide information on how to prevent sexual and GBV and support victims.
- *Soul City* is an example of edutainment – a multi-media campaign in South Africa which combines TV and radio drama tackling a range of health and social issues, including HIV and violence against women, with distribution of print materials through newspapers, schools and civil society.
- Breakthrough's *Bell Bajao!* launched in India in 2008, is a cultural and media campaign that models constructive ways to 'interrupt' violence through simple actions, such as ringing the door bell to deliver mail, ask for sugar or other excuse. The campaign includes a series of public service announcements combined with community outreach to build a new norm supportive of intervening in violence against women.

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 behaviours 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 employed at global, regional and national levels, rigorous evaluations on their effectiveness are scarce. This assessment identified four strong evaluations on media and awareness raising campaigns, all randomized trials with no control group.[1] The evaluations measured changes in awareness, attitudes and norms but *none* measured actual changes in violent behaviour or changes in rates of violence against women and girls.

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG – To date there is *little evidenc*e that simple awareness campaigns have an impact on the prevalence or incidence of VAWG. This is partly because existing evaluations have not measured violence as an outcome, and because it is difficult to attribute changes to media campaigns. However, it is likely that single-component communications campaigns are seldom intensive enough or sufficiently theory-driven to transform norms or change actual behaviours (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 USA 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 regards 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 regarding the appropriateness of sexual harassment or the cultural acceptability of violence (Usdin et al., 2005).

Greater intensity of interventions or exposure to messaging through more than one component appears to increase the effectiveness of campaign interventions. 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 only to the media component.

3.1.2 Community mobilization and advocacy: Multi-component interventions

Types of Evidence
II–1: Evidence from at least one controlled trial without randomization, and evidence from unpublished RCT

Evidence of effectiveness of the interventions:
F.   Fair evidence to recommend this intervention

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[1] *Soul 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 mobilisation 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 United States: a random telephone survey before and after the intervention (Gadomski, 2001).

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 trainings aimed at shifting attitudes and behaviours by interrogating prevalent norms. They are often accompanied by localised campaigns and community mobilisation 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. Some community mobilisation interventions emphasise changes with men, such as the *Cambodian Men's Network, Men's Action for Stopping Violence Against Women (MASVAW)* in India and the *One Man Can* 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 and Sri Lanka Pakistan), together with a non-randomized control trial in Bangladesh and qualitative in-depth analysis of the change processes in different settings (Hughes, 2012; Raab, 2011; Rajan, 2010; William, 2011). Also included is a mixed method (quantitative and qualitative) evaluation of *Somos Diferentes, Somos Iguales (SDSI)*, mixed method impact evaluation of a *Raising Voices* programme (not SASA!) in Uganda (Raising Voices, 2003) and preliminary unpublished findings from a pair-matched cluster randomized controlled trial (CRT) in eight communities in Uganda of SASA! (Watts et al., forthcoming). The SASA!

> **Examples of community mobilization campaigns**
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> - *SASA!* is a community mobilisation intervention that was started by Raising Voices in Uganda and seeks to change community attitudes, norms and behaviours that result in gender inequality, violence and an 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.
> - *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.

Evaluation is the first study to assess the impact of a partner violence prevention intervention at a community level, rather than among direct 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 of domestic violence. Initial findings from the *SASA!* evaluation found that past year physical IPV experienced by women was significantly lower in intervention versus control communities, although there was no significant decrease in sexual IPV (Watts, forthcoming). The evaluation of another intervention by *Raising Voices* also all demonstrated a decrease in

all forms of IPV in the community (quoted in Arango, 2014). A non-randomized control trail of the *We Can Campaign* in Bangladesh found there is evidence to suggest that the campaign, where implemented with significant intensity, can reduce intra-martial violence, although primarily among the Change Makers rather than the general community (Hughes, 2012).

Impact on risk factors for VAWG – There is fair evidence that community mobilization campaigns have the potential to change risk factors for VAWG, particularly violence condoning attitudes and beliefs, however a linear relationships between attitudes and behaviour has not yet been established. For example, the evaluation of the One Man Can Campaign (Hughes, 2012) showed that whilst changes in attitudes were limited, change in perpetration was quite substantial. Initial findings from the SASA! evaluation found that the social acceptance of IPV was significantly lower for women but not for men. A qualitative evaluation of MASVAW documents some changes in behaviour of individual men, in couple relationships, and in community norms around the acceptability of violence but more research on such interventions is needed.

The current evidence suggests that community based social norms interventions are most effective with workshops. 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 including longitudinal studies are needed and greater effort is required to evaluate multi-component interventions in a sophisticated and comprehensive way.

3.2 Social empowerment interventions with vulnerable groups of women/ girls

Women's and girl's social empowerment has long formed a cornerstone of the violence prevention movement, first based on the understanding that VAWG is fundamentally about gender inequality and women's subordination. There is strong qualitative evidence that women's disempowerment and dependence on men both make them vulnerable to experiencing violence, and less able to challenge or leave situations of violence. Women's and girl's empowerment has been conceptualised in many ways, and is commonly recognised as being a process, rather than a 'state of being', per se. This section focuses on: educational interventions through schools, that may either seek to increase girls' enrolment in schools, or use schools as a vehicle for delivering complementary gender transformative intervention messaging to girls; and gender sensitisation and transformative programming, which seek to enable women and girls to imagine their world differently and to realise that vision by changing the relations of power that have kept them in poverty, restricted their voice and deprived them of their autonomy.

Types of Evidence:
I: Evidence obtained from at least one properly randomized controlled trial (RCT)
Evidence of effectiveness of intervention:
F. There is insufficient evidence (in quantity or quality) to make a recommendation.

Description of the interventions:

Similar to community mobilisation, but taking women and girls as a starting point rather than working more broadly across communities, 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 on life skills, including around rights and violence prevention, or skills around leadership and collective organising[3] with the purpose of building women/ girls awareness of their rights, how to access services and how to protect themselves against violence They can also include one-to-one support for particularly vulnerable individuals

> Examples of Social Empowerment Programmes
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> - The Oxfam Raising Her Voice programme (2008-2013) was a broad ranging portfolio of 19 projects across 17 countries working in different ways and contexts to strengthen women's participation and voice in governance. It focused on networking, advocacy, training, disseminating good practice among other activities.
> - The Sonagachi project based in Calcuttapromotes the use of health services and STI treatment for SWs to reduce HIV incidence. It includes multifaceted, multilevel interventions with SWs 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.

through home visits, typically by trained health professionals or non-professional mentors, providing training on issues around health, family roles, violence and services available[4]. These interventions are sometimes complemented by work with the girls' or women's community and or sexual partners 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).

This section focuses on social empowerment interventions targeting vulnerable groups of women and girls including Female Sew Workers (FSWs) who are highly vulnerable to violence from many men, including clients, pimps, the police, as well as their partners[5]. FSW empowerment programmes include a broad range of initiatives, from warning sex workers about men who are known to be violent; to self-defence classes; 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.

Summary of evidence available

This assessment identified 30 studies on social empowerment initiatives with poor and vulnerable women and girls that either measured the impact of interventions specifically on violence reduction or on other related outcomes. A total of 26 studies were of 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; Tawai et al., 2005; Taft et al., 2011), three quantitative non-RCT studies on interventions with women with mental disabilities (Khemka, 2000; 2005; Mittenberg et al., 1999) and one

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[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 ten weeks to two and a half years.

[4] The number of home visits varied, but in the studies we found were between six and 13 home visits to pregnant at risk women over the course of a pregnancy or a year, and ten to 12 sessions to women with mental disabilities (not including follow-up), for up to 12 weeks.

[5] Preliminary survey evaluations of violence among female sex workers in India found that between 11% and 26% had been beaten or raped in the past year (WHO, UNAIDS, 2010)

RCT on vulnerable drug users (Wechsberg et al., 2013). The other four studies were on interventions with groups of poor or marginalised girls in general 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 reduction in VAWG, which was largely IPV, apart from the sex worker studies which also included abuse by clients and the police. Other outcomes measured include 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 sex worker collectivisation initiatives showed a positive impact on reducing violence and participants' ability to better manage client risk behaviours related to violence. For example, studies of the Avahan HIV prevention programme in Karnataka showed that FSWs' membership in a collective group was associated with less experience of violence and police coercion, particularly in districts with programmes of longer duration (Karnataka Health Promotion Trust 2012; Blanchard, A., 2013). A study of the Ashodaya Samithi initiative in Mysore (Reza-Paul., S. et al., 2012) found that violence decreased by 84% over five years, and police-perpetrated violence and violence by clients decreased substantially, after a safe space was established for sex workers to meet and crisis management and advocacy was initiated with different stakeholders.

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 reductions in IPV, particularly where these visits were up to a year or more and 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 and provision of a card with details on community resources for abused women was also effective in reducing psychological but not sexual abuse (Tiwari et al., 2005). However, these studies were in HICs and required extensive resources making them difficult to replicate in LMICs. There is also some evidence to support leardership trainings with a study with low-income Latina immigrant and refugee women, reporting a decrease in incidents of coercive or violent behaviours 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 collectivisation interventions reported an impact on women's self-esteem, acceptance of IPV, their ability to challenge male behaviour, and resist unequal relations in the family (Brandl et al., 2003; Unterhalter et al., 2013), knowledge of pregnancy and STI symptoms, savings, self-confidence and social capital (Engebretsen, 2013). In Brazil, a study of Fio da Alma, which established a drop-in centre to create a safe space for sex workers to access health services and mobilize for collective action, found that participants' ability to manage client risk behaviours related to alcohol, drugs and violence increased significantly pre–post intervention (Kerrigan, 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, knowledge on women's right, self-confidence (YWCA Solomon Islands, 2013).

3.3 Economic interventions

There is a substantial body of evidence that outlines the multiple ways in which poverty and lack of economic autonomy for women, intersects with and reinforces gender inequalities (Jewkes and Morrell, 2010). While not necessarily 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 (Weiser et al., 2007, Dunkle et al., 2004).

This has led to an increasing number of calls to tackle the structural determinants of VAWG and more widely HIV-risk and vulnerability (Gupta et al., 2011, Gupta et al., 2008). Economic approaches targeting women and girls have been at the forefront of structural interventions, given the clear recognition of how poverty and gender inequalities are intertwined. While there has been increased focused on these approaches there has also been recognition of the fact that they occur in contexts of widespread poverty and do not transform economic systems (Kim and Watts, 2005).

Types of Evidence: I: Evidence obtained from at least one properly randomized controlled trail

Evidence of effectiveness of intervention: B: There is fair evidence to recommend combination microfinance and gender transformative approaches particularly amongst older women, however there is less evidence for younger women; and limited evidence for economic approaches alone.

Description of the interventions:

Interventions to increase productive assets and build gender equality typically seek to (i) build women's economic resources; 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 out of school, tend to receive livelihood or vocational training, whilst young women tend to receive savings interventions.

Dominant approaches to building economic resources:

1. Microfinance or village savings and loans associations (VSLA) which are group-based approaches to savings and lending to women normally excluded from formal banking/loans systems

2. Increasing access to formal savings facilities in the banking sector – often seen as a precursor to formal work/economic opportunities

3. Vocational or job training programmes that seek to build skills and knowledge of participants to seek work more effectively, develop skills for informal sector work or develop alternative livelihood strategies.

4. Cash transfers to women who care for children as a form of social protection

Many interventions also include training around gender, communication skills, HIV, and 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 mobilisation component, to work on 'gender' at the community level, although the impact of this element is generally poorly evaluated. Interventions vary significantly in length – the shortest is the Sisters for Life Programme, that has ten one-hour sessions, delivered over a six month period during the loan group meeting. The timing of these interventions are often based on cycles 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 and economic strengthening interventions alone, such as microfinance. Cash transfers directed to carers may also have a long-term benefit for children targeted through them.

The review found 75 individual and multi-country studies, which included an economic component around women's and girls' empowerment. 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 this was intimate partner or non-partner sexual violence. An additional ten studies using non-randomised 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 especially vulnerable groups of women or girls (e.g. survivors of violence, MSM, women with disabilities or HIV/AIDS, indigenous women, sex workers or other minorities). Further, very few studies assessed the sustainability of intervention impacts: 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:
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 and weak research designs. There is stronger evidence that interventions that sought to simultaneously tackle economic and social factors had consistently stronger positive outcomes than interventions that focused on economic factors alone.

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

There remains mixed evidence on the impact of social protection programmes on the mothers targeted, some suggest women experience a decrease in IPV (Haushofer and Shapiro, 2013; Hidrobo, Peterman and Heise, forthcoming), others however show no impact and one reported an increase in emotional forms of violence and controlling behaviours (Bobonis and Castro, 2010; Hidrobo and Fernald, 2013) suggesting a range of contextual factors are critical in shaping outcomes.

Impact on risk factors for VAWG - Microfinance and social interventions also show promise at shifting a range of behaviours that are potentially protective of VAWG. These include economic measures, gender/health measures, including condom use, negotiation of partner's HIV related behaviour, sexual power and number of partners. Other studies looking at savings and job training interventions combined with social empowerment components also showed a range of positive changes in proxy determinants of violence, such as increased condom use, and reduction in number of sexual partner (Hallman and Roca, 2011; Ssewamala et al., 2010). For example, one RCT in Zimbabwe showed significant improvements 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 targeting mothers to benefit their child) showed increases in positive outcomes for protective factors only for girl children, and no impact on boy-children [ref].

3.4 Changing institutions: Prevention in schools

School-based interventions aim to prevent violence in schools, and also use schools as an entry point for preventing violence against women, dating violence and sexual abuse. The analysis of school based interventions is based on systematic and non-systematic reviews, and individual and multi-country evaluations. We included a range of school-based interventions, including: 'whole school' or other holistic approaches; improving school infrastructure or services (WASH and menstrual cups); working with teachers to raise their awareness about violence and their skills to behave 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 they become deeply ingrained in youth. Bystander programmes which often take place in schools are discussed separately in section 3.5.2.

3.4.1 Whole school and other holistic approaches

Types of Evidence:
II: Evidence obtained from at least one well-designed control trial, without randomization.
Evidence of effectiveness of intervention:
F. There is insufficient evidence (in quantity and quality) to make a recommendation.

Description of the interventions:

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

- **Teachers and other staff**: teacher training including on gender responsive pedagogy and teaching specific violence prevention/healthy relationship curriculum; developing codes of conduct and manuals to address school based violence; creating or strengthening formal guidance and counselling
- **Pupils**: establishing girls or children's clubs; life skills and rights training;
- **Reporting mechanisms**: setting up boxes in school to anonymously report violence; allocating responsibility for particular staff to address 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 attitudes and behaviours towards violence;
- **National level and government:** advocacy at the national level to raise awareness and promote advocacy for prevention and response to violence in schools.

> **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.

Summary of evidence available:

This rapid review found ten studies of the 'whole school approach' including five multi-country or global portfolio evaluations and five individual studies from LMICs. Only one of these was an RCT, currently being implemented[6], the rest being largely non-randomised quantitative/ mixed method studies, two qualitative studies and one where the methodology was unclear. We also found three individual studies evaluating standalone interventions working with teachers to address VAWG, either by training existing teachers or recruiting female classroom assistants with a specific mandate to support students at risk of violence. These studies had a range of methods including RCT, quantitative non-RCT and qualitative.

Only four of these studies measured the impact of the intervention specifically in terms of the reduction of the prevalence of violence in schools[7]. These are all of the NGO interventions and one is the RCT not completed. However, all of 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 and attitudes towards violence; girls' enrolment, attendance and attainment; increased parental support to girls and improved mental and 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 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 reductions in violence. Of the three completed studies that measure impact on reduction of violence, there is an indication that violence has been reduced, but this largely relates to corporal punishment in general, rather than specific violence against girls. The studies do not appear to be highly rigorous, incorporating untriangulated data collected from students' focus groups discussions. One study found that corporal punishment had been reduced, but this was attributed to the establishment of participatory school codes of conduct rather than 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 (e.g. collecting water) and there did not appear to have been a reduction in sexual violence.

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[6] This RCT is of the Raising Voices Good Schools Toolkit in Uganda and is currently being conducted by the London School of Hygiene and Tropical Medicine.

[7] These are two studies of Plan International interventions Leach et al., 2013, Reilley, 2014, one of The Save the Chidlren Rewrite the Future Global Evaluation Final Report (Save the Chidlren 2011) nd the Raising Voices RCT still underway , Devries et al., 2013

Impact on risk factors for VAWG - There did however, appear to be 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 in six countries, found that students generally feel safer and more supported in child-friendly schools, and that on average female students have 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 teachers' improved understanding of how to report school-related GBV (USAID and DevTech, 2008) .

These 'whole school' approaches also show positive outcomes in terms of improving school enrolment and attendance[8]; improving girls' school performance[9]; and improving girls' self-confidence and other capabilities. A few studies also noted an improvement in teacher and parent understanding and attitudes towards violence.

In terms of what should be included within a whole school approach, a recent evidence review (Radford et al., 2014) of prevention and response to child sexual abuse and exploitation argues that whilst there exist few robust experimental studies 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;
- basing this work on grounded, context-specific research, particularly qualitative studies, and involving young people in this research where possible.

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

Types of Evidence:
I: Evidence obtained from at least one properly randomized controlled trial (RCT)

Evidence of effectiveness of intervention:
C: The existing evidence is conflicting and does not allow to make a recommendation for or against the intervention. This stands for interventions at all educational levels.

Description of the interventions:
In-school stand-alone interventions specifically to increase students' knowledge about and attitudes toward violence include informational sessions delivered through students' curricula, school assemblies, or smaller groups sessions. These sessions are sometimes complemented by life skills work, to build students' capacity to respond to violence, through recognising what constitutes violence, including child sexual abuse (CSA), saying no, and reporting it. Interventions at the primary and secondary level, are sometimes curriculum-based, taking part within the

Examples of school curriculum approaches:
Gender Equity Movement in Schools (GEMS) in India (coordinated by ICRW) and the **Love Journey** in Viet Nam (coordinated by Paz y Desarrollo) use a combination of the cognitive -affective approach and life skills, undertaken in institutional settings, to bring transformative and sustained changes 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, coupled with school level campaigns and orientation workshops with teachers, parents and the local community. In Viet Nam, in school counsellors also augment the intervention.

[8] For example among rural primary school girls in
[9] Measured through test scores in Nigeria in TEGINT

classroom as part of the school day. 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 United States, and many of the individual studies reviewed are from there.

From a perspective of taking primary prevention to scale, school systems provide an opportunity to reach 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 prevention of VAWG.

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 of in-school interventions (Zwi et al., 2007; Mikton and Butchart, 2009), 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 out of the 26 studies from the USA 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-randomised control trials and four were other types of quantitative/mixed studies. Two appeared to have no control group; three used other types of methodologies including one qualitative study and another longitudinal study; 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, attitudes towards it and changes in self-protection skills/ behaviour.

Only two of studies (Wurtele et al., 1986; Achyut, 2011) tested different types of treatment interventions, combining education with skills building. Moreover, it is often unclear how studies control for attrition— between the pre-test and intervention, or during the intervention if it is more than a one-off.

Effectiveness of the intervention:
Impact on perpetration or experience of VAWG – This assessment found that there is little evidence of actual changes in levels of violence. In the few cases where school- or college-based studies measured impact on rates of violence, this was always insignificant, non-existent, or mixed (Achyut, 2011). One RCT (Breitenbecher, 2001) in the USA on a 90 minute sexual assault educational session focusing on psychological barriers to resistance, found that it was unsuccessful in reducing sexual assault; another non-randomised control trial 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 is the Second Steps (Espelage, 2013), a 15-week violence prevention curriculum in American middle schools, which resulted in self-reported decreases in substantial reduction (42%) of 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) conclude that studies show significant improvements 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. Leach et al. (2013), in their review of promising school-based GBV prevention interventions, found that few of these knowledge and attitudes interventions in development contexts have been evaluated formally, in terms of their longer-term attitude 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. Studies in the United States 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 United States (Drake et al., 2003) found that children had a harder time understanding emotional abuse than other kinds of abuse.

More research is needed to understand the best delivery method, however general the more effective interventions are:

- combination interventions combining the education component with skills training
- those thay include more than a one-off activity
- longer term programmes (for example two years compared to one)

3.4.3 School attendance interventions (infrastructure, services and economic)

Types of Evidence:
I: Evidence obtained from at least two properly randomized controlled trials (RCT) on link between WASH, provision of menstruation pads and economic interventions and school attendance, but not on links to violence reduction.

Evidence of effectiveness of intervention:
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 and their impact on reducing VAWG. These include interventions to **reduce the direct and indirect costs of schooling**, through 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 water, sanitation and hygiene (WASH) facilities and provision of menstrual pads. WASH related infrastructure interventions usually include the provision of improved, sex-segregated toilets, where toilet areas are seen as inadequate and as sites where VAWG can take place, as well as provision of spaces next to the toilets to change and wash menstrual pads.

Summary of evidence available:
This assessment did not identify any studies that specifically explored the impact of economic incentive or infrastructure improvement interventions on VAWG, only ones measuring impact on educational outcomes including girls' attendance, drop-out and progression. Specifically, we identified three RCTs, two other 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/ WASH studies, despite research showing girls' concerns about violence taking place around WASH spaces we found no individual studies on the links between infrastructure provision and VAWG in schools. We did however, find a systematic review, plus four individual studies including two

robust RCTs, plus two qualitative studies analysing the impact of sex-specific toilets and 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 schooling 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 the costs related to high levels of monitoring and enforcement.

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 improvements in school attendance or dropout to wider gender-related measures, including impact on STIs and early/child marriage which may have relevance to reducing IPV in the short- 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 reductions in STIs[10]. In a number of studies, where school attendance and child marriage were measured, more mixed results were seen. Studies in Ethiopia (Erulkar and Muthengi, 2009) and Zimbabwe (Hallfors et al., 2011) that used economic incentive packages[11] to increase school attendance found that child marriage was delayed while school attendance was increased. However, two studies 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 around early marriage. Yet, 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 provision of WASH facilities increased girls' attendance at school. Birdthistle et al. (2011) and Unterhalter et al. (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 et al. found limited evidence of impact on girls' participation in schools of menstrual supplies which was reflected 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.

3.5 Intervention primarily targeting men and boys

The interventions to prevent violence against women that are directed at men have gained a momentum in the last decade, with an increased attention to measuring what works. Interventions with men are firstly based on the premises they are the ones who perpetrate this violence. Secondly, constructions of masculinity – the social norms associated with manhood and the social organisation of men's lives and relations – play a crucial role in shaping violence against women. Thirdly, men and boys have a positive role

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[10] While the Zomba trial suggests a number of potential pathways 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

[11] CCTs in Ethiopia and a feeding programme in Zimbabwe

to play in helping to stop violence against women, and they will benefit personally and relationally from this (Flood, 2013). Section 3.5 covers group education combined with community mobilization, bystander interventions plus interventions to transform masculinities.

3.5.1 Group education (outside school) combined with community mobilization

> **Types of Evidence:**
> II–1: Evidence from well-designed controlled trials without randomization
> **Evidence of effectiveness of intervention:**
> B. There is fair evidence to recommend the intervention

Description of intervention:

This section looks at interventions targeting men and combining group education and community mobilisation only. These interventions are usually implemented in LMICS (Chile, South Africa, Brazil, India) and usually train small groups of boys and men[12] between 15 and 18 years old, recruited through schools or communities, to go and mobilise others. The training sessions are facilitated by trained facilitators or peers, implemented over a few days[13], or spread out over six months[14]. Group education methods are used, often based on existing curricula and material, such as Program H or White Ribbon Campaign Education and Action Kit. Typically, they cover topics such as conceptual understandings of masculinity, gender, VAW, concepts of power in relationships, sexuality, human rights, men's participation in domestic activities. Some curricula ask men to draft personalised plans for how to make changes to their life styles. These trained boys and men then organise community events to raise awareness and engage other males against VAW, such as football tournaments, lifestyle social marketing campaigns, community dialogues, reaching an average of 1500 people.

> **The programmes directed at boys and men show an evolution in the content of interventions:**
> - 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 the emergence of regional and international networks and organisations (Flood, 2013);
> - 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).

Types of evidence available:

Four reviews recently analysed programmes engaging men; they have different foci but all included community mobilisation and group education interventions (Barker 2009, Dworkin, 2013; Flood, 2013; Ricardo, 2011). Together, 11 interventions were extracted for

> **Example of group education intervention:**
>
> **Program H** seeks to engage young men and their communities in critical reflections 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. Program 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 sites around the world.

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[12] Between 150 and 260 men are trained in average;
[13] 4-5 days for the One Man Can Campaign intervention in S
[14] 6 months for the Program H

this analysis.[15] This included six control trials without randomisation; three without control groups; and three mixing routine data analysis, surveys for some and qualitative interviews. Ten measure attitude change (five of those using the Gender Equitable Men Scale) but only four studies measure perpetration of VAW (Instituto Promundo, 2012c; PATH, 2012; Pulerwitz, 2010; Verma, 2008) but two of those have methodological challenges (social desirability issues[16] and absence of control group).

Existing reviews and impact evaluation findings point to several issues that limit the strength of the evidence though. Changes in attitudes and behaviours 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 a year. Evaluations are mainly conducted with men participating in programme and not in the general population (except Instituto Promundo, 2012c that included a community-wide survey before and after to assess diffusion effects); study participants are often self-selected, hence more likely to change.

Effectiveness of the intervention:

Interventions combining group education with boys and men (sometimes in combination with women and girls) that adopt a gender transformative approach and intense community mobilisation, are a promising area (Heise, 2011; Dworkin, 2013; Barker 2009). Dworkin points 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"**.**

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) evaluating the Ethiopia Male Norms Initiative (Using the Program H curriculum) shows a decreased IPV perpetration in both intervention's arms (36 versus 16 percent in the group education and community mobilisation arm, and 36 versus 18 percent in the community education arm). An Instituto Promundo study in India (2012c), using Program H, Stepping Stones and White Ribbon campaign methodologies, showed a decrease of IPV but not significantly different to the control community. The evaluation of Yaara Dosti, Program H in India showed declines of IPV, including sexual violence, in the intervention group, six months after the intervention. PATH 2012 study in Kenya (2012) showed declines in all types of violence perpetration, and significant declines in three types of violence perpetration 12 months after the intervention. However, the strength of these findings are limited by a high loss to follow up (1357 to 578 people) and the absence of comparison group.

Impact on risk factors for VAWG – There is substantial evidence of the effectiveness of these types of interventions to improve men and boys' gender-related attitudes, a risk factor for perpetration. Out 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 attitudes change (Promundo 2012b) was conducted in health facilities and included a facilitators' training for government health professionals. It was different from the other interventions, where the community mobilisation component was through campaigns/edutainment.

3.5.2 Bystander interventions

Types of Evidence
I: Evidence obtained from one properly randomized controlled trial

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

Evidence of effectiveness of the interventions:
C. The existing evidence is conflicting and does not allow for recommendations either for or against the intervention, also majority of evidence is from North America and there remains limitations in the generalisability of these findings beyond Anglo-American populations.

Description of the interventions:

Bystander action refers to actions 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 USA, mainly with groups of men and more rarely with women or both sexes. Bystander approaches can also be included in social marketing campaigns when they aim at promoting societal norms supporting bystander interventions. They can be brief one-off interventions or be longer, implemented by teachers or trained educators.

Types of evidence available

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

There is currently no evidence available for bystander interventions in LMICs, although Safe Dates is being evaluated in South Africa at present. Further Bell Bajao and Soul City have bystander elements, aiming to get people to intervene to stop violence and are discussed in 3.1.1. However, there remains limitations in the generalizability of these findings beyond Anglo-American populations (Radford, 2014).

Examples of bystander interventions: • **Coaching boys into men** targets coaches and high school male athletes from 16 American high schools. The intervention consists in a 60-minutes training of coaches, followed by brief weekly scripted discussions of 10-15 minutes with athletes. • **Bringing in the bystanders** is based on one 4.5 hours long 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 information about sexual violence, as well as learning and practising appropriate and safe bystander skills.

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, 2012). At a 12-month follow-up, this cluster RCT demonstrated reductions in negative bystander intervention behaviours (fewer intervention athletes supporting peers' abusive behaviours) 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.

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

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

For example, in Coaching Boys into Men, compared with control subjects, at three months, athletes exposed to full-intensity implementation of the intervention demonstrated improvements in intentions to intervene and recognition of abusive behaviours, and positive bystander behaviours but these outcomes were not sustained at the one-year follow-up. Bringing in the Bystander (Moynihan, 2010) provide some of the strongest evidence (Ricardo, 2011; Powell, 2012), but the impact on attitude is still limited. Significant difference in bystander efficacy was found at two month follow-up but not for rape myth acceptance.

3.5.3 Transforming masculinities

Description of interventions:

Narratives of masculinity that justify and celebrate men's capacity for violence, control over women and their bodies, and dominance in sexual, economic and political spheres remain enormously influential in many local contexts around the world. The controlling behaviour and use of violence of individual men occurs within this broader social context of gender norms and identities (masculinities and feminities).

A wide spectrum of interventions can be categorised by the shared goal of transforming forms of masculinity associated with violence to those associated with caring, equality and peace. They include smaller scale interventions with groups of individual men that use critical reflection to make explicit the harmful effects of adhering to hegemonic masculinities, to larger scale efforts with multiple methods to

Examples of intervention to transform masculinities:

The **Regional Learning Community (RLC),** a network facilitated by Partners for Prevention, consisted of a grouping practitioners, activists and academics from the East and Southeast Asian region focused on greater critical consciousness and analysis for transforming masculinities in the region. The RLC created an inclusive learning space for practitioners from the region to share their knowledge, experience and challenges on transforming masculinities for gender justice and violence prevention. The RLC produced a regional curriculum to enhance understanding of gender theory, gender justice and transforming masculinities and to enhance the skills needed to apply this knowledge across diverse contexts and programmes. The curriculum can be found here: http://partners4prevention.org/resource/regional-curriculum-transforming-masculinities-towards-gender-justice

The RLC curriculum has been locally adapted and translated in selected countries across the region. For example, in Mongolia, as part of its national adaptation of the curriculum, members of civil society networks are created a safe space in which men, women, boys, girls, transgender and intersex individuals can engage in self-reflection and collective analysis of dominant masculinities, unpacking the term 'man,' and dissecting masculinities in the global, national, and local contexts of culture, politics, and economy.

transform social norms. Such interventions are clear about the change focus on masculinities, rather than on individual men, and can employ various and overlapping strategies to achieve this goal, including working with different groups of women, men, girls and boys, both together and separately at different intervals.

Types of evidence available

Evidence of the effectiveness of such interventions is limited, as rigorous evaluations are few. Methodological and conceptual shortcomings include only gauging participants' satisfaction with the programme, or assessing attitudes and not behaviours. Post-intervention follow up is often short and comparison groups lacking.

Effectiveness of the interventions

A recent review suggests that gender-transformative programming can play an important role in increasing protective sexual behaviours, changing harmful attitudes, preventing violence, and reducing STI/HIV (Dworkin et al., 2013). This suggests that effective interventions with men and boys *address masculinity* rather than just specific behaviours or attitudes. They explicitly address the norms, behaviours, and relations associated with ideals of manhood. Interestingly, two-thirds of the stronger interventions in the systematic review worked with both women and men, which is essential for sustained gender transformation.

3.6 Peer or relationship interventions

The majority of violence against women occurs at the relationship level with intimate partner violence being the most common form of VAWG globally. A number of cross-sectional household studies have shown that women are at increased risk of intimate partner violence where relationship discord is higher. There is some evidence to suggest that some forms of violence within relationships can be in part attributed 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 it may have elements of learnt behaviour that need to be challenged. Further, IPV may be more likely when either partner supports attitudes or belief that condone violence within relationships or support power inequalities between men and women. Interventions at the relationship level aim to address these risk factors.

3.6.2 Relationship level interventions

Types of Evidence (relationship-level intervention)
I: Evidence obtained from two properly randomized controlled trials

Evidence of effectiveness of the interventions:
B. There is fair evidence to recommend the interventions

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" (quoted in Heise, 2011).

Examples of relationship-level interventions:

- **Stepping Stones** is a small-group relationship intervention which has been implemented in dozens of countries worldwide, and includes 13 participatory training sessions with 50 hours of intervention over a 6-8 week period. It covers topics such as gender inequalities 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 Program in Uganda. It includes training workshops; capacity building of professionals around 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 distribution of learning materials

This assessment includes 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 2776, a two year follow-up and measured perpetration and experiences of IPV. The Share evaluation had a sample of 5339 (intervention) and 6112 (control), with two follow-up visits immediately following the intervention and 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, S. Africa, Ethiopia, Angola, Tanzania, Uganda and Fiji; and Heise's (2011) reviews the effectiveness of interventions aimed at changing individual, community and social norms implemented in low and middle income countries.

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG - The Stepping Stones evaluation from South Africa found a decrease in men's reports of IPV perpetration by 38% at 24 months in the intervention group. However there was no change in reports 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 and 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 decreases in risk factors such as problem drinking at 12 months (Stepping Stones). All of them also show increases in protective factors such as education and better communication skills within relationships. A review of the Stepping Stones interventions in seven countries revealed that out of the five studies investigating gender equity, only one did not show any change.

Overall, there is strong evidence of the effectiveness of relationship-level interventions grounded in gender theory in decreasing IPV, however, more is needed to understand what leads to a decrease in perpetration for wider prevention. It is proven that one-off workshops, when not grounded in change theories are not effective. When looking at interventions solidly grounded in gender theory, there is no consensus on the number of sessions required to reach 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).

3.7 Interventions with families

Families are often the site of VAWG, and an important entry-point for intervention. Poor or harsh parenting is not only a critical risk factor for maltreatment worldwide, particularly in the early years, but is also a risk factor for VAW. There is strong evidence associating poor parenting and later violent behaviour including IPV, coming from the USA and other HICs. There is also direct evidence associating conduct disorder, 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 a key goals in and of themselves as well as contributing to the prevention of other forms of violence against women and girls. Parenting interventions aim to stem the cycle of events by which child abuse elevates the societal risk years later for wife abuse, sexual aggression, and heightened violent crime (MacKloskey, 2011).

3.7.1 Parenting programmes

Types of Evidence (relationship-level intervention)

> I: Evidence obtained from two properly randomized controlled trials
>
> **Evidence of effectiveness of the interventions:**
> B. There is fair evidence to recommend the interventions

Description of interventions:

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

Another grouping of interventions can be characterised by a specific focus on fatherhood, men's roles as caretakers, and men's roles in teaching their sons to respect women. Two campaigns that fit this description including the global MenCare campaign, coordinated by the MenEngage Alliance, and the Futures without Violence 'Respect' campaign. A group education model run by Men Stopping Violence in Atlanta, USA is called 'Because we have daughters'. Evaluation evidence from these fatherhood interventions does not yet exist.

> **Examples of parenting programmes:**
>
> - The **Nurse Family Partnership**, includes nurse visits conducted with low-income first-time mothers during pregnancy 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 behavioral interventions and workforce training; media coverage and communication strategies; and distribution of material to support parenting.
> - **The Spokes Project** is a multi-component intervention which 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.

Summary of evidence available:

Two systematic reviews recently analysed parenting interventions. Knerr (2011) analyses evidence from 12 RCTs or quasi-experiments involving 1580 participants in nine LMICs. This review investigates the effectiveness of parenting interventions for reducing harsh or abusive parenting, increasing positive parenting practices, attitudes and knowledge, and improving parent–child relationships. MacKloskey (2011) reviews 22 studies from HICs with a total of 5160 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, which includes parenting interventions and Heise (2011) reviews 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 effectiveness of the widespread Triple P intervention (Wilson et al., 2012).

We extracted 34 interventions from these reviews and other searches. Only nine of these interventions come from LMICS (six home visiting programmes; one community-based; two implemented in clinics). A high proportion of the evaluations were methodologically weak (Knerr, 2011; Mackloskey, 2011; Mikton, 2009). In Knerr's review focusing on LMICs, out of 12 studies, only three studies had a low risk of bias[17]. 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 impacts on abuse are also limited. Most studies aimed at improving parenting and child development and only three studies in LMICs measured the impact on reducing parent/child conflict or abuse (Aracena, 2009; Oveisi, 2010; Kagitcibasi, 2001).

Effectiveness of the interventions:

Impact on perpetration or experience of VAWG - The results of parenting programmes are uncertain about reduction in child maltreatment itself, in part because such outcomes were not measured. Home-visiting 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% 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 standardised instruments (conflict tactics scale) (Fergusson, 2005; Jouriles, 2005, Linares, 2006,ve: Ovisi, 2010). In LMICs, the three studies that measured reduction on negative, harsh or abusive parenting had positive results[18]. Transferability of home visiting programmes remains in questions due to cultural adaptation and the high cost which may make them unaffordable for LMICs.[19]

Impact on risk factors for VAWG - The evidence suggests that parenting interventions can 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 control group. A home visiting programme conducted in Pakistan (Rahman, 2009) suggests significant effects on mother's knowledge and attitudes about child development at a 12 months follow-up, compared to 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. Multicomponent 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 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 USA, including home visiting programmes Healthy Families (Dumont, 2008) and Healthy Start (Duggan, 2004), and Triple P. Prinz (2009), who evaluated Triple P with a sample of 85 000 people, found preventative effects on

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

[18] Aracena, 2009 is a home-visiting programme in Chili; Oveisi et al. 2010, is set in a clinic; Kagitcibasi, 2001, in Turkey, is a community-based intervention.

[19] The estimated total cost of the Nurse Family Partnership is around US$ 4,500 a year for each person taking part in the programme

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. (Wlison 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[20].

3.8 Individual level interventions – addressing alcohol abuse

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. Other evidence suggests that women whose partners have been drinking preceding violent incidents are significantly more likely to be injured than women whose partners had not been drinking. A recent meta-analysis likewise demonstrated a clear association between IPV and women's drinking, although the direction of 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 that alcohol use leads to dis-inhibition, hinders problem-solving abilities, 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).

3.8.1 Tackling alcohol abuse

Types of Evidence:
 I: Evidence obtained from at least one properly randomized controlled trial (RCT) in HICs
Evidence of effectiveness of intervention:
B-F. Fair evidence from HICs to recommend structural, group and self-help interventions, but insufficient evidence on such interventions in LMICs to recommend.

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 inquiry during history taking; 2) Structural interventions restricting 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 dialogues; 4) Treatment and self-help support systems such as Alcohol Anonymous (Heise, 2011).

The multi-components 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 of the former did not measure outcomes related to alcohol abuse and the latter is currently undergoing a RCT.

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[20] Sanders, 2012, contested the findings from Wilson. Additional recent Triple P evaluations include Morawska (2014), who evalated 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 behavioural problems and parenting style, self-efficacy, and confidence, at a 6 months follow-up.

> **Examples of alcohol reduction interventions:**
> - **The RISHTA programme in India** explicitly integrates programming related to harmful alcohol use into their 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 combining community-based education, advocacy and capacity building.

Summary of evidence available

Although there is now a substantial evidence base about the relative effectiveness of different strategies for reducing the rates of alcohol-related harm, most of the evidence derives from HICs and cannot be transposed directly to LMIC settings (Benegal, 2009). However, some reviews identified and analysed evidence coming from LMICs, such as Heise (2011), or Benegal (2009), who 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 population prevalence of IPV. For example, recent longitudinal study conducted in Australia found a significant association between alcohol outlet density and rates of domestic violence (Livingston et al, 2001). In Greenland, a coupon system limiting beer consumption to 72 beers per month decreased by 58% the number of police calls for DV (Room et al., 2003). Based on the analysis of 112 studies, Wagenaar et al. (2009) showed that, as an effect of alcohol tax increase, drinking goes down, including among youth and problem drinkers. The only intervention measuring impact of price on IPV was conducted in the mid-eighties and showed that a price increase in alcohol decreased the probability of IPV, but given the age of this study it should be treated with caution (Markowitz, 2000). The Share Trial implemented in Uganda with a sample of 5339 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 for people with hazardous and harmful alcohol use, 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 combines the Brief Intervention for Hazardous and Harmful Drinking with HIV risk-reduction counselling model for STI patients, was evaluated through a RCT and showed a 65% 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 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[21]. However, it found no reduction in alcohol use surrounding sex, considered here as a mediator between IPV and HIV.

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[21] 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.

The small group intervention Stepping Stones in South Africa achieved significant reduction in problem drinking among men at 12 months. Self-help groups could constitute a simple low-cost model of intervention in LMICs, and it is implemented through religious organisations in Latin America. It is not possible to do an RCT of AA because it contradicts the oranizational philosophy of a group open to anyone wishing to change their lives. But a study using propensity score matching to deal with selection bias saw a significant reduction in harmful drinking (Benegal, 2009; Heise, 2011). Structured interventions tackling couples are promising, but their affordability and feasibility in LMICs is improbable, due to the shortage of mental health skilled professionals. Most of detoxification interventions successful in HICs, such as residential treatments, would not be affordable to LMICs (Heise, 2011; Benegal, 2009). However, Benegal identified packages (Benegal, 2009) of care for alcohol abuse in LMICs that includes community-based treatment camps to support alcohol-dependant men detoxification, and interventions to help maintain sobriety, such as self-help groups or use of drugs.

4. Discussion

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 within the last ten years. We now have several well conducted RCTs in low and middle income countries showing some success in preventing violence against women and girls. 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. Most rigorous evaluations of interventions to prevent VAWG are from the United States and other HICs and there has been little testing of how these programmes might be adapted or applied in low and middle income settings. In addition, some intervention areas have received more attention than others. For example, school-based interventions, economic 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 for especially 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.

Many studies of prevention interventions fail to include measures of VAWG as an outcome, making an assessment of their effectiveness difficult. In addition, few evaluations have carefully tested the different impacts on different types of violence.

Even where they do measure impact on violence, it is among direct intervention recipients, or their partners and not the impact at a community level. The field of violence prevention needs to identify approaches to prevent violence at a community level, not just at the individual level.

Key evidence gaps

- Limited evidence from LMICs
- Particularly limited evidence on some intervention types, i.e. transforming masculinities and social norm change
- Majority of evaluations do not measure violence as an outcome
- Majority of evaluations assess the impact on direct intervention recipients and not at a community level
- Limited evidence on interventions relevant for especially vulnerable groups
- Indicators vary widely in nature and in data collection making comparisons 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 between intervention components
- Limited evidence on scalability of interventions

Some evaluations show changes in risk and protective factors, for example attitudes to violence. While they should not be a replacement for measure of VAWG they are still useful because it is challenging for three to five year interventions to have a strong impact on violence reduction. Therefore, achieving secondary outcomes such as increasing well-being, decision-making capacity and knowledge or attitudes related to GBV are steps in the right direction (Beardon and Otero, 2013).

Nevertheless, there is an over-reliance on the use of attitude measures as proxies for behaviours, however this assumption of linear progression from attitude change to behaviour change is not fully convincing. Across evaluations, indicators of VAWG and related risk factors vary widely in nature and in data collection method, making comparisons across settings difficult.

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

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 impacts. For example, the lack of evidence on the impact of livelihood programmes alone could suggest that reductions in poverty, per say, are not enough to reduce women's risk of violence. It remains unclear whether pathways for change relate to reduce levels of economic stress in the household; social capital and establish new social norms around violence; empowerment effects or other things. As another example, studies found collectivisation/ group based initiatives effective in reducing violence target at vulnerable groups such as FSWs. However, it is not clear from the studies found what it is about the collective action by a vulnerable group, that can lead to violence reduction, more research is needed to understand this. Is it, for example, enough for a group of vulnerable women and girls to collectively meet on their own or is it the presence of an NGO/ CBO to facilitate the process and provide other services that leads to self-awareness and empowerment of individuals which also leads to a reduction in IPV in particular? Is it the growing self-awareness of individuals, 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 reduction of VAWG?

Whilst many studies suggest that it is important to take a holistic approach to prevention, for example a whole of school approach, it is difficult to attribute outcomes between 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? What minimum package of interventions is required to have greatest impact on school based violence and in particular violence against women and girls? 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. Furthermore, a number of the study findings suggest that 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 found a greater impact on boys attitudes after two years compared with one year. However, it is not clear in many cases what is optimal in terms of balancing cost-effectiveness and impact. For example, one-to-one interventions with pregnant women in HICs showed marked reduction in IPV but they require a lot of resources which might not be possible in LMICs. It would be worth exploring whether 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.

Most evaluations included in this assessment are of 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 scalability. VAWG is a hugely pervasive issue which 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.

4.2 Synthesis of findings

Despite the limitations in the evidence base, overall this rapid review concludes that that **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; interventions that primarily target boys and men through group education combined with community mobilization; and parenting programmes. Currently there is **insufficient evidence to recommend:** single component communications campaigns. 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 to be of most use. There is insufficient evidence on school-based interventions mainly because they have not sufficiently measured VAWG as an outcome, but they show promise in reducing risk factors for violence. Finally, there **is conflicting evidence** on bystander programmes which does not allow us to make a recommendation for or against the intervention.

Table 1 presents a summary of the evidence for different types of interventions to prevent VAWG. Darker colours represent stronger evidence, ranging from no evidence to fair evidence. Blue suggests that the interventions have been shown to be effective in preventing VAWG, green suggest 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.

Table 1: Summary of evidence for different types of interventions to prevent VAWG

IMPACT OF INTERVENTION				
	EFFECTIVE (Impact on VAWG)	• Microfinance and gender transformative approaches • Relationship-level interventions • Group education with community outreach (men/boys) • Community mobilization – changing social norms	• Collectivisation and one-to-one interventions with vulnerable groups • Alcohol reduction programmes (limited evidence from LMICs)	
	PROMISING (Impact on risk factors only)	• Parenting programmes	• Whole-school interventions • School curriculum based interventions	• Transforming masculinities

	FAIR EVIDENCE	INSUFFICIENT EVIDENCE	NO EVIDENCE
CONFLICTING	• Bystander interventions	•	
INEFFECTIVE		• Single component communications campaigns • WASH interventions in schools	

STRENGTH OF 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 fail to find a change in rates of violence. This may be because interventions lack the intensity 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 to be 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 often 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 of these types of interventions, however, make the assumption that by removing specific barriers to girls' attendance that they will enrol in school and learn. Some WASH interventions also make 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 the social norms, attitudes and behaviours that lead to gender inequality and VAWG, girls are not guaranteed to learn or to be protected from violence through these interventions alone. Bystander interventions and some parenting interventions also did not show any robust evidence of impact on VAWG but are being rolled out widely. We suggest that it is equally 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 are 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**, with evaluations tending to report a change in one but not the other. Furthermore, where evaluations have measured the impact different types of violence, we often we 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 showing 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 are more effective than single-component ones in preventing VAWG**. 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. And two studies showed that combining in-school awareness raising and skills building works better than either on its own. The relative success of multi-component interventions makes sense in light of what we know about violence against women; that there is no single cause but instead 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.

The assessment also reveals that g**ender transformative approaches are more effective** than interventions simply targeting attitude and behaviour change. Whether that be in 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 of those interventions classified as gender transformative or 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 into 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 marginalised men in economic interventions, especially when linked with gender-transformative components.

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

4.3 What does this mean for the prevention agenda?

The findings from this assessment suggest that the following top ten areas and approaches should be prioritised in terms of violence prevention in the future:

1. **Interventions that have a clear theory of change**
2. **Multi-component programmes:** those that employ multi-methods, target multiple risk factors and or work across multiple settings
3. **Interventions that aim to have a broad impact on community level violence,** not just individual behaviour of those undergoing the intervention.

4. **Interventions that work with men and women**, either simultaneously or sequentially. Future prevention interventions should not be defined or prioritized by whether or not they 'work with men' but rather by their specific objectives related to a reduction in violence and factors most associated with perpetration, including transforming masculinities.

5. **Interventions that combine face–to–face work with other approaches, and include skills building elements** (for example relationship, communication, economic skills)

6. **Interventions that take a holistic approach** across a certain setting, for example a whole of school approach, or a whole family approach

7. **Interventions that are gender transformative** and grapple with the larger social and cultural milieu that perpetuates violence against women

8. **Different interventions to target different forms of VAWG**. Sophisticated evaluations are also required to examine the impact of the interventions on different types of violence.

9. **Interventions targeting particularly vulnerable populations or those at high risk of perpetration**. 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 the most relevant for particularly vulnerable groups of women and girls. Similarly, perpetration of some forms of violence, such as non-partner rape, appear to be driven primarily by a sub-group of men – for example youth who are part of gangs and involved in other anti-social behaviour. Therefore it is equally important to design specific interventions targeted high-risk youth, who will likely require very different approaches to the general population.

10. **Interventions targeting different age groups**. Addressing the fact that VAWG occurs across the life cycle and is driven by factors operating across it.

11. **Interventions that are scalable** in terms of human and financial resources**: g**iven the dimensions of the problem, any intervention to prevent VAWG needs to be implementable and scalable in LMICs. A key to scale is to consider whether there are existing platforms that can be marshalled as a foundation for anti-violence programming. Clearly radio, television and social media can reach hundreds of thousands of individuals at low cost, but experience strongly suggests that some element of face to face engagement is necessary to achieve lasting social and behavioural change.

5 Recommendations

Priorities for supporting prevention innovation and research are illustrated in the following diagram:

Figure 1: Recommendations for the What Works research and innovation agenda

Overarching research questions:

- What is the role of contextual factors on the impact of interventions?

- What intensity & dosage is needed for impact?

- Does the intervention have an impact on violence at the community level not just the individual level?

- How scaleable is the intevention and how can it be scaled? How can they be implemented affordably?

- What are the pathways of impact, how does change happen?

- What is the potential relevance for different age groups and situations?

Interventions of interest:	**Entry Points of interest:**	**Populations of interest:**
• Community mobilisation • Whole school interventions • Peer or relationship interventions • Parenting interventions • Small group interventions • Economic interventions combined with gender training • Social change media & communication • Psychotherapeutic /counselling interventions	• Schools • Families • Workplaces • Communities	• Marginalised groups of women • Adolescent boys with multiple risk factors for perpetration e.g. gang involved • Younger boys & girls • Couples • Very high prevalence settings • Parents & children

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References

Abrahams, N., Mathews, S. & Ramela, P. 2006. Intersections of 'sanitation, sexual coercion and girls' safety in schools'. *Tropical Medicine & International Health,* 11**,** 751-756.

Achyut, P., Bhatla, N., Khandekar, S., Maitra, S. & Verma, R. K. 2011. Building Support for Gender Equality among Young Adolescents in School: Findings from Mumbai, India. New Delhi: ICRW.

Ackerson, L., Kawachi, I., Barbeau, E. & Subramanian, S. V. 2008. Effects of Individual and Proximate Educational Context on Intimate Partner Violence: A Population-Based Study of Women in India. *American Journal of Public Health,* 98**,** 507-514.

Actionaid & Institute Of Education 2012. Transforming education for girls in Nigeria: Endline research summary report. London: ActionAid.

Adler-Baeder, F., et al. 2007. The impact of relationships education on adolescents of diverse backgrounds. *Family Relations*, 56(3), 291–303,

Ahmed, N. 2005. Intimate partner violence against women: experiences from a woman-focused development programme in Matlab, Bangladesh. *Journal of Health, Population and Nutrition,* 23**,** 95-101.

AIZER, A. 2006. Wages, Violence and Health in the Household.

Amar, A. F., et al. 2012. "Evaluation of a bystander education program." *Issues Ment Health Nurs* 33(12): 851-857.

Amin, S. & Suran, D. 2005. Program Efforts to Delay Marriage Through Improved Opportunities: Some Evidence from Rural Bangladesh. Washington: Population Council.

Antle, B., et al. 2011. Healthy relationship education for dating violence prevention among high-risk youth. *Children and Youth Services Review*, 3(1), 173–179

Antonowicz, L. 2010, Too often in silence: A report on school based silence in West and Central Africa, UNICEF, Plan West Africa, Save the Children Sweden West Africa and ActionAid

Aracena, et al. 2009. A cost-effectiveness evaluation of a home visit program for adolescent mothers. Journal of Health Psychology, 2009. 14(7): p. 878-87.A cost-effectiveness evaluation of a home visit program for adolescent mothers. *Journal of Health Psychology*, 2009. 14(7): p. 878-87.

Arango et al. 2013. Draft, Interventions to prevent or reduce violence against women and girls: a systematic review of reviews.

Austrian, A. & Muthengi, M. 2013. Safe and smart savings Products for vulnerable adolescent girls in Kenya and Uganda. New York: Population Council.

Ayoo, S. 2008. Women Empowerment for Peace Project Mid-Term Evaluation. Care Uganda.

Baird, S., Ferreira, F., Ozler, B. & Woolcock, M. 2013. Relative Effectiveness of Conditional and Unconditional Cash Transfers for Schooling Outcomes in Developing Countries: A Systematic Review *Campbell Systematic Reviews.* Washington: Campbell Collaboration.

Baird, S., Garfein, R., Mcintosh, C. & Ozler, B. 2012. Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trail. *Lancet*.

Bajracharya, A. & Amin, S. 2013. Microcredit and Domestic Violence in Bangladesh: An Exploration of Selection Bias Influences. *Demography,* 50**,** 1819-1843.

Ball, B., et al. "Like a Family but Better Because You Can Actually Trust Each Other": The Expect Respect Dating Violence Prevention Program for At-Risk Youth". *Health Promotion Practice*, 10(1), 45-58.

Bandiera, O., Buehren, N., Burgess, R., Goldstein, M., Gulesci, S., Rasul, I. & Sulaiman, M. 2012. Empowering Adolescent Girls: Evidence from a Randomized Control Trial in Uganda World Bank.

Bank, et al. 2008. Catalyzing personal and social change around gender, sexuality, and HIV: Impact evaluation of puntos de encuentro's communication strategy in Nicaragua, Horizons Final Report. Washington, DC: Population Council.

Banyard, et al. 2007. Sexual Violence Prevention Through Bystander Education: An Experimental Evaluation. *Journal of Community Psychology*. 35(4), 463–481.

Barker, G., et al. 2009. "Questioning gender norms with men to improve health outcomes: Evidence of impact." *Glob Public Health* 5(5): 539-553.

Barker, G.et al. 2006. "Promoting gender-equity among young Brazilian men as an HIV prevention strategy," Horizons Research Summary, Washington, D.C.: The Population Council Inc.

Barker, G. et al. 2007. "The individual and the political: Promundo's evolving approaches in engaging young men in transforming masculinities," Report for the Politicising Masculinities Symposium, Institute for Development Studies. Dakar.(in Arango)

Barlow et al. 2007. Role of home visiting in improving parenting and health in families at risk of abuse and neglect: results of a multicentre randomized controlled trial and economic evaluation, Archives of Diseases in Childhood, 92, 229-233.

Barrera-Osorio, B. 2008. The Effects of a Reduction in User Fees on School Enrollment: Evidence from Colombia in Tembon and Font: Girls' Education in the 21st Century Gender Equality, Empowerment, and Economic Growth. Washington: World Bank.

Beardon, H. & Otero, E. 2013. Women's Right to Be Heard: An evaluation of Oxfam GB's "Raising Her Voice" portfolio. Oxford: Oxfam.

Beattie, T., Bhattacharjee, P., Ramesh, B., Gurnanj, V., Anthony, J., Isac, S., Mohan, H., Ramakrishnan, A., Wheeler, T., Bradley, J., Blanchard, J. And Moses, S. 2010. Violence against female sex workers in Karnataka state, south India: impact on health, and reductions in violence following an intervention program, *BMC Public Health* 2010, 10:476.

Bellows, N., Bellows, B. & Warren, C. 2011. The use of vouchers for reproductive health services in developing countries: systematic review. *Tropical Medicine & International Health,* 16**,** 84-96.

Birdthistle, I., Dickson, K., Freeman, M. & Javidi, L. 2011. What impact does the provision of separate toilets for girls at schools have on their primary and secondary school enrolment, attendance and completion? A systematic review of the evidence. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

Blanchard, A., Mohan, H., Shahmanesh, M., Prakash, R., Isac, S., Rameh, B. Bhattacharjee, P., Gurnani, V., Moses, S. and J. Blanchard (2013) Community mobilization, empowerment and HIV prevention among female sex workers in south India, BMC Public Health 2013, 13(234)

Blattman, C., Green, E., Annan, J. & Jamison, J. 2013. Building Women's Economic and Social Empowerment Through Enterprise An Experimental Assessment of the Women's Income Generating Support (WINGS) Program in Uganda. Washington: World Bank.

Bobonis, G. & Castro, R. 2010. The Role of Conditional Cash Transfers in Reducing Spousal Abuse in Mexico: Short-Term vs. Long-Term Effects

Bobonis, G., Gonzales-Brenes, M. & Castro, R. 2013. Public Transfers and Domestic Violence: The Roles of Private Information and Spousal Control. *American Economic Journal: Economic Policy,* 5**,** 179–205.

Bradley, J.E., et al. 2011. Evaluation of stepping stones as a tool for changing knowledge, attitudes and behaviors associated with gender, relationships and HIV risk in Karnataka, India. *BMC Public Health*, 2011. 11(496).

Brady, M., Assaad, R., Ibrahim, B., Salem, A., Salem, R. & Zibani, N. 2007. Providing new opportunities to adolescent girls in socially conservative settings: The Ishraq program in rural Upper Egypt. New York: Population Council.

Brandl, B., Hebert, M., Rozwadowski, J. and D. Spangler (2003) Feeling Safe, Feeling Strong: Support Group for Older Abused Women, Violence Against Women, December 2003 vol. 9 no. 12 1490-1503.

Brunk MA, et al. 1987. Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect, *Journal of Consulting and Clinical Psychology* 55(2): 171–178

Breitenbecher, K. H. & Scarce, M. 2001. An evaluation of the effectiveness of a sexual assault education program focusing on psychological barriers to resistance. *Journal of Interpersonal Violence,* 16**,** 397-407.

Bugental, D. & Schwartz, A. 2009. A cognitive approach to child mistreatment prevention among medically at-risk infants, *Developmental Psychology* 45, 284-288.

CASA 2010. Evaluation of the Dadaab firewood project, Kenya.

Chaffin M, et al. 2004. Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports, *Journal of Consulting & Clinical Psychology* 72(3): 500–510

Cho, H., Hallfors, D. & Mbai, I. 2011. Keeping adolescent orphans in school to prevent human immunodeficiency virus infection: evidence from a randomized controlled trial in Kenya. *Journal of Adolescent Health,* 48**,** 523-526.

Cho, Y., Kalomba, D., Mobarak, A. & Orozco, V. 2013. Gender Differences in the Effects of Vocational Training Constraints on Women and Drop-Out Behavior. Washington: World Bank.

Cicchetti, et al. 2006. Fostering secure attachment in infants through preventive interventions. *Development and Psychopathology* 18, 623-649

Cluver, L., Boyes, M., Orkin, M., Molwena, T. & Sherr, L. 2013. Child-focused state cash transfers and adolescent risk of HIV infection in South Africa: a propensity-score-matched case-control study. *Lancet Global Health,* 1.

Concern Worldwide & OXFAM GB 2011. Walking the Talk: Cash Transfers and Gender Dynamics. London: Oxfam.

Colvin, C. 2009. Report on the Impact of Sonke Gender Justice Network's 'One Man Can' Campaign in Limpopo, Eastern Cape and Kwa-Zulu Natal Provinces, South Africa

Cooper, Tomlinson et al. 2009, Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: randomised controlled trial. *BMJ*, 2009. 338: p. b974.

Cowan, et al. 2009. Promoting father's engagement with children: Preventive interventions for low-income families. *J. Marr and the Family* 71, 663-679.

Dake, J. A., Price, J. H. & Murnan, J. 2003. Evaluation of a child abuse prevention curriculum for third-grade students: assessment of knowledge and efficacy expectations. *Journal of School Health,* 73**,** 76–82.

Dalal, K., Dahlström, Ö. & Timpka, T. 2013. Interactions between microfinance programmes and non-economic empowerment of women associated with intimate partner violence in Bangladesh: a cross-sectional study. *BMJ Open,* 3**,** e002941.

Das, A., et al. 2012. "Reviewing responsibilities and renewing relationships: an intervention with men on violence against women in India." *Cult Health Sex* 14(6):659-75.

Dawe, S., & Harnett, P. 2006. Reducing potential for child abuse among methadone-maintained parents: Results from a randomized controlled trial. *J. of Substance Abuse Treatment*, 32, 381-390

De Walque, D., Dow, W. H. & Nathan, R. 2012. Incentivising safe sex: a randomised trial of conditional cash transfers for HIV and sexually transmitted infection prevention in rural Tanzania. *BMJ Open,* 2.

Devries, K., Allen, E., Child, J., Walakira, E., Parkes, J., Elbourne, D., Watts, C. & Naker, D. 2013. The Good Schools Toolkit to prevent violence against children in Ugandan primary schools: study protocol for a cluster randomised controlled trial. *Trials,* 14**,** 232.

Deyessa, N., Berhane, Y., Ellsberg, M., Emmelin, M., Kullgren, G. & Hogberg, U. 2010. Violence against women in relation to literacy and area of residence in Ethiopia. *Global Health Action,* 3.

Dickson, K. & Bangpan, M. 2012. Providing access to economic assets for girls and young women in low-and-lower middle-income countries: A systematic review of the evidence. London: DfID.

Ditlopo, P., Mullick, S., Askew, I., et al. 2007. Testing the effectiveness of the Men as Partners program in Soweto, South Africa. USAID: PEPFAR.

Douglas, M. (1998). Restriction of the hours of sale of alcohol in a small community: a beneficial impact. *Australian and New Zealand Journal of Public Health*, 22:714–719.

Duflo, E., Dupas, P., Kremer, M. & Sinei, S. 2006. Education and HIV/AIDS Prevention: Evidence from a randomized evaluation in Western Kenya. Washington: World Bank.

Duggan, et al. (2004) Randomized trial of a statewide home visiting program: impact in preventing child abuse and neglect. *Child Abuse Negl* 28,597-622.

DuMont K, et al. 2008. Healthy, Families New York (HFNY) randomized trial: Effects on early child abuse and neglect, *Child Abuse Negl* 2008 Mar;32: 295-315

Dunbar, M. S., Kang-Dufour, M., Mudekunye, I., Lambdin, B. & Padian, N. Under Review. SHAZ! Phase II Intervention Results. *Plos One*.

Dunbar, M. S., Maternowska, M. C., Kang, M. S., Laver, S. M., Mudekunye-Mahaka, I. & Padian, N. S. 2010. Findings from SHAZ!: a feasibility study of a microcredit and life-skills HIV prevention intervention to reduce risk among adolescent female orphans in Zimbabwe. *J Prev Interv Community,* 38**,** 147-61.

Dworkin, S. L. & Blankenship, K. 2009. Microfinance and HIV/AIDS prevention: assessing its promise and limitations. *AIDS Behav,* 13**,** 462-9.

Dworkin, S. 2013. Gender-Transformative Interventions to Reduce HIV Risks and violence with heterosexually-active men: A review of the global evidence.

Easton CJ, et al., 2007. A cognitive behavioral therapy for alcohol dependent domestic violence offenders: an integrated substance abuse-domestic violence treatment approach (SADV). *American Journal on Addictions*;16(1):24–31.

Eckenrode J. 2000. What works in nurse home visiting programs. In: Alexander G, Curtis PA, Kluger MP, eds. What works in child welfare. Washington DC: Child Welfare League of America, Inc., 35–43.

Engebretsen, S. 2013. Evaluation of Filles Eveillees (Girls Awakened): A Pilot Program for Migrant Adolescent Girls in Domestic Service New York: Population Council.

Erulkar, A. & Chong, E. 2005. Evaluation of a Savings & Micro-Credit Program for Vulnerable Young Women in Nairobi. New York: Population Council.

Erulkar, A. & Muthengi, M. 2009. Evaluation ofBerhaneHewan:A Program ToDelay ChildMarriage in Rural Ethiopia. *International Perspectives on Sexual and Reproductive Health*.

Espelage, D., Low, S., Polanin, J. & Brown, E. 2013. The impact of a middle school program to reduce aggression, victimization, and sexual violence. *Journal of Adolescent Health,* 53**,** 180-186.

Euser, S., Souverein, D., Rama, P., Gowda, N., Shekar Gowda, C., Grootendorst, D., Ramaiah, R., Barot, S., Kumar, S., Jenniskens, F., Kumar, S. and J. Den Boer (2012) Pragati: an empowerment programme for female sex workers in Bangalore, India

Falb, K. 2011. IRC Thailand: Gender-based violence program evaluation. New York: International Rescue Committee

Fancy, K. & et al. 2013. Building Skills for Life: Global Mid-Term Evaluation Report for PLAN UK. London: SDDirect.

Fancy, K. & Mcaslan Fraser, E. Forthcoming-a. DFID Guidance Note: Part A. Addressing Violence against Women and girls in Education Programming. London: DfID.

Fancy, K. & Mcaslan Fraser, E. Forthcoming-b. DFID Guidance Note: Part B. Addressing Violence against Women and girls in Education Programming: Practical Guidance. London: DfID.

Fay, K. & Medway, F. 2007. An Acquaintance Rape Education Program for Students Transitional to High School. *Sex Education,* 6**,** 223-236.

Feltey, K. M., Ainslie, J. J. & Geib, A. 1991. Sexual coercion attitudes among high school students: The influence of gender and rape education. *Youth and Society,* 23**,** 229-250.

Flood M., 2013, Violence: A global health priority. Eds. C. Ward and P. Donnelly, Oxford University Press.

Foshee, et al. 2004. Assessing the long-term effects of the safe dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. *American Journal of Public Health*, 94, 619-24

Foubert, J. D. & Marriott, K. A. 1997. Effects of a sexual assault peer education program on men's belief in rape myths. *Sex Roles*, 36, 257-266.

Freeman, M., Greene, L., Dreibelbis, R., Saboori, S., Muga, R., Brumback, B. & Rheingans, R. 2012. Assessing the impact of a school-based water treatment, hygiene and sanitation programme on pupil absence in Nyanza Province, Kenya: a cluster-randomized trial. *Tropical Medicine & International Health,* 17**,** 380-391.

Gadomski, A., et al. 2001. Impact of a rural domestic violence prevention campaign. *Journal of Rural Health*, 17(3), 266-277.

Gardner, S. P., Boellaard, R. 2007. Does Youth Relationship Education Continue to Work After a High School Class? A Longitudinal Study. Family *Relations* 56 (5), 490-500

Gibbs, A., Willan, S., Misselhorn, A. & Mangoma, J. 2012. Combined structural interventions for gender equality and livelihood security: a critical review of the evidence from southern and eastern Africa and the implications for young people. *Journal of the International AIDS Society,* 15**,** 17362.

Gidycz, C.A., et al. 2011. Preventing Sexual Aggression Among College Men: An Evaluation of a Social Norms and Bystander Intervention Program. *Violence Against Women*. 17: 720-742

Gidycz, C. et al. 2001. An Evaluation of an Acquaintance Rape Prevention Program: Impact on Attitudes, Sexual Aggression, and Sexual Victimization. *Journal of Interpersonal Violence*, 16 (11); 1120-1138

Gidycz, C. A., Rich, C. L., Orchowski, L., King, C. & Miller, A. K. 2006. The evaluation of a sexual assault self-defense and risk reduction program for college women: A prospective study. *Psychology of Women Quarterly,* 30**,** 173-186.

Global Network of Sex Work Projects (2012) Promoting Health and Human Rights: Documenting Good Practice by Sex Worker-Led Organisations #1 - Addressing Violence Against Sex Workers.

Goldkamp, J. S., et al. 1996. The role of drug and alcohol abuse in domestic violence and its treatment: Dade County's domestic violence court experiment (final report). Philadelphia, PA: Crime and Justice Research Institute.

Gomez, C., Hernandez, M. and B. Faigeles (1999) Sex in the new world: An Empowerment Model for HIV Prevention in Latina Immigrant Women, Health Educ Behav 1999 26:200

Gupta, J., Falb, K. L., Lehmann, H., Kpebo, D., Xuan, Z., Hossain, M., Zimmerman, C., Watts, C. & Annan, J. 2013. Gender norms and economic empowerment intervention to reduce intimate partner violence against women in rural Cote d'Ivoire: a randomized controlled pilot study. *BMC Int Health Hum Rights,* 13**,** 46.

Hadi, A. 2000. Prevalence and Correlates of the Risk of Marital Sexual Violence in Bangladesh. *Journal of Interpersonal Violence,* 15**,** 787-805.

Hallfors, D., Cho, H., Rusakaniko, S., Iritani, B., Mapfumo, J. & Halpern, C. 2011. Supporting adolescent orphan girls to stay in school as HIV risk prevention: evidence from a randomized controlled trial in Zimbabwe. *American Journal of Public Health,* 101**,** 1082–1088.

Hallman, K. & Roca, E. 2011. Siyakha Nentsha: Building economic, health, and social capabilities among highly vulnerable adolescents in KwaZulu-Natal, South Africa. *Transitions to Adulthood.*

Handa, S., Huang, C., Peterman, A., Halpern, C., Pettifor, A. E. & Thirumurthy, H. 2014. Impact of the Kenya Cash Transfer for Orphans and Vulnerable Children on early pregnancy and marriage of adolescent girls. *Plos One*.

Hargreaves, J. R. & Boler, T. 2006. Girl power: the impact of girls' education on HIV and sexual behaviour. London: ActionAid.

Hargreaves, J. R., Morison, L. A., Kim, J., Bonnell, C. P., Porter, J. D., Watts, C., Busza, J., Phetla, G. & Pronyk, P. 2008. The association between school attendance, HIV infection and sexual behaviour among young people in rural South Africa. *Journal of Epidemiology and Community Health,* 62**,** 113-119.

Haushofer, J. & Shapiro, J. 2013. Welfare Effects of Unconditional Cash Transfers: Evidence from a Randomized Controlled Trial in Kenya. *Unpublished Working Paper*.

Hidrobo, M. & Fernald, L. 2013. Cash transfers and domestic violence. *Journal of Health Economics,* 32**,** 304– 319.

Hidrobo, M., Peterman, A. & Heise, L. 2013. The effect of cash, vouchers and food transfers on intimate partner violence: Evidence from a randomized experiment in Northern Ecuador.

Hilton, N. Z., Harris, G. T., Rice, M. E., Krans, T. S. & Lavigne, S. E. 1998. Antiviolence education in high schools: Implementation and evaluation. *Journal of Interpersonal Violence,* 13**,** 726-742.

Holmes, R., Mannan, F., Hossain Dhali, H. & Parveen, S. 2010. Gendered risks, poverty and vulnerability in Bangladesh: Case Study of the Challenging the Frontiers of Poverty Reduction programme (CFPR), Specially Targeted Ultra Poor II (STUP II). London: ODI.

Hughes, K. 2012. Effectiveness Review: We Can Campaign, Bangladesh, Oxfam

ICRW 2002. Domestic Violence in India: Exploring Strategies, Promoting dialogue - Women Initiated Community level responses to domestic violence: Summary Report of Three Studies. Washington: ICRW.

Instituto Promundo et al. 2012. Engaging Men to Prevent Gender-Based Violence: A Multi-Country Intervention and Impact Evaluation Study

IRC No date. Getting down to business: Women's economic and social empowerment in Burundi. New York: International Rescue Committee.

Jan, S., Ferrari, G., Watts, C., Hargraves, J., Kim, J., Phetla, G., Morison, L. A., Porter, J. D., Barnett, A. & Pronyk, P. M. 2012. Economic evaluation of combined microfinance and gender training intervention for the prevention of intimate partner violence in rural South Africa. *Health Policy and Planning*.

Jana, S., Basu, I., Rotheram-Borus, J. M., & Newman, A. P. (2004). The SONAGACHI Project: A Sustainable Community Intervention Program. AIDS Education and Prevention, 16(5), 405–414.

Jaycox L. H, et al. 2006. Impact of a school based dating violence prevention program among Latino teens: a randomized controlled effectiveness trial. *J Adolesc Health*; 39(5):694-704.

Jewkes, R., Gibbs, A., Willan, S., Misselhorn, A., Jama, N., Sikweyiya, Y., Mbatha, N. & Washington, L. 2013. Stepping Stones And Creating Futures Intervention: Outcomes Of A Formative Evaluation Of Behavioural And Structural Pilot Intervention For Young People. *South African AIDS Conference.* Durban.

Jewkes, R., et al. 2008. Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. BMJ: 337:a506.

Jin, Sun et al. 2007. "Care for Development" intervention in rural China: a prospective followup study. *Journal of Developmental and Behavioral Pediatrics*, 2007. 28 (3): p. 213-8

Jones, N., Moore, K., Villar-Marquez, E. & Broadbent, E. 2008. Painful Lessons: The politics of preventing sexual violence and bullying at school. London: PLAN/Overseas Development Institute.

Jouriles, et al. 2010. Improving parenting in families referred to for child maltreatment: A randomized controlled trial examining effects of project support. *Journal of Family Psychology*, 243, 328-338

Kabeer, N. 2001. Conˉicts Over Credit: Re-Evaluating the Empowerment Potential of Loans to Women in Rural Bangladesh. *World Development,* 29**,** 63-84.

Kagitcibasi, C., et al. 2001. Long-term effects of early intervention: Turkish low-income mothers and children. *Applied Developmental Psychology*, 2001. 22 : p. 333-361

Kalichman, S. C., et al. 2009. "Integrated gender-based violence and HIV Risk reduction intervention for South African men: results of a quasi-experimental field trial." *Prev Sci* 10(3): 260-269.

Kalichman, S.C., et al. 2008. Randomized trial of a community-based alcohol-related HIV Risk-reduction intervention for men and women in Cape Town South Africa. *Annals of Behavioral Medicine*. 36: p.270---279.

Kantor, G.K. N.D. Final Report: Evaluation of Prevent Child Abuse Vermont's SAFE-T Program

Karim, Q. A. 2014. Reducing HIV in Adolescents: RHIVA Trial Key Conclusions. Durban: CAPRISA.

Karnataka Health Promotion Trust (2012) Evaluation of Community Mobilisation and Empowerment in relation to HIV Prevention among Female Sex Workers in Karnataka State, South India

Kerrigan, D., Fonner, V., Stromdahl, S. and C. Kennedy (2013) Community Empowerment Among Female Sex Workers is an Effective HIV Prevention Intervention: A Systematic Review of the Peer-Reviewed Evidence from Low- and Middle-Income Countries, AIDS and Behavior July 2013, Volume 17, Issue 6, pp 1926-1940

Kerrigan, D., Telles, P., Torres, H., Overs, C. and C. Castle (2008) Community development and HIV/STI-related vulnerability among female sex workers in Rio de Janeiro, Brazil, Health Education Research Vol. 23(1), 137-145

Khemka, I. 2000. Increasing independent decision-making skills of women with mental retardation in simulated interpersonal situations of abuse. *American Journal on Mental Retardation,* 105.

Khemka, I., Hickson, L. & Reynolds, G. 2005. Evaluation of a decision-making curriculum designed to empower women with mental retardation to resist abuse. *American Journal of Retardation,* 110**,** 193-204.

Krishnan, S., Subbiah, K. Khanum, S., Chandra, P.S. and N. S. Padian (2012) An Intergenerational Women's Empowerment Intervention to Mitigate Domestic Violence: Results of a Pilot Study in Bengaluru, India, Violence against Women 18: 346

Kim, J., Ferrari, G., Abramsky, T., Watts, C., Hargraves, J., Morison, L. A., Phetla, G., Porter, J. D. & Pronyk, P. 2009. Assessing the incremental effects of combining economic and health interventions: the IMAGE study in South Africa. *WHO Bulletin,* 87**,** 824-832.

Kirk, J. & Winthrop, R. 2005. Changing the gendered dynamics of refugee classrooms in West Africa: Introducing female classroom assistants. New York.

Kohler, H. P. & Thornton, R. 2010. Conditional Cash Transfers and HIV/AIDS Prevention: Unconditionally Promising?

Klein and Rye. 2004. Interaction-oriented Early Intervention in Ethiopia: The MISC Approach. *Infants and Young Children*, 2004. 17(4): p. 340-354.

Heise, L.L. 2011. What works to prevent partner violence: An evidence overview. Strive.

Hughes JR, Gottlieb LN. 2004. The effects of the Webster-Stratton parenting program on maltreating families: Fostering strengths. *Child Abuse & Neglect* 28(10): 1081–1097.

Knerr et al, 2011, Parenting and the prevention of child maltreatment in low- and middle-income countries: A systematic review of interventions and a discussion of prevention of the risks of future violent behaviour among boys. SVRI, MRC, Oak Foundation.

Lanier, C. A., et al. 1998. Evaluation of an intervention to change attitudes toward date rape. Clinical and Program Notes. *Journal of College Health*, 46(4), 177-180.

Leach, F., Slade, E. & Dunne, M. 2013. Desk Review for Concern: Promising Practice in School Related Gender Based Violence (SRGBV) Prevention and Response Programming Globally London: Concern Worldwide.

Letarte, M. J., et al. 2010. Effectiveness of a parent training program "Incredible Years" in a child protection service. *Child Abuse Negl* 34(4): 253-261.

Lippman, S., Donini, A., Dı́az, J., Chinaglia, M., Reingold, R. and D. Kerrigan (2010) Social-Environmental Factors and Protective Sexual Behavior Among Sex Workers: The Encontros Intervention in Brazil, American Journal of Public Health Supplement 1, 2010, Vol 100, No. S1

Lobo, T. R. 2004. Evaluation of a Sexual Assault Prevention Program for College Men: Effects on Self-Reported Sexually Aggressive Behavior, Social Perceptions, and Attitudes. Doctoral dissertation submitted to the Philosophy department of the College of Arts and Sciences of Ohio University.

Lonsway, K. A., Klaw, E. L., Berg, D. R., Waldo, C., Kothari, C., Mazurek, C. J. & Hegeman, K. E. 1998. Beyond "no means no": Outcomes of an intensive program to train peer facilitators for campus acquaintance rape education. *Journal of Interpersonal Violence,* 13**,** 73-92.

Lonsway, K. A. & Kothari, C. 2000. First Year Campus Acquaintance Rape Education: Evaluating the Impact of a Mandatory Intervention. *Psychology of Women Quarterly,* 24**,** 220-232.

McCloskey, L. 2011. A systematic review of parenting interventions to prevent child abuse tested with RCT designs in high income countries, SVRI, MRC, Oak Foundation.

Macgowan, M. J. 1997. An evaluation of a dating violence prevention program for middle school students. *Violence and Victims*. 12(3):223-235

MacMillan HL, et al. 2005. Effectiveness of home visitation by public-health nurses in prevention of the recurrence of child physical abuse and neglect: A randomised controlled trial. *Lancet* 365(9473): 1786–1793.

Maiden, R. 1997. Alcohol dependence and domestic violence: Incidence and treatment implications. *Alcoholism Treatment Quarterly*, 15, 31–50.

Mcaslan Fraser, E. 2012. Violence Against Teachers: Review of Evidence Base. Nigeria: ESSPIN.

Mejdoubi, J., Van Den Heijkant, S. C. C. M., Van Leerdam, F. J. M., Heymans, M. W. & Hirasing, R. A. 2013. Effect of Nurse Home Visits vs. Usual Care on Reducing Intimate Partner Violence in Young High-Risk Pregnant Women: A Randomized Controlled Trial. *Plos One,* 8.

Mgalla, Z., Schapink, D. & Ties Boerma, J. 1998. Protecting school girls against sexual exploitation: A guardian programme in Mwanza, Tanzania. *Reproductive Health Matters,* 6**,** 19-30.

Mikton, C. & Butchart, A. 2009. Child Maltreatment Prevention: A Systematic Review Of Reviews. *WHO Bulletin,* 87**,** 353-361.

Miller, E., et al. 2013. One-year follow-up of a coach-delivered dating violence prevention program: a cluster randomized controlled trial. *Am J Prev Med* 45(1): 108-112.

Miller, E., et al. 2012. ""Coaching boys into men": a cluster-randomized controlled trial of a dating violence prevention program." *J Adolesc Health* 51(5): 431-438.

Miltenberger, R. G., Roberts, J. A., Ellingson, S., Galensky, T., Rapp, J. T., Long, E. S. & Lumley, V. A. 1999. Training and generalization of sexual abuse prevention skills for women with mental retardation. *Journal of Applied Behavior Analysis,* 32**,** 385-388.

Moynihan, M. M., et al. 2011. "Sisterhood may be powerful for reducing sexual and intimate partner violence: an evaluation of the Bringing in the Bystander in-person program with sorority members." *Violence Against Women* 17(6): 703-719.

Moynihan M.M, et al. 2010. Engaging intercollegiate athletes in preventing and intervening in sexual and intimate partner violence. *J Am Coll Health*. Nov-Dec; 59 (3):197-204

O'Farrell, T. J., et al. 2004. Domestic violence before and after couples-based alcoholism treatment: The role of treatment involvement and abstinence. *Journal of Clinical and Consulting Psychology*, 72, 202–217.

O'Farrell, T. J., & Murphy, C. M. 1995. Marital violence before and after alcoholism treatment. *Journal of Consulting and Clinical Psychology*, 63(256), 262[3].

Olds et al. 2002. Home visiting by paraprofessionals and by nurses: A randomized, controlled trial, *Pediatrics* 110, 486-496

Olds DL, et al., 1997 Long-term effects of home visitation on maternal life course and child abuse and neglect: fifteen-year follow-up of a randomized trial. *JAMA* 278:637-43. PMID:9272895 doi:10.1001/jama.278.8.637

Open Society Foundation For South Africa 2001. What do we want to tell our children about violence against women? Evaluation report for the project developing a model 'gender and conflict' component for the primary school curriculum. Cape Town: Open Society Foundation for South Africa.

Oster, E. & Thornton, R. 2011. Menstruation, Sanitary Products, and School Attendance: Evidence from a Randomized Evaluation. *American Economic Journal: Applied Economics,* 3**,** 91-100.

Oveisi, Ardabili et al. 2010, Primary prevention of parent-child conflict and abuse in Iranian mothers: A randomized-controlled trial, *Child Abuse and Neglect*, 34 (3): p. 206-213

Paluck, E.L., & Ball, L. (2010). Social norms marketing aimed at gender based violence: A literature review and critical assessment. New York: International Rescue Committee.

Pande, R., Kurz, K., Walia, S., Macquarrie, K. & Jain, S. 2006. Improving the Reproductive Health of Married and Unmarried Youth in India: Delaying Age at Marriage in Rural Maharashtra, India. New Dehli: ICRW.

PATH. 2012. Evaluation summary: changing gender norms of Kenyan scouts. Washington DC: PATH;

Pettifor et al. 2013. Feasibility and acceptability of Project Connect: A couples-based HIV-risk reduction intervention among young couples in Johannesburg, South Africa

Pettifor, A. E., Levandowski, B. A., Macphail, C., Padian, N. S., Cohen, M. S. & Rees, H. V. 2008. Keep them in school: the importance of education as a protective factor against HIV infection among young South African women. *Int J Epidemiol,* 37**,** 1266-73.

Pettifor, A. E., Macphail, C., Nguyen, N. & Rosenberg, M. 2012. Can money prevent the spread of HIV? A review of cash payments for HIV prevention. *AIDS and Behaviour,* 16**,** 1729-1738.

Plan International 2012. A Girl's Right to Learn without Fear: Working to end Gender Based Violence in Schools New York: Plan Limited.

Pronyk, P. M., Hargreaves, J. R., Kim, J. C., Morison, L. A., Phetla, G., Watts, C., Busza, J. & Porter, J. D. 2006. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial. *Lancet,* 368**,** 1973-83.

Peltzer, K., et al. 2008. Evaluation of alcohol screening and brief intervention in routine practice of primary care nurses in Vhembe district, South Africa. *Croatian Medical Journal*, 49(3): p. 392---401.

Powell 201., Review of bystander approaches in support of preventing violence against women; Victorian Health Promotion Foundation, Victoria, Australia;

Prinz, et al. 2009. Population-based prevention of child maltreatment: The U.S. Triple P System Population Trial. *Preventative Science*, 10(1): P.1-12

Pulerwitz, J., et al. 2010. Promoting Gender Equity for HIV and Violence Prevention: Results from the Male Norms Initiative Evaluation in Ethiopia. 2010, PATH: Washington D.C.

Raab, M. 2011. The 'We Can' Campaign in South Asia, 2004-2011 Evaluation

Radford, L., Allnock, D. & Hynes, P. 2014. Preventing and Responding to Child Sexual Abuse and Exploitation in Low- and Middle-Income Countries and Humanitarian Emergency Contexts: Evidence review.

Rahman, Iqbal et al. 2009, Cluster randomized trial of a parent-based intervention to support early development of children in a low-income country, Child Care, *Health & Development*, 2009.35(1): p. 56-62.

Raising Voices and the Center for Domestic Violence Prevention, 2003, Mobilizing communities to prevent domestic violence, Kawempe Division, Uganda. Impact Assessment.

Rajan, A. 2010. Assessment of We Can Phase II India Project

Raj, A., Saggurti, N., Lawrence, D., Balaiah, D. & Silverman, J. 2010. Association between adolescent marriage and marital violence in young adulthood in India. *International Journal of Gynecology and Obstetrics,* 110**,** 35-39.

Reilley, A. 2014. Adolescent girls' experiences of violence in school in Sierra Leone and the challenges to sustainable change. *Gender and Development,* 22**,** 13-29.

Reza-Paul, S., Lorway, R., O'Brien, N., Lazarus, L., Jain, J., Bhagya, M., Fathima, M., Venukumar, K., Raviprakash, K., Baer, J. and R. Steen (2012) Sex worker-led structural interventions in India: a case study on addressing violence in HIV prevention through the Ashodaya Samithi collective in Mysore, Indian J Med Res. Jan 2012; 135(1): 98–106.

Roberts, K. 2009. Counselor Education. An Evaluation of the Expect Respect: Preventing Teen Dating Violence High School Program.

Rocca, C., Rathod, S., Falle, T., Pande, R. & Krishnan, S. 2009. Challenging assumptions about women's empowerment: social and economic resources and domestic violence among young married women in urban South India. *International Journal of Epidemiology,* 38**,** 577-585.

Rosenberg, M., Pettifor, A. E., Thirumurthy, H., Halpern, C. & Handa, S. 2014. The impact of a national poverty reduction program on the characteristics of sex partners among Kenyan adolescents. *AIDS and Behaviour,* 18**,** 311-316.

Ricardo. 2011. Engaging Boys and Young Men in the Prevention of Sexual Violence: A systematic and global review of evaluated interventions, SVRI, Instituto Promundo, Oak Foundation, MRC

Royal Norwegian Ministry Of Children, Equality And Social Inclusion, Un Special Representative Of The Secretary General On Violence Against Children And The Council Of Europe, 2011. Tackling violence in schools: High-Level Expert meeting co-organised by the Government of Norway, the Council of Europe and the UN Special Representative of the Secretary-General on Violence against Children Oslo, 27-28 June 2011: Final report of the meeting

Sanders, M., K Turner and C Markie-Dadds. 2002. The development and dissemination of the Triple P – positive parenting programme: a multi-level, evidence based system of partnering and family support, *Prevention Science*, 3(3): 173-189

Schensul, S.L., et al. 2010. Community-level HIV/STI intervention and their impact on alcohol use in urban poor populations in India. *AIDS and Behavior* 14:p.S158---S167.

Schuler, S., Hashemi, A., Riley, K. & Akheter, A. 1996. Credit programs, patriarchy and men's violence against women in rural Bangladesh. *Soc Sci Med,* 43**,** 1729-1742.

Schultz, S. K., et al. 2000. Evaluation of a university-based date rape prevention program: Effect on attitudes and behavior related to rape. *Journal of College Student Development*, 41(2), 193-201.

Schumm, J., et al. 2009. Partner violence before and after couples based alcoholism treatment for female alcoholic patients. *Journal of Consulting and Clinical Psychology*, 77, 1136–1146.

Search for Common Ground. 2011. Informing Refugees and Returnees on Gender based Violence: Program Evaluation. Kinshasa, DRC: Search for Common Ground

Shahnaz, R. & Karim, R. 2008. Providing microfinance and social space to empower adolescent girls: An evaluation of BRAC's ELA centers. Bangladesh: BRAC.

Shapiro, J. P., et al. 2001. "An evaluation of residential treatment for sexually aggressive youth." *J Child Sex Abus* 10(1): 1-21.

Skevington, S. M., et al. 2013. "A systematic review to quantitatively evaluate 'Stepping Stones': a participatory community-based HIV/AIDS prevention intervention." *AIDS Behav* 17(3): 1025-1039.

Ssewamala, F., Ismayilova, L., Mckay, M., Sperber, E., Bannon, W. & Alicea, S. 2010. Gender and the effects of an economic empowerment program on attitudes toward sexual risk-taking among AIDS-orphaned adolescent youth in Uganda. *Journal of Adolescent Health,* 46**,** 372-378.

Stephens, K. A., & George, W. H. 2009. Rape Prevention with College Men: Evaluating Risk Status. *Journal of Interpersonal Violence*, 24, 996-1013

Stuart, G. L., et al. 2003. Reductions in marital violence following treatment for alcohol dependence. *Journal of Interpersonal Violence*, 18, 1113–1131.

Swaminathan, H., Ashburn, K., Kes, A., Duvury, N., Walker, C., Aliber, M. & Nkosi, B. 2007. Women's property rights, HIV and AIDS, and domestic violence: Research findings from two rural districts in South Africa and Uganda. Pretoria: HSRC.

Taft, A. J., Small, R., Hegarty, K. L., Watson, L. F., Gold, L. & Lumley, J. A. 2011. Mothers' Advocates In the Community (MOSAIC)—non-professional mentor support to reduce intimate partner violence and depression in mothers: a cluster randomized trial in primary care. *BMC Public Health,* 11**,** 178.

Taylor, B, et al. 2010. The Effects of Gender Violence/Harassment Prevention Programming in Middle Schools: A Randomized Experimental Evaluation. *Violence and Victims*, 25(2).

Teferra and Tekle. 1996. Mediational intervention for sensitizing caregivers: Ethiopia, in Early intervention: Cross-cultural experiences with a mediational approach, P. Klein, Editor. 1996, Garland:NewYork. p. 95-112.

Tiwari, A., Leung, W. C., Leung, T. W., Humphreys, J., Parker, B. & Ho, P. C. 2005. A randomized controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG,* 112**,** 1249–1256.

Usdin, S., et al. 2005. Achieving social change on gender-based violence: A report on the impact evaluation of Soul City's fourth series. *Social Science and Medicine*, 61, 2434-2445.

UNICEF 2009. Global Evaluation Report: Child Friendly Schools Programming New York: UNICEF.

UNICEF, UN WOMEN, UNFPA, ILO & Office Of The Special Representative Of The Secretary General On Violence Against Children 2013. Breaking the Silence on Violence against Indigenous Girls,

Adolescents and Young Women - A call to action based on an overview of existing evidence from Africa, Asia Pacific and Latin America. New York: UNICEF.

Unterhalter, E., North, A., Arnot, M., Lloyd, C., Moletsane, R., Murphy-Graham, E., Parkes, J. & Saito, M. 2013. Interventions to enhance girls' education and gender equality: A rigorous review of literature. London: Institute of Education.

USAID South Africa. 2013. Evaluation of Project Concern International.

USAID & DevTech 2008. Safe Schools Project Final Report. Washington: USAID.

Verma, R., et al. 2008. Promoting gender equity as a strategy to reduce HIV risk and gender--based violence among young men in India, in Horizons Final Report. 2008, Pop. Council: Washington D.C.

Vyas, S. & Watts, C. 2009. How does economic empowerment affect women's risk of intimate partner violence in low- and middle-income countries? A systematic review of published evidence. *Journal of International Development* 21**,** 577–602.

Wagman J., 2014. A Cluster Randomized Trial of the Impact of an Intimate Partner Violence and HIV Prevention Intervention on Emotional, Physical and Sexual Abuse, Sexual Risk Behaviors and HIV Incidence in Rakai, Uganda

Weatherley, R., Siti-Hajar, A., Noralina, O., John, M., Preusser, N. & Yong, M. 2012. Evaluation of a school-based sexual abuse prevention curriculum in Malaysia. *Child and Youth Services Review,* 24**,** 119-125.

Wendland-Carro, Piccinini et al. 1999. The role of an early intervention on enhancing the quality of mother-infant interaction. *Child Development*, 1999. 70(3): p.713-21

Weschsberg, W., Jewkes, R., Novak, S., Kline, T., Myers, B., Browne, F., Carney, T., Lopez, A. M. & Parry, C. 2013. A brief intervention for drug use, sexual risk behaviours and violence prevention with vulnerable women in South Africa: a randomised trial of the Women's Health CoOp. *BMJ Open,* 3.

WHO 2005. WHO multi-country study on women's health and domestic violence against women. Geneva: WHO.

WHO. 2009. Violence prevention, the evidence. Promoting gender equality to prevent violence against wome. Series of briefings on violence prevention. WHO, Geneva.

WHO and UNAIDS. 2010. Addressing violence against women and HIV/AIDS: What works? WHO: Geneva

WHO, UNFPA, UNAIDS, NSWP and World Bank (2013) Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions - Chapter 2: Addressing Violence against Sex Workers

William, et al., 2011, Changemaking: How we adopt New attitudes, Beliefs and practices. Insights from the We Can Campaign. We Can Campaign, 2011

Wolfe, D., et al. 2003. Dating violence prevention with at-risk youth: A controlled outcome evaluation. *Journal of Consulting and Clinical Psychology*, 71(2), 279–291

Wolfe, D., et al. 2009. A school based program to prevent adolescent dating violence: A cluster randomized trial. *Archives of Pediatrics & Adolescent Medicine*, 163(8), 692–699

Wright, V. et al. 2000. The Community Awareness Rape Education (CARE) program for high school students. *Journal of Emergency Nursing*, 26(2), 182-185.

Wurtele, S. K., Saslawsky, D. A., Miller, C. L., Marrs, S. R. & Britcher, J. C. 1986. Teaching personal safety skills for potential prevention of sexual abuse: a comparison of treatments. *Journal of Consulting & Clinical Psychology,* 54**,** 688-692.

YWCA SOLOMON ISLANDS 2013. Rise Up! Young Women's Leadership Program: Evaluation Report. Solomon Islands: YWCA.

Zwi, K. J., Woolfenden, S. R., Wheeler, D. M., O'brien, T. A., Tait, P. & Williams, K. W. 2007. School-based education programmes for the prevention of child sexual abuse. USA: Cochrane database of systematic reviews.