# A Summary of the Evidence and Research Agenda for **What Works**: A Global Programme to Prevent Violence against Women and Girls

## BACKGROUND

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 a global public health problem – 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. It impoverishes individual women, and their families, communities and countries. Even the most conservative estimates measure the national costs of VAWG in the billions of dollars.

*What Works* To Prevent Violence is a global programme administered by a consortium led by the Medical Research Council of South Africa, in partnership with the London School of Hygiene and Tropical Medicine and Social Development Direct, on behalf of DFID. Its aim is to build knowledge on what works to prevent violence against women and girls. There are many forms of violence against women and girls, but the programme focuses on intimate partner violence (emotional, economic, physical, sexual), non-partner sexual violence, and child abuse (emotional, physical, sexual). The focus of the consortium is on identifying effective strategies for prevention – that is, preventing violence from ever occurring by addressing the root causes or established risk factors for violence. Such interventions may entail interventions with women and girls and/or men or boys, and include men or boys who have already perpetrated violence if their goal is to stop further perpetration, or perpetration of another type of VAWG. Similarly it may include interventions with women or girls who have experienced violence if they have a goal to prevent further violence of the same or a different type.

The programme will make innovation grants to support 10-14 national organisations or international non-profit organisations working in DFID priority countries to fund innovative approaches to preventing violence. In addition to providing funds for innovative programming, the grants will help strengthen the capacity of researchers to conduct rigorous evaluation research on VAWG interventions. The programme will also undertake operations research and impact evaluations of promising existing interventions to assess their effectiveness or, if proven effective, to better understand the economics of scale up.

## REVIEW OF THE EVIDENCE

To inform the priorities for innovation grants and research under the *What Works* programme, the Consortium has undertaken a review of the evidence on VAWG and interventions to prevent it. These reviews are presented in four rapid evidence review papers with accompanying summaries (available at www.whatworks.co.za).

1. **Evidence Review of the state of the field of violence against women and girls: What do we know and what are the knowledge gaps?** Paper 1 outlines the current knowledge base regarding the scale, scope and drivers of VAWG and identifies where our understanding needs to be expanded in order to deliver the most comprehensive and effective interventions and reduce the prevalence of VAWG globally
2. **Evidence Review of interventions to prevent violence against women and girls.** Paper 2 examines the evidence base for the effectiveness of interventions designed explicitly to prevent violence against women and girls. This includes interventions that engage with boys and men, those designed to empower women and girls and interventions designed to address risk factors such as child abuse.
3. **Evidence Review of the effectiveness of response mechanisms to prevent violence against women and girls.** Paper 3 reviews interventions that are developed and deployed with a primary goal to strengthen the response of the police and criminal justice system, health system or social sector to violence against women and girls. The paper assesses any evidence that interventions can achieve a secondary goal of prevention of violence against women and girls.
4. **Evidence Review of approaches to assess value for money and scale up of violence against women and girls Prevention.** Paper 4 provides an overview of the evidence, approaches and economic issues to be considered when designing and assessing VAWG programmes in order to inform future programme scale up.

**This paper presents an *overall* summary of the findings of these 4 evidence reviews, and based upon these findings presents an overarching research and innovation agenda for the *What Works* programme.**

## THE PROBLEM

**TABLE 1: WHAT DO WE KNOW ABOUT VAWG?**

| | IPV | Non-partner sexual violence | Child abuse |
|---|---|---|---|
| Prevalence and patterns | IPV is a significant social problem worldwide, with estimates that 30% of women over the age of 15 have experienced physical or sexual violence by an intimate partner in their lifetime (1). However, the level of violence varies greatly between countries and even within countries. | Sexual violence is a global problem - the global estimate for the proportion of women who have experienced non-partner sexual violence is 7.2% - but levels of violence vary significantly across and within countries (2). | In high-income countries (HICs), the annual prevalence of physical abuse ranges from 4% to 16%. A recent meta-analysis estimates that 18% of women and 7.6% of men worldwide have experienced sexual abuse in childhood (3). In most settings girls typically report rates 2 to 3 times higher than boys in HICs (4), but in some settings boys repost of sexual abuse are higher than girls (2). |
| Perpetrators | In low and middle-income countries (LMICs), the majority of partner violence in perpetrated by men against women. In higher income countries, a greater proportion of violence appears to be mutual, although the health and social consequences of men's violence remain more severe for women. | The majority of sexual offences are committed by men known to the victim, with approximately half being serial offenders. Perpetration of non-partner sexual violence usually starts in adolescence. Data suggests that between 50-75% of men who rape do so for the first time as teenagers (5, 4). | The majority of child abuse takes place in the home and in schools, perpetrated primarily by someone known to the victim. Physical abuse and maltreatment is perpetrated most commonly by parents or caregivers. |
| Overlap with other forms of violence | Universally, types of violence (sexual, physical, emotional, economic) overlap in relationships, although the patterning of violence varies among countries. In most countries sexual violence usually occurs with physical violence, however in a number of settings in South East Asia sexual violence occurs on its own (5, 6). | There is a strong overlap between the perpetration of non-partner sexual violence and intimate partner sexual violence. There is also a strong overlap between men's perpetration of rape against women and against other men (5). | Types of violence against children and adversity in families frequently overlap. Child abuse also often occurs concurrently with intimate partner violence. This means that researchers must understand family environments that put children at risk rather than studying one type of violence at a time. |
| Causes and risk factors | No single factor causes partner violence. Violence emerges from the interplay of multiple interacting factors at different levels of the social "ecology". Some factors appear consistently potent in their power to elevate risk of partner violence in LMICs - exposure to violence in childhood; presence of community norms that support wife abuse; binge drinking; harmful notions of masculinity and rigid gender roles. | The perpetration of non-partner sexual violence is motivated primarily by sexual entitlement (2). Some factors appear consistently potent in their power to increase risk of non-partner sexual violence in LMICs - adverse childhood experiences, personality disorders, peer influences, delinquency, inequitable ideals of masculinity that emphasise heterosexual performance, and control of women. | Different types of violence against children have different constellations of risk and protective factors. However, common risks factors include poverty, approval of corporal punishment, mental health problems, low educational achievement, alcohol and drug misuse, having been maltreated oneself as a child, and violence between other family members. |

## What are the key gaps in our knowledge base regarding VAWG?

The field of violence against women and girls has advanced considerably over the past two decades. We have much more information on the prevalence of violence in low and middle income countries as well as an expanding body of knowledge on risk and protective factors. This positions us well to develop and implement strong primary prevention interventions with a rigorous theory of change. However, there are still key gaps in our knowledge that need to be addressed in order to move towards more comprehensive models of intervention, and ultimately end VAWG. Figure 2 highlights those critical areas where more evidence is needed.[1]

**TABLE 2: WHAT ARE THE KNOWLEDGE GAPS REGARDING VAWG?**

| | | | |
|---|---|---|---|
| Data on sexual violence is a gap compared to physical violence against women | Child sexual abuse, especially against boys and perpetrated by women | Men's perpetration of VAWG is a gap compared to women's victimization | There is a large geographical gap in the literature on VAWG in Middle East and Central Asia |
| There is limited data on VAWG in fragile states | We need more information on what helps buffer and protect individuals from risk. For example, what promotes resilience among children who have experienced abuse? | The current evidence base is highly skewed toward individual level predictors of abuse. More evidence is needed on relationship and community level risk and protective factors | Macro-level factors influence the geographic distribution of different types of violence and how global, economic and political processes feed into and affect the dynamic of VAWG |
| There is a substantial data base on risk factors for VAWG, but its unclear which are merely "markers" for other variables and which are causally related to the outcome | Interaction between factors across and within levels of the ecological model. e.g. protective effect of education is dampened when violence is highly acceptable in the community | Little is know about whether risk factors vary by age group | It is well established that adverse childhood experiences increase the risk of VAWG, however, we need to better understand how the experience of child abuse relates to other adverse childhood environments |
| The timing of risk factors and what is cause and effect | We must explore the extent of overlap between pathways to perpetration for different types of violence. | More evidence is needed on the impact of mental health/PTSD/antisocial behaviour on the perpetration of and experiences of violence | There has been limited research into the role that environment X gene interactions (epigenetics) play in the aetiology of different types of abuse. |

# THE SOLUTIONS

## Types of prevention interventions

There are multiple risk factors for women's experiences and men's perpetration of different types of VAWG. Therefore, there are many possible solutions - many types of interventions that have the potential to prevent VAWG. In the rapid review of evidence, we considered interventions with a primarily goal to prevent violence from occurring in the first place, such as community mobilization campaigns, social and empowerment interventions, school-based interventions, engaging men and boys, and early childhood interventions. We also reviewed interventions that primarily aim to respond to VAWG where prevention is a secondary or parallel goal, such as intervention within the police and justice sector, crisis

[1] More details can be found in the paper in this series, *State of the field of violence against women and girls: What do we know and what are the knowledge gaps?*

intervention, health sector, and social sector. Although, there is increasing evidence to point to the value of combination interventions an multi-sector interventions, there have been a very limited number of studies on these; most studies are of single interventions.[2]

## How effective are different types of interventions in preventing VAWG?

There has been an impressive increase in the evidence base on violence prevention interventions over the last 10 years. We now have several well-conducted randomised control trails (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 several rigorous impact evaluations of programmes in the pipeline. However, there are still many gaps.

In terms of prevention interventions, the review of evidence concluded that **there is fair evidence to recommend:** group based relationship-level interventions working with males and females, such as Stepping Stones; group based microfinance combined with gender-transformative approaches such as IMAGE; community mobilization interventions to change social norms; interventions that target boys and men (alongside women and girls) 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 may be that such interventions should be combined with broader prevention initiatives to achieve greatest impact. 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.

In terms of the potential preventive effect of response mechanisms, there is **fair evidence to recommend**: protection orders and shelters. Currently there is **insufficient evidence** to recommend (either because there is not enough evidence or because the impact on VAWG occurrence has not been measured): most of the other police and legal interventions, including police training, sexual offender policies, disruption plans, community policing, women's police stations, and paralegal interventions and community-based legal interventions (although these show some promise); crisis interventions including hot lines and One Stop Centres; alternative or restorative justice mechanisms; and counselling, therapy and psychological support (although these show promise). There is **conflicting evidence** on proactive arrest policies (except where linked to protection orders) second responder interventions, specialised courts, advocacy interventions that provide information and support to help access legal redress and resources in the community, perpetrator's programmes, and screening interventions with therapeutic intervention (CBT) within health services which does not allow us to make a recommendation for or against the intervention. Finally there is **evidence against** routine screening of women for experience of violence in health facilities, and against mandatory reporting and arrest in cases of domestic violence. It should be noted that this review does not assess the effectiveness of these interventions other than in terms of preventing VAWG.

While some response mechanism evaluations show some impacts on reducing repeat violence among those attending (or completing) the intervention, almost all the response interventions are used by only a small proportion of all women and girls who experience violence. This is because most women do not report the violence they experience to the police nor do they seek external care or formal services. Thus, at a population level, interventions through response mechanisms are unlikely to ever result in prevention of many incidents of violence.

Table 3 presents a summary of the evidence for different types of prevention interventions and response mechanisms to prevent VAWG. Darker colours represent stronger evidence, ranging from no evidence to fair evidence. Green suggests that the interventions have been shown to be effective in preventing VAWG, blue suggest they are promising, 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 and purple represents interventions where the impact on VAWG has not been measured.

[2] A detailed descriptions of different intervention types can be found in the main papers in this series, available at www.whatworks.co.za

**Table 3: Sum**mary of evidence for different types of interventions to prevent VAWG

| IMPACT OF INTERVENTION ON REDUCING VAWG | | | | |
|---|---|---|---|---|
| EFFECTIVE (Impact on VAWG) | • Microfinance and gender transformative approaches[3]<br>• Group based relationship-level interventions<br>• Group education with community outreach (men/boys)[4]<br>• Community mobilization – changing social norms | • Collectivisation and one-to-one interventions with vulnerable groups<br>• Alcohol reduction programmes (limited evidence from LMICs) | |
| PROMISING (or impact on risk factors only) | • Parenting programmes<br>• Protection orders (with proactive arrest)<br>• Shelters | • Whole-school interventions<br>• School based curriculum interventions<br>• Counselling, therapy and psychological support (some promising indications for couples therapy)[5] | • Transforming masculinities (qualitative studies only)<br>• Paralegal programmes and community-based legal interventions (only one study with very limited follow-up)[6] |
| CONFLICTING | • Bystander interventions<br>• Batterers (perpetrators) programmes<br>• Advocacy interventions/ support to access services | • Proactive arrest without a protection order<br>• Second responder programmes<br>• Specialised courts<br>• Alternative and restorative justice mechanisms<br>• Screening with referral (e.g. CBT) in health facilities<br>• Sexual offender registers and disruption plans | • Women's police stations/units |
| INEFFECTIVE (or not recommended due to risks) | • Routine screening for VAWG in health services<br>• Mandatory reporting and arrest for domestic violence | • Single component communications campaigns<br>• WASH interventions in schools | |

[3] Impact of microfinance found to be conflicting when not implemented with gender training.
[4] Most effective when implemented with boys and men with women and girls.
[5] A RCT study of women receiving counselling services following a stay in a shelter in the United States found that the intervention group reported significantly less violence than the control group two years after the intervention and there is some evidence of positive impact on communication in relationships as well as on the psychological health or women and children.
[6] A RCT of a legal advocacy programme in the US which trained law school students to work intensively with women seeking protection orders found women in the treatment group reported significantly less physical and psychological re-abuse and marginally better emotional support compared to women in the control group, but it was only at 6 weeks follow-up.

| | | | |
|---|---|---|---|
| NOT MEASURED | | | • Police and security personnel training (without systemic intervention)<br>• Community policing<br>• Hotlines<br>• One stop centres |
| | FAIR EVIDENCE | INSUFFICIENT EVIDENCE | NO EVIDENCE |

**STRENGTH OF EVIDENCE**

## What do we know about scalability?

A number of interventions to prevent and address violence against women and girls have been found to be effective and have been replicated in various settings, but little is known about their value for money (VFM) and how to take them to scale. Only five studies on violence prevention interventions were identified from LMICs with cost or economic evaluation data: in South Africa (IMAGE and Soul City), Uganda (SASA!), Brazil (Programme H) and India (Avahan). Even fewer studies analysed cost-effectiveness for a violence outcome, rather than presenting a unit cost. Only one allowed for a comparison with an international threshold of what is considered acceptable and cost-effective (WHO), namely the gender/HIV training component added on to a microfinance scheme (IMAGE) for poor women in rural South Africa. It was cost-effective even when only factoring in its impact on partner violence.

**What was measured?**

Financial costs – money spent to deliver the intervention

Economic costs – the value of other non-financial inputs, such as office space and volunteer time

Unit cost – cost per intervention output produced

**What was not measured?**

Costs to participants in interventions

The breadth of benefits of effective violence prevention

Approaches to preventing VAWG are likely to have multiple spillover effects on women's health, as well as their children's health and education. Moreover, development interventions that address the underlying structural causes of violence, such as poverty, could indirectly impact on VAWG outcomes. For this reason, it is important that the multiple benefits of VAWG programmes are assessed and included in value for money assessments.

A considerable number of studies, particularly from high-income countries, have sought to quantify the economic cost of violence, or the cost to society of not intervening to address VAWG. Such evidence could be an important input into value for money assessments that incorporate a broad range of costs and benefits.

Current evidence on effective interventions point to the importance of participatory group-based intervention delivery, larger scale social norm and community mobilisation approaches, as well as the value of structural level changes. Group-based participatory interventions that engage over time with women, men, girls and boys could possibly best be scaled up as add-ons to large-scale programmes in various sectors, such as such as education, economic development, social welfare and health, with potentially low incremental cost. By addressing the multiple economic and health needs of their beneficiaries, such an approach could enable existing investments to be leveraged for greater impact on VAWG prevention. Community-level mobilisation intervention models delivered by a local NGO may be more efficiently expanded through replication by other similar organisations. This 'franchise' model has been used to scale up community-focused HIV programmes to good effect.

## What are the current limitations and gaps in the evidence base for prevention interventions and scale-up?

**Prevention and response interventions**

- Most rigorous evaluations of prevention interventions and response mechanisms are from High Income Countries (HICs) and there has been little testing of how these programmes may impact differently in Low and Middle Income Countries (LMICs).
- 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.
- Most interventions have not been evaluated for their impact on VAWG occurrence, making an assessment of their effectiveness difficult.
- The population and community level impact of prevention and response mechanisms has rarely been studied or modelled.
- There is limited evidence on the effectiveness of prevention and response mechanisms to reduce violence occurrence in vulnerable groups.
- The use of various and often inconsistent outcome measures (e.g. police records of repeat offence, victim reports) complicates the interpretation of study findings.
- There is limited synthesis across interventions of key pathways through which interventions may be achieving their impacts.
- Evaluations are often conducted after short follow-up periods, meaning that we understand little about how change is sustained.
- Intervention evaluations often do not acknowledge the extent to which comprehensive impact on women's lives is dependent on elements beyond the control of the intervention.

**Scalability and costing**

- Very few studies on violence prevention interventions from LMICs have cost or economic evaluation data
- Costing analyses varying in quality, and use a range of intervention outputs, making it difficult to understand the relative efficiency of different interventions.
- Most cost estimates are from single sites and small-scale pilots, making it difficult to generalise and use current unit cost data to inform future budgeting at a national or global level.
- Very few studies analysed cost-effectiveness for a violence outcome, rather than presenting a unit cost, making it difficult to say whether VAWG interventions are good value for money

## IMPLICATIONS FOR PREVENTION INTERVENTIONS

Overall, the evidence review suggests the following considerations when developing and implementing prevention interventions.

**1. Know the specific landscape of violence in the setting**

This review has demonstrated that the prevalence, patterns, and drivers associated with men's perpetration of violence vary both across and within countries. Before embarking on a intervention to prevent VAWG, it is important to assess the exact types and combinations of violence that are most prevalent in the context. Which populations are most vulnerable to victimisation and to perpetration? Which risk factors are likely to heighten individual-level risk? Which factors drive the overall level of physical and sexual violence in the population? Prevention programmes must be aware of and respond to these specificities in the local landscape of violence.

It is also important to remember that correlation does not equal causation. Many of the factors identified to date may turn out to be "markers" of increased risk rather than true links in a causal chain.

**2. Build the intervention from a well-articulated theory of change, drawing on existing evidence and related theories**

Good practice in intervention design begins with a well-articulated theory of change that articulates exactly how each programme component addresses one or more links in the hypothesized pathway between the problem and proposed solution. If using the socio-ecological model, it is not sufficient to focus only on the individual level or haphazardly pick a range of factors from different levels of the model and present this as a theory of change. Rather, a theory of change must articulate a comprehensive vision of how the intervention addresses key factors along a hypothesized causal pathway.

It is important to anticipate possible interactions between factors operating at different levels and to monitor these during project implementation as well as potential intervening variables that may either mediate (serve as a pathway for) or moderate (potentiate) the likelihood of violence. This is necessary to "test" different links in the theory of change. For example, did the women's empowerment group actually change women's bargaining power in the household and did this have the hypothesized impact on the frequency and severity of partner violence? If women's bargaining power increased but violence stayed the same, this raises questions either about the validity of the underlying causal theory, the appropriateness of the measures, the fidelity of implementation, the role of context, or the time required to see change.

**3. Design and implement interventions for different age groups, across the life-cycle, linked together**

VAWG occurs across the life cycle and is driven by factors operating across the life cycle. Therefore a variety of interventions are needed to target different age groups. For example, given that some risk factors for perpetration of sexual violence start from birth, it is essential that prevention programmes include interventions directed at the first five years of life. The goal of these interventions is to strengthen care giver child attachment, reduce use of physical punishment, and enhance parenting. Similraly, given the evidence that sexual violence perpetration most often starts in adolescents, rape perpetration interventions are needed to target boys before they rape and so must span all of the teenage years.

**4. Design and implement different interventions to target the general population and high-risk groups – both are important**

Given the high prevalence of VAWG and its association with social norms around the acceptability of violence, or aggressive forms of masculinity, interventions aimed at the general population level are important to prevent VAWG. However, some forms of violence, such as non-partner rape, appear to be driven perpetrated 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 to target high-risk youth, who will likely require very different approaches to the general population.

5. **Design and implement interventions that address multiple risk factors and/or work across multiple settings**

The review suggests 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.

**6. Target the intervention to maximize potential impact**

While all violence is an abuse of human rights, programme designers may want to consider the relative merits of focusing initially on the more severe forms of violence in a setting or on populations at higher risk of victimisation or perpetration. It is sometimes easier to begin to build social consensus against a practice when it is at the extreme end of a continuum. Another option for targeting is to start with settings (family, school, community) or types of violence most amenable to intervention and where positive synergies can be achieved across setting, age group or overlapping social problems.

**7. Understand the larger social and cultural milieu that perpetuates violence against women. Consider opportunities to address aspects of the structural scaffolding of violence as part of your intervention**

All forms of violence against women and girls are embedded in webs of symbolic, material and normative practices and that posit the basic superiority of men over women, and reinforce hierarchies based on age, economic standing, race and ethnicity. These practices are buttressed by legal structures, the media, religious teachings and everyday interaction.

The implications of this review are that complex interventions are needed that work at multiple levels, particularly addressing environmental and structural factors as well as those working on individual level factors, such as gender attitudes. For example, the review found that gender 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; or economic interventions that also aim to transform gender relationships.

**8. Contemplate the scalability of proposed interventions in terms of human and financial resources**

Given the dimensions of the problem, any intervention to prevent violence against women or children will need to be scalable. It does little good to prove that a 50-session intervention run by skilled counsellors can help reduce violence if there is no viable way to implement and scale up the intervention in LMICs.

Central to scale up 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. Likewise schools are another obvious platform for large scale influence. Here the challenge is to equip enough change agents to engage with students, teachers, and parents.

## THE *WHAT WORKS* RESEARCH AND INNOVATION AGENDA

Based on an overall review of the knowledge and evidence base as presented in the other papers in this series (see www.whatworks.co.za) and described above, *What Works* Component 1 will implement the following research agenda, presented as Figure 1. There are no sets of interventions that were found to have a good evidence base, therefore the agenda focuses on interventions that were identified to be promising or effective but where the quality and quantity of the evidence needs to be expanded. Overall, this evidence review suggests that interventions to improve the role of response mechanisms in preventing VAWG should not be a major priority compared to the promise of various community-level prevention mechanisms. This is both because of the limited number of men and women that can be impacted through response mechanisms as well as various limitations in what such interventions can achieve. Nonetheless, there may be a case for limited further work in this area.

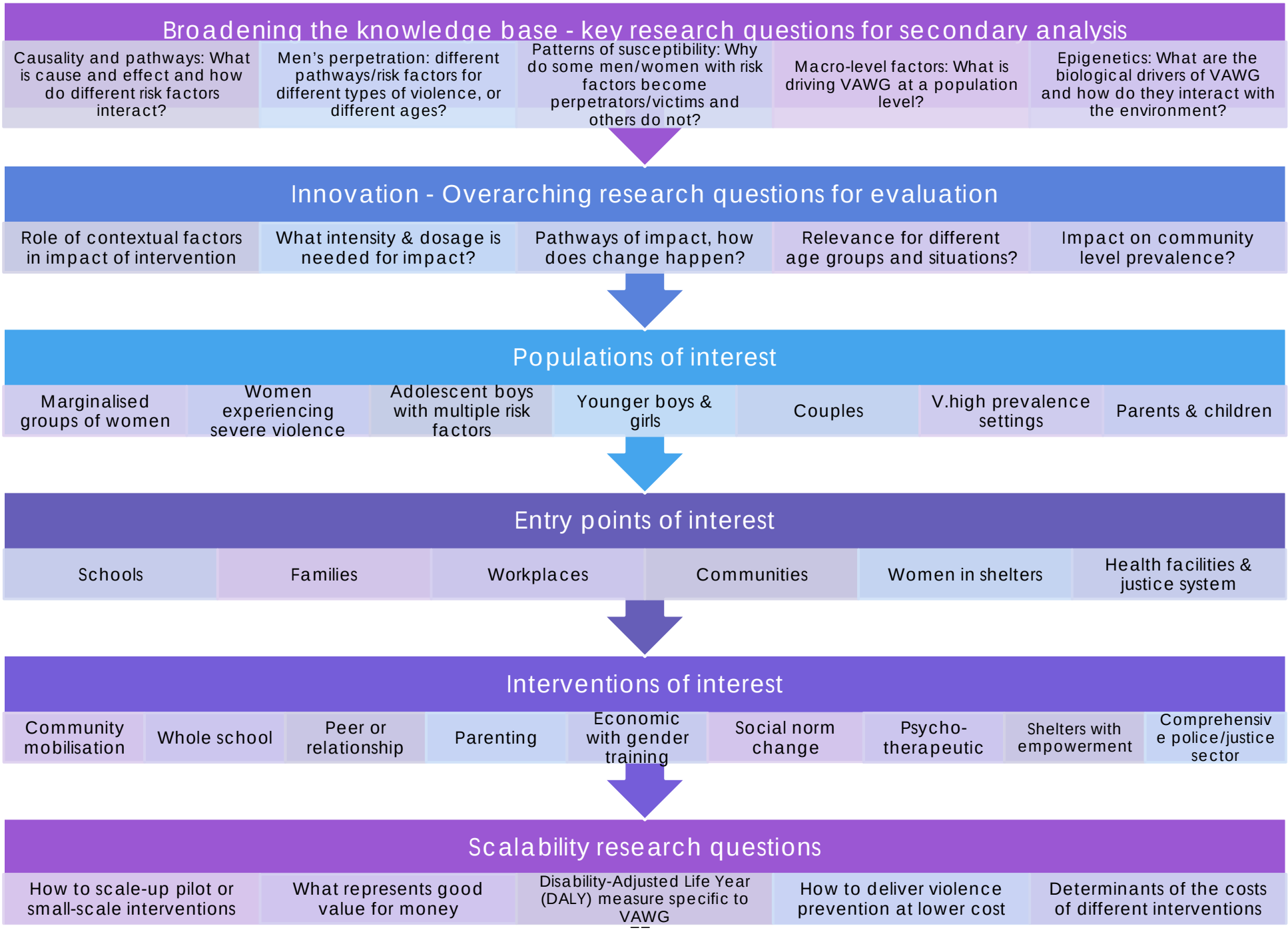
This research agenda applies to both the selection of innovation grantees and programmes for impact evaluation and operations research. The priorities for innovation grants and evaluation research are not separated as it is anticipated that there will be cross-learning between these two components of the programmes. The key research questions outlined in the first level of the figure, have been identified based on a review of the gaps in the knowledge (see Table 1), and will inform the secondary analysis of existing data.

The model outlined in Figure 1, with populations, entry points and interventions of interest was developed to enable multiple different models of prevention to potentially be included in the *What Works* programme. The field of violence prevention is relatively young and this model allows scope for innovation and mixing and matching across sectors. The clearly identified that multi-component interventions were particularly promising, therefore this model allows for research and interventions that address multiple populations, use multiple methods and work across multiple sectors. For example, a single programme may work in a family context, with parents, couples, and children and may implement strategies to address relationship skills, parenting practices, economic empowerment and gender transformation.

The overarching research questions for evaluation should inform all innovation grantees and evaluations and it is expected that each project should contribute to answering more than one of these questions at the same time. For example, an evaluation of a community mobilization intervention with workshops could explore pathways for change, intensity and dosage needed and community level impact. The scalability research questions likewise apply to all components of the programme and addressing these questions will be incorporated into the design of interventions and research from the outset.

By implementing this research agenda, the *What Works* programme aims to significantly expand the knowledge and evidence base on what interventions work to prevent VAWG in LMICs, how they work, and how effective interventions can be scaled up. With comprehensive communication and research uptake this evidence will lead to more effective, evidence-based programmes and policies to prevent VAWG, and more innovations taken to scale. Ultimately we envisage that this will result in more women and girls receiving improved quality prevention and response services and, in time, a decrease in the prevalence of violence in the Global South.

**Figure 1: What Works research and innovation agenda**


Broadening the knowledge base - key research questions for secondary analysis
Causality and pathways: What is cause and effect and how do different risk factors interact?
Men's perpetration: different pathways/risk factors for different types of violence, or different ages?
Patterns of susceptibility: Why do some men/women with risk factors become perpetrators/victims and others do not?
Macro-level factors: What is driving VAWG at a population level?
Epigenetics: What are the biological drivers of VAWG and how do they interact with the environment?
Innovation - Overarching research questions for evaluation
Role of contextual factors in impact of intervention
What intensity & dosage is needed for impact?
Pathways of impact, how does change happen?
Relevance for different age groups and situations?
Impact on community level prevalence?
Populations of interest
Marginalised groups of women
Women experiencing severe violence
Adolescent boys with multiple risk factors
Younger boys & girls
Couples
V.high prevalence settings
Parents & children
Entry points of interest
Schools
Families
Workplaces
Communities
Women in shelters
Health facilities & justice system
Interventions of interest
Community mobilisation
Whole school
Peer or relationship
Parenting
Economic with gender training
Social norm change
Psycho-therapeutic
Shelters with empowerment
Comprehensive police/justice sector
Scalability research questions
How to scale-up pilot or small-scale interventions
What represents good value for money
Disability-Adjusted Life Year (DALY) measure specific to VAWG
How to deliver violence prevention at lower cost
Determinants of the costs of different interventions

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5. Gilbert, R., et al. (2009). "Burden and consequences of child maltreatment in high-income countries." The Lancet **373**(9657): 68-81.

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