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Intimate partner violence prevention

An evidence gap map

June 2017

Evidence Gap Map Report 8

Health

International Initiative for Impact Evaluation

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About this evidence gap map report

This report provides the supporting documentation for the 3ie evidence gap map on intimate partner violence prevention, developed as part of a project funded by an anonymous donor. All of the content of this report is the sole responsibility of the authors and does not represent the opinions of 3ie, its donors or its Board of Commissioners. Any errors and omissions are also the sole responsibility of the authors. Please direct any comments or queries to the corresponding author Mario G Picon at mpicon@3ieimpact.org.

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Intimate partner violence prevention: an evidence gap map

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Summary

Intimate partner violence (IPV) is a global health concern and a human rights violation. According to the World Health Organization (2013), about one third of women worldwide will suffer some form of partner violence at one point in their lives, and closer to two thirds in some countries. In recent years, stakeholders – from grassroots activists to international donors – have devoted increasing attention to this issue. Increases in IPV prevention programming in low- and middle-income countries, including the adaptation or replication of high-profile interventions in new settings, reflect this stakeholder interest. Recent work in this area is also driven by the growth in research on the nature, determinants and risk factors associated with IPV incidence.

IPV prevention programming has the potential to improve gender power relations in communities significantly and to have a positive impact on people's lives. Impact evaluations – studies assessing the true impact of an intervention by developing a counterfactual and using experimental and quasi-experimental methods – can improve programming by providing insights into what works, for whom and why.

3ie evidence gap maps provide a visual display of completed and ongoing systematic reviews and impact evaluations in a sector or policy issue, structured around a framework of interventions and outcomes (Snilstveit et al. 2017). They identify areas where there is little to no evidence, as well as clusters of evidence that could be used for syntheses.

This report summarises the findings of an evidence gap map of 47 completed and 28 ongoing impact evaluations of programmes and policies aimed at IPV prevention in low- and middle-income countries. In this mapping exercise, we found no completed or ongoing systematic reviews that met our inclusion criteria (included low- or middle-income countries and had a medium or high confidence rating using the 3ie systematic review assessment tool). We coded studies across 18 intervention categories and 17 outcome categories.

A consultative process with stakeholders from several agencies and organisations informed the development of the framework used for the map, which is inspired by the conceptual framework that informs most IPV prevention programming, the ecological model (Heise 1998).

This report focuses primarily on the results of the completed impact evaluations. The evidence base is barely a decade old. It is highly concentrated in a handful of low- and middle-income countries (particularly South Africa, Uganda and India), with a clear preference for experimental rather than quasi-experimental designs. Impact evaluation of IPV prevention interventions in conflict-afflicted or post-conflict countries, or in humanitarian contexts, is limited to three studies in Côte d'Ivoire, with new ones under preparation for the Democratic Republic of the Congo and Haiti.

A significant proportion of impact evaluations included in the evidence gap map focus on interventions targeted at individuals, particularly economic and social empowerment interventions targeting women. The interventions with the second largest number of impact evaluations are those using multicomponent approaches. This category of

interventions target different levels of the social ecology using various combinations of approaches.

When shifting the focus to outcomes, there is a clear effort to report on indicators focused on women's actual experience of IPV, mainly based on self-reporting. Less than 40 per cent of completed impact evaluations provide information on vulnerable groups, or report effects beyond 24 months after the intervention.

A gender analysis of the evidence base indicates that only about a quarter of studies actually discuss how gender norms affect the effectiveness of the programmes evaluated, with about a third of them assessing outcomes related to changes in gender norms.

As expected, we find a high concentration of studies for interventions aiming at and reporting outcomes on women. However, there is little information on outcomes for men, something confirmed by our examination of sex disaggregation across completed studies. Approaches, such as bystander or parenting interventions that are well represented in recent programming, have no impact evaluations in the evidence gap map.

Similarly, there is a low number of studies evaluating interventions at the institutional level; and also at the community level when outcomes reported are not focused on women. To fill this gap in evidence, there is an opportunity for the use of quasi-experimental designs to evaluate outcomes at these socio-ecological levels.

Multicomponent programmes could also provide opportunities to fill the evidence gaps we have identified. Impact evaluations could provide an overall assessment of the programme but also focus more consistently on the effectiveness of the different interventions within them. In turn, they in turn would allow for greater use of cost-effectiveness analysis when evaluating IPV prevention programmes.

Finally, while there are a number of clusters of rigorous evidence, the high variety of the interventions may complicate synthesis efforts. In the short term, attention should be given to the evolution of this evidence base. There were 28 impact evaluations already under preparation at the time of our search and screening, which would more than double the number of studies in this map and provide new opportunities for synthesis.

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Abbreviations and acronyms

CBO	Community-based organisation
EGM	Evidence gap map
GBV	Gender-based violence
ICT	Information and communications technology
IPV	Intimate partner violence
ICT	Instrumental variable
L&MICs	Low- and middle-income countries
PSM	Propensity score matching
RCT	Randomised controlled trial
VAWG	Violence against women and girls
WHO	World Health Organization

1. Introduction

In the past few years there has been a growing recognition of gender-based violence (GBV), and intimate partner violence (IPV) in particular, as not only a global health epidemic and concern but also a human rights violation (Contreras-Urbina et al. 2016; WHO 2013; Heise 2011). As the World Health Organization's (WHO) *Global and regional estimates of violence against women* states, this is a reflection of the commitment around the world to document the magnitude of the GBV[1] epidemic, as well as the growing body of evidence on the prevalence and consequences of the violence (WHO 2013).

Recognition of the problem has been spurred by large numbers of dedicated professionals, activists and survivors at the grassroots level, academia, government and the international community, and by media outlets, which, over time and in more places, are willing to bring a long-standing problem, traditionally taboo, to the forefront of public attention. The outcry that followed the Delhi gang rape and murder of Jyoti Singh, a 23-year-old female physiotherapy intern, in 2012 was a reflection of this changing environment. It carried repercussions internationally, heightening the attention of other actors in the international development arena, including donors.

This increased attention has been matched by increased programming, with more interventions around the world aimed at the prevention or mitigation of GBV. In particular, experience from well-known and researched programmes, such as IMAGE (Intervention with Micro-finance for AIDS and Gender Equity) in South Africa or SASA! in Uganda, has informed and inspired their adaptation in other countries.

In this context, access to evidence from an expanding set of interventions around the world, under varying conditions and with varying implementation experiences, becomes ever more important. Experts from around the world have, in recent years, produced important pieces of research reviewing and assessing interventions, programmes and policies implemented in low- and middle-income countries (L&MICs) to improve our understanding of what works in preventing GBV. Recent examples are the Global Women's Institute's review of community-based approaches to IPV (Contreras-Urbina et al. 2016); Fulu and colleagues (2015) review of interventions to prevent violence against women and girls (VAWG); Fulu and Heise's (2015) summary of evidence around VAWG; Arango et al.'s (2014) systematic review of reviews around interventions to prevent or reduce VAWG; *The Lancet*'s series on violence against women and girls (Watts et al. 2014); and Heise's (2011) IPV prevention evidence overview.

Donors have also stepped up their efforts in this area in at least three distinct ways: 1) by assessing their own portfolios; 2) by funding global initiatives to build the evidence base and to identify successful and promising interventions; and 3) by funding innovative

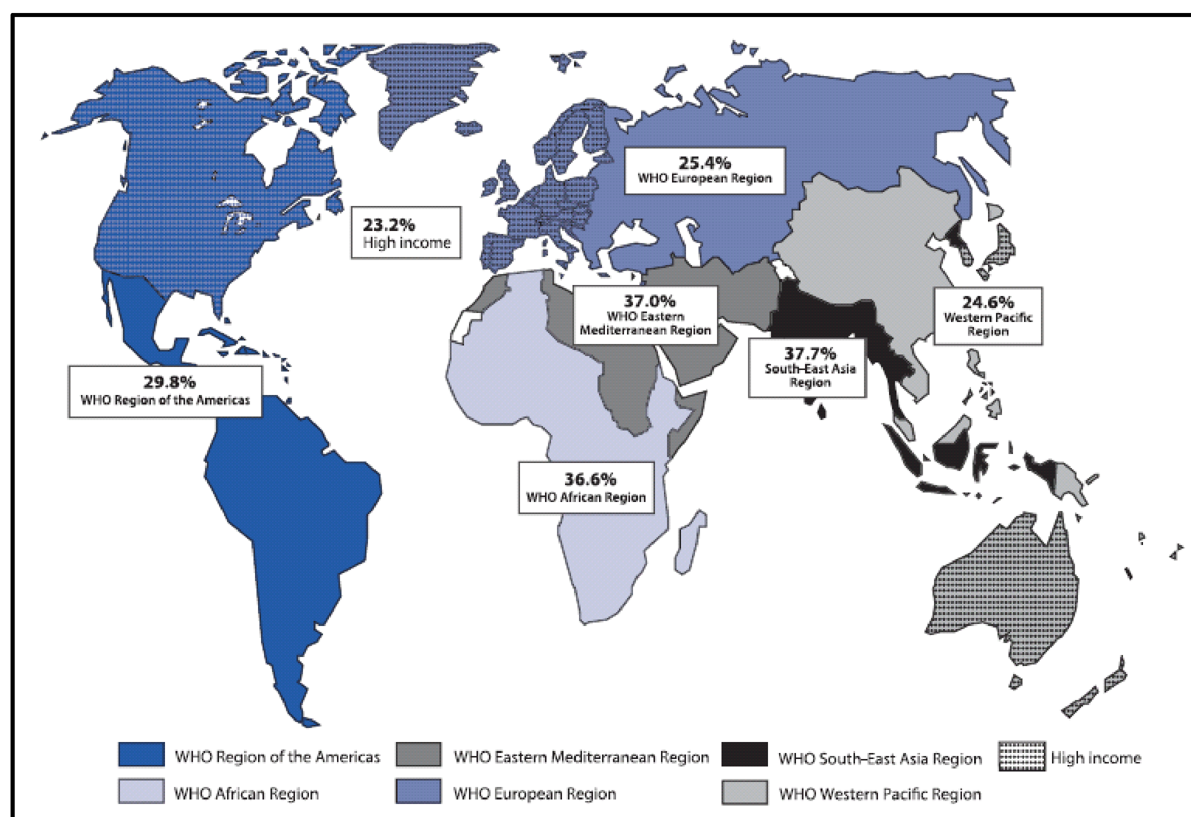
[1] Throughout this report, we use the term GBV instead of violence against women and girls (VAWG) as we also set up this evidence gap map to identify studies where men are victims of violence by a partner, as well as women. However, whenever a study is mentioned that has an explicit focus on VAWG, we respect this when discussing it. In the overwhelming majority of reported cases of IPV, a woman is the subject of violence, and this is also reflected in the evidence base.

approaches to prevent violence. For example, USAID evaluated the implementation of its global GBV strategy in 2015. In 2016, DfID published an independent review of its work in VAWG, and it currently funds the £25 million, five-year *What works to prevent violence against women and girls programme*. The Inter-American Development Bank has funded pilots and scaled up initiatives, such as *Ciudad Mujer*, True Love, and the adaptation of the IMAGE programme in Peru.

The IPV prevention evidence gap map (EGM) featured in this report complements these and other efforts by different stakeholders working in the IPV prevention in L&MICs, by providing a framework to organise and access evidence interventions, policies and programmes addressing IPV prevention or reporting on IPV prevention outcomes.

The focus of this EGM is on IPV, instead of GBV. The reasons behind this are multiple. First, IPV is the most common form of GBV. WHO (2013) estimates that around one third of women that have been in a relationship around the world will suffer violence by a partner at some point in their lifetime. Devries et al. (2013) estimate that this ranges from 16% in some countries in East Asia to 66% in countries of Central Sub-Saharan Africa. Moreover, a focus on IPV makes sense because more research is available on partner violence than other GBV types, opening more opportunities for review and syntheses. Programmes concentrating on IPV also help to reduce other types of violence because they focus on the family – where inter-generational habits are shaped – hence building a foundation to prevent other types of GBV (Heise 2011).

Figure 1: Regional prevalence of IPV by WHO region



Source: WHO (2013)

Finally, this EGM is built around the prevention of IPV, rather than mitigation or response. We acknowledge the importance of IPV response interventions for victims and their families; however, prevention facilitates the reduction of the overall level of violence in the medium to long term (Heise 2011).

1.1 Evidence gap maps: definition and purpose

3ie's evidence gap maps collect and organise evidence on the effects of interventions, policies and programmes for a given theme (Snilstveit et al. 2017). They facilitate rapid knowledge transfer and capture, combining methods from systematic reviews and mapping methods with data visualisation in an interactive platform. Evidence is organised around a framework of interventions and outcomes, built after a systematic search and screening of relevant literature and consultation with key stakeholders.

The rows of the gap map framework list relevant intervention categories, while the columns represent outcomes pursued by those interventions, typically organised along a causal chain. The same study can evaluate more than one intervention and outcomes, and hence it can appear in multiple cells in the EGM.

1.2 Study objectives

Thus, the objective of the IPV prevention EGM is to identify and map the evidence base and gaps around IPV prevention in L&MICs. Consistent with this, the EGM will: a) identify existing gaps in evidence to better inform future investment in research; b) identify clusters of impact evaluations that offer opportunities for evidence synthesis; and c) identify, appraise and summarise existing evidence from systematic reviews of the effect of interventions related to IPV prevention.

1.3 Methodology and limitations

1.3.1 Methodology

We developed the EGM framework in early 2016 after a gathering of researchers and NGO and donor representatives in London, after which followed discussions with an advisory group and an extensive literature review. This process resulted in a proposed set of intervention categories, outcome categories and cross-cutting themes to be represented in the map.

To test the draft map framework, we conducted a cursory search and screening of relevant studies found in 3ie's impact evaluation repository. We identified eight studies, which we plotted on a 'teaser map'. This teaser map allowed the team to check for missing categories in the framework and to assess how intuitive it is for the coding process, as well as for fine-tuning category names and definitions. We shared the framework and teaser map with the project's advisory group and incorporated relevant feedback.

Next, we developed a search strategy (Table A1 in Appendix A) to guide the inclusion process for studies. The team searched 16 indices and database providers, 44 websites and 4 research registries. We conducted three different types of searches: publication database searches, targeted searches of specialised websites and databases, and backwards and forwards snowballing, checking references of studies identified for

inclusion, as well as the online curricula vitae and websites of authors with at least one study identified for inclusion. We searched for general terms connected to IPV, such as family violence, spousal abuse, domestic abuse and GBV. In each database, we searched the indexed terms and used thesauri when available to capture other articles related to our search terms. We did not limit the search to only violence of men on women or on heterosexual couples. A complete list of the searched resources is available in Table A2 in Appendix A.

Upon completing the search, and identifying and removing duplicates, we used a pre-determined screening protocol (Table A3 in Appendix A) to screen results by titles, abstracts and then full text. We developed the protocol using the criteria detailed in section 2 of this report. At least two reviewers screened each study. A key challenge for this particular EGM was to distinguish between evaluations of interventions to prevent GBV and those to prevent IPV. A similar challenge was to discriminate between IPV prevention and IPV response. The way the screening protocol flows allows this, methodically minimising the risk of missing relevant studies along the way. If the intervention evaluated is clearly an IPV prevention one, it is included in the study for coding. If the intervention is not IPV prevention-focused, it is included for coding only if it reports effect sizes for IPV prevention outcomes as described on the EGM framework.

We coded impact evaluations for relevant metadata and populated the EGM. Coding was reviewed by another researcher and the principal investigator.

In the case of systematic reviews, they were assessed against 3ie's rating tool in order to determine confidence in their findings and to evaluate the risk of bias in each review. The review indicates that the evidence base for the effectiveness of IPV prevention in L&MICs is by and large not synthesised, and thus it is not yet possible to make generalisations about intervention effectiveness.

We screened over 300 potentially relevant reviews, excluding reviews for two primary reasons: either because the reviews primarily included evidence from high-income countries; or because they did not have a research question specific to IPV prevention.

In the first case, given that the evidence base is fairly recent and that there are only 47 completed impact evaluations for L&MICs and nearly 200 for high-income countries, it is not surprising that systematic reviews largely include evidence from high-income countries.

Regardless of the location of evidence, the systematic reviews focused more broadly on interventions related to violence against women or GBV. We did consider reviews that had multiple research questions and sought to synthesise evidence related to IPV prevention separately. Other reviews focused on IPV in L&MICs but in the context of understanding risk factors, not the effectiveness of interventions. In the end, no systematic reviews met our inclusion criteria.

1.3.2 Limitations

We conducted the search using only terms in English and in databases and websites that contain studies primarily in English. The search, however, did capture a number of studies in other languages such as Spanish, French or Portuguese.

The screening protocol and process was carefully designed, and included several quality checks. However, there is always the possibility of error, particularly of false negatives. This means that we could have excluded some studies that should be on the map when screening at the title or abstract level, if information there was not indicative of a study that was both an impact evaluation and topic-relevant. We do take additional steps to minimise the likelihood of this happening, including random quality checks and snowball checks.

Finally, the process of building a framework for the EGM is always challenging, and the IPV prevention EGM was no exception. There was no consensus throughout the consultative process on all intervention categories or outcomes in the framework. We took into consideration all different points of view expressed and settled for a framework that we feel is consistent with the logic of an EGM, and at the same time closely considers the point of view of end-users.

1.4 Report structure

Section 2 of the report features the scope of this EGM. In section 3, we present the results of the search and screening, as well as an analysis of the main characteristics of the evidence base. Section 4 concludes and discusses implications of the EGM. The attached appendices include information on methodological processes (Appendix A); an EGM based on information available for ongoing studies (Appendix B); and a bibliography of included studies (Appendix C).

2. Scope of the evidence gap map

We include impact evaluations and systematic reviews of effectiveness studies in our EGM. The scope is defined by a framework of 18 interventions and 17 outcome categories, in addition to five cross-cutting themes. These categories are informed by the concepts we define below.

2.1 Topics considered for the evidence gap map

2.1.1 Working definitions

Over the years, the discussion of IPV prevention among practitioners, researchers and donors has featured slightly different definitions across countries and among different authors. Box 1 presents the most important working definitions that we have used throughout the report.

Box 1: Key definitions

Intimate partner violence: We use the World Health Organization's definition of IPV as any behaviour in an intimate relationship that causes physical, sexual or psychological harm, including aggression, sexual coercion, psychological abuse and controlling behaviour (WHO 2005).

Intimate partner: While IPV is typically inflicted on women, men can also be victims. In general, an intimate partner is defined as a person with whom an individual has a close, personal relationship that may be characterized by emotional connectedness, regular contact or sexual behaviour, identification as a couple and cohabitation. Examples of intimate partners may include current or former spouses, boyfriends or girlfriends, dating partners, and ongoing sexual partners (Breiding et al. 2015).

IPV prevention: Throughout the report, prevention refers to to all activities: a) seeking to reduce the overall likelihood that anyone will become a victim or a perpetrator by creating conditions that make violence less likely to occur (for example, through awareness and sensitisation campaigns, or pursuing a reduction in binge drinking); b) focused on identifying and addressing early signs of abuse or abusiveness (for example, IPV screening when aimed at prevention, or when the study authors explore the effects of screening on prevention); c) focused on individuals who are already abused or abusive in order to reduce the recurrence of violence they experience or inflict (for example, psychological support when coupled with soft skills and empowerment).

These working definitions allowed us to make clear distinctions between IPV prevention and other related topics during the screening and coding process to guide the inclusion or exclusion of studies when building the EGM.

a. IPV prevention versus IPV mitigation or response

In order to be included in the map, the evaluated intervention, programme or policy had to include a description of a theory of change behind it that focused on prevention. For example, take the case of a medical intervention or psychological assistance, or screening for a person victimised by an intimate partner. If these interventions are evaluated without a clear argument on how they help to prevent IPV, or they do not report effect sizes for IPV prevention-specific outcomes, they are not included in the EGM.

b. Interventions designed versus interventions evaluated for IPV prevention

In general, studies evaluating interventions with a theory of change explicitly aimed at IPV prevention are included in the EGM. If an intervention is not designed for IPV prevention, but the study does report effect sizes for outcomes considered under the framework, the study is still included in the EGM. Microfinance programmes are examples of the latter.

c. Intimate partner violence versus gender-based violence

As per the definitions above, the EGM includes studies with a focus on IPV prevention. IPV is just one type of GBV, as the latter can be inflicted by and upon any individual, not only intimate partners. Studies focused on GBV are included only if the theory of change for the intervention evaluated contained in the study specifically discusses IPV prevention.

Thus, studies exclusively focused on other forms of abuse and violence, including child abuse, rape, sexual assault, or any form of abuse or violence not perpetrated by an intimate partner, are not included in this EGM.

d. IPV prevention versus IPV risk factors

Additionally, we include in the EGM framework outcomes related to IPV risk factors, such as education, economic development, livelihoods, empowerment, drug and alcohol use, pregnancy, reproductive health and child marriage. However, those outcomes are only coded for studies of interventions aimed at IPV prevention.

To illustrate these inclusion criteria, take the case of cash transfers. Cash transfers are not designed with the explicit goal of reducing IPV. However, if the study estimates effect sizes of a cash transfer programme on an IPV prevention outcome such as 'incidence of IPV' at the community level, the study will be included in the EGM. If the study discusses the effect of cash transfers on GBV in a community (and not on IPV specifically), the study is not included in the EGM. And if the study is an impact evaluation of a cash transfer programme and reports only effects on education achievement or employment, for example, the study will not appear in the EGM, even though educational attainment and employment status are widely acknowledged in the literature as IPV risk factors.

2.2 Study types

The IPV prevention EGM includes impact evaluations. They measure the change in the key outcome indicators that occurs because of an intervention, programme or policy. They utilise experimental or quasi-experimental study designs to conduct a counterfactual analysis, which allows for the attribution of changes in an outcome to a specific intervention, or compare the effects of different types of programmes (3ie 2012).

Specifically, we include studies featuring the following types of research design:

a. Randomised controlled trial (RCT);
b. Regression discontinuity design;
c. Before and after studies using appropriate methods to control for selection bias and confounding, such as propensity score matching (PSM) or other matching methods, instrumental variable estimation (or other methods using an instrumental variable such as the Heckman two-step approach), difference-in-differences r a fixed- or random-effects model with an interaction term between time and intervention for baseline and follow-up observations;
d. Cross-sectional or panel studies with an intervention and comparison group using methods to control for selection bias and confounding as described above;
e. Studies explicitly described as systematic reviews and reviews that describe methods used for search, data collection and synthesis as per the protocol for the

3ie database of systematic reviews (Snilstveit et al. 2013). Systematic reviews also need to have been given an assessment of medium or high confidence in their methods, per 3ie's systematic review assessment tool.

2.3 Other inclusion criteria

In addition to the study's topic relevance and the study type, we consider the following characteristics when making inclusionary decisions. First, the study must have been published from 1990 onwards; second, the country where the intervention, programme or policy is implemented must be labelled as a low- or middle-income country by the World Bank at the time of the study's publication. Finally, it must be considered that the search was conducted in English only; however, studies published in French, Spanish and Portuguese found in the search were screened and accepted if they met all other inclusion criteria.

2.4 The EGM framework

2.4.1 Intervention categories

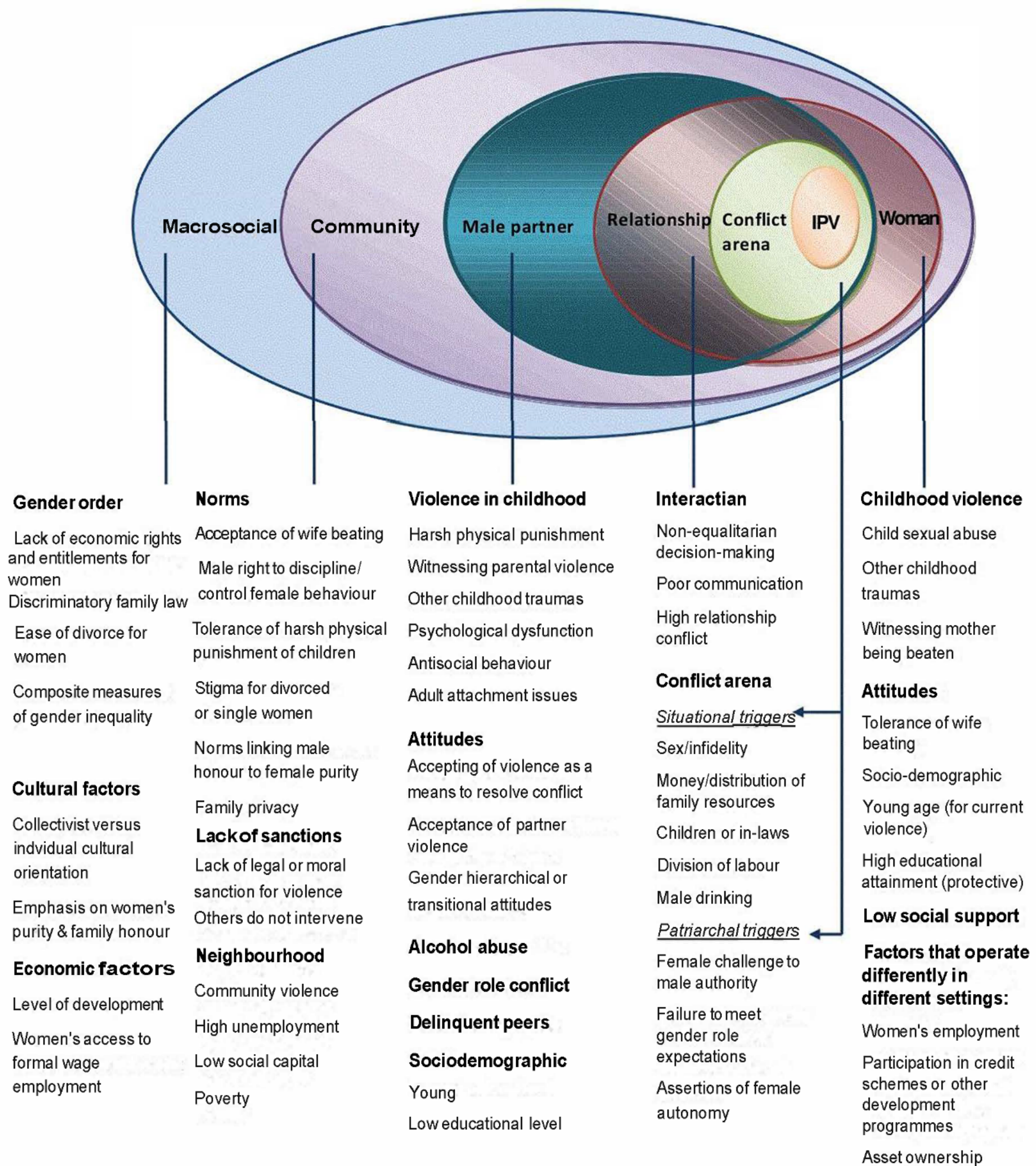
Table 1 presents the intervention categories used for this EGM. Categorising interventions, from small, localised pilots to national policies, is always challenging and open to debate. The approach used for this EGM builds on how others have done it in the past (Fulu et al. 2015; Arango et al. 2014; Ellsberg et al. 2014; Heise 2011) but also introduces a few differences given the logic of an EGM.

First, intervention categories are organised at different targeted levels of a *social ecology*. A social ecology is the collection of personal background and personality factors that both men and women bring to their relationships, together with the context and situational factors that affect their lives, including the prevailing social norms around them. They are reinforced by family members, friends and social institutions. These norms and expectations are shaped by structural factors, such as ideology, religion or prevailing economic power relationships (Heise 2011).

The EGM borrows heavily from ecological models of human development, originally proposed by Bronfenbrenner (1994). Bronfenbrenner argues that we need to consider the entire ecological system in which humans grow in order to understand their development. He conceptualised five sub-systems, from the microsystem or the relationship of an individual with its immediate environment, to the macrosystem or institutional patterns prevalent in one's society. Heise (1998) adapts the model to the discussion of violence against women and girls, with a framework that recognises there is no single factor that 'causes' partner violence. The premise is that the likelihood that a partner will become abusive or that a community will have high rates of IPV depends on many factors that interact at levels that range from the individual and his/her own life experience, to a couple's interaction, the household, community (or communities) they belong to, as well as their society. The key of the model is that all ecological levels interact to perpetuate IPV, and a positive intervention on one level can be undone or neutralised by a risk factor on another level. Hence the importance of an ecosystem view of IPV prevention.

Figure 2, taken from Heise (2011), represents the conceptual framework for partner violence under the socio-ecological model, with a list of risk factors linked to partner violence in the literature at different ecological levels.

Figure 2: Conceptual framework for partner violence



Source: Heise (2011)

Our EGM considers four main levels: individual, relationship/household, community and institutional. We could have separated the relationship level from the household level, or introduced other intermediate levels reflecting alternative spheres of influence in behaviour. However, the proposed framework allows us to consolidate a core set of categories under each level.

In addition to this, having an intervention category under a given level indicates that the intervention operates heavily, but not necessarily exclusively, there. One example is the case of a communication campaign that reaches an entire community but is intended to reach individuals, or aims at changing the acceptability of IPV at the household level, while also potentially influencing formal and informal institutions. A second example is the case of cash transfers that benefit individuals but can alter the way a couple interacts or the decision-making in a household. Since the framework not only includes interventions, but also outcomes organised under the ecological model, it is still possible to organise information on the effects of an intervention for outcomes across the social ecology, even if the intervention itself is anchored under a particular level.

There are indeed differences in the way certain interventions are organised in various reviews. Fulu and Kerr-Wilson (2015), for example, organise school-level curricular changes relevant to IPV prevention as institutional-level interventions. In this EGM, the focus is the population immediately affected by such reform: students at school, and therefore, all interventions addressing in-class delivery are under the household level; while the institutional/societal level is reserved to efforts to change laws, regulations, local norms to prevent IPV, and the enforcement of such laws and regulations.

Finally, the EGM introduces certain flexibility when dealing with recent approaches to IPV prevention, under the label of 'emerging approaches'. We identify here two means for channelling the intervention (information communications technology and local traditions) and a separate row for multicomponent programmes. Creating this section for interventions also facilitates the introduction of other interventions or approaches in the future, when the EGM is updated.

Table 1: Intervention categories[2]

Individual level: Studies that focus on interventions targeted at men or women, irrespective of their belonging to a community, interest group or other collective.		
A1	Economic, income generation	Includes impact evaluations and systematic reviews of economic interventions and their effects on IPV prevention outcomes. The intervention itself is typically not designed to prevent IPV, but the study does look into its effects on IPV prevention and risk factors. Examples include microfinance, vocational or job training programmes, cash transfers.
A2	Social empowerment, skills building, awareness raising	Interventions focusing on social empowerment through non-economic means targeting mainly women (particularly from vulnerable groups), but also men. Interventions include gender sensitisation, transformative programming, awareness-raising around women's rights, access to services, how to protect oneself from violence, building soft skills or organisational skills. These interventions can be delivered to groups or one-to-one for particularly vulnerable individuals through home visits and may be focused on health issues, family roles, violence and services available.

[2] The definition of intervention categories is adapted from different sources, including Fulu and Kerr-Wilson (2015); Michau et al. (2014); Jewkes et al. (2014); Heise (2011); Knerr et al. (2011); and Paluck et al. (2010).

A3	Attention to physical or psychological health	Interventions that assist victims by providing physical and psychological health services, as well as working with victimisers when psychological assistance is needed, are included if and only if they have a prevention component, or the study deals with their effect on IPV prevention outcomes. Physical health includes the treatment of alcohol abuse, but alcohol abuse can also be targeted through other types of interventions.
A4	Bystander interventions	Interventions that organise or promote action taken by a person (or persons) not directly involved as the subject 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. They can be targeted at men, boys, women or girls.
Relationship and household level: Studies of interventions targeted at: i) a couple; ii) specific members of a couple if focused on their interaction; iii) other members of the household identified as key in the prevention of IPV, such as children, in-laws, parents.		
B1	Counselling, critical awareness of gender roles	Interventions under this type include workshops and direct counselling directed at men and women separately or together, which may 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 address the power relationships between women and others in the community.
B2	Parenting interventions	Interventions targeting parents who have abused or neglected their children, or are at risk of doing so, or that aim at utilising parental roles as a channel for gender role sensitisation. Activities include counselling, role play, media modelling of positive behaviours, structured play, production and delivery of communication materials, among others. They can be delivered through home visits, be community based, implemented in a health clinic or other settings.
B3	Curriculum-based activities at school	Interventions delivered at school through formal courses, in-class workshops, or modification at an institutional level of the curricula or educational approaches with an IPV prevention aim.
B4	Extra-curricular activities for children, adolescents	Activities outside school and focused in children (under 13), or adolescents (13–17). Sports, music, theatre and other extra-curricular activities are included here when not part of a community-wide programme.
Community level: Interventions targeting entire communities or specific interest groups, fostering collective action through education and capacity building to address inequitable norms and practices.		
C1	Communication and advocacy campaigns	Awareness campaigns that aim to raise awareness or increase knowledge about a service, a law or about IPV as an issue in general. Advocacy campaigns often take the form of a regional or national coalition of individuals and organisations that are encouraged to take action to influence policy change. They often include media interventions, using television, radio, newspapers, magazines and other printed publications. Campaigns include social norms marketing used to change perceptions about attitudes and behaviour considered normal by the community, and to activate positive social norms and discourage harmful ones.

C2	Community-wide mobilisation	Community mobilisation interventions attempt to empower women, engage with men and change gender stereotypes and norms at a community level. They can take the form of community workshops and peer training aimed at shifting attitudes and behaviour by interrogating prevalent norms. They are often accompanied by localised campaigns and community mobilisation activities, including video, radio broadcasts or dramas.
C3	Activities and mobilisation through common-interest groups or associations	Activities for groups formed around shared characteristics or affiliations (churches, universities, savings groups, women's groups). For example, IPV training for microfinance groups would be categorised here.
C4	Workplace and private sector interventions	Sensitisation campaigns and targeted training at the workplace, workplace regulations.
Institutions and society level: Known also as the macro-social level under the ecological framework, interventions at this level are intended to reduce gender inequality and impact on the cultural and economic factors contributing to the perpetuation of IPV by changing laws and policies, and enforcing existing regulation.		
D1	Awareness and advocacy focused on authorities	When the training, campaign or sensitisation programme is aimed at leaders and politicians to generate change from above, the intervention is categorised here.
D2	Promotion of local norms, legislation and debates	Initiatives to establish new norms, rules or laws that are expected eventually to change prevailing gender norms by fostering an enabling environment conducive to changes in gender relations. Examples are a system of quotas for women's participation in local governance or discussion of women's issues linked to IPV during elections to encourage voting and influence the debate. Campaigns for women's equality in leadership positions can also be included here.
D3	Police activities/ enforcement of existing laws and regulation	When the intervention is focused on police or other agents responsible for enforcing existing regulations, including the judiciary system. Also included are interventions that enforce health policy or legislation relevant to IPV prevention.
Emerging trends in IPV prevention: A separate grouping is considered for types of interventions defined not by a specific level of the ecological model, but by the channel used to deliver the intervention, or when the design tackles multiple levels.		
E1	ICT-based interventions	Includes mobile phones, Internet, hotlines. While the use of mobile phones or Internet could be part of a larger effort at one or more levels, we try to identify evidence around its use to understand its impact.
E2	Using traditions, festivals to channel messages	Interventions are coded here when the key mechanisms to pass information and create awareness about IPV are local traditions, ceremonies or festivals. For example, a recent impact evaluation of IPV prevention through coffee ceremony in Ethiopia (ongoing).
E3	Multicomponent interventions	Here we include studies evaluating interventions that operate across different levels of the social ecology, either evaluating the programme as a whole, or evaluating multiple interventions at more than one level of the social ecology. For example, an intervention looking to empower women by training them in soft skills, while also providing relationship counselling, would be coded under this category. Similarly, a study that reports on the overall effect of a programme looking to influence multiple levels such as SASA!

2.4.2 Outcomes

Table 2 lists the outcome categories that form the columns of the EGM, along with their corresponding code and a brief description. The outcomes are organised by the main target they refer to (women, men, couple/household members and community/society). Within each of these groupings, outcome categories try as much as possible to follow the causal chain. Thus, outcomes go from awareness of the problem and life skills to attitudes and self-efficacy against violence, to risk factors, and then to a category for the actual experience of violence. We also include a category for access to services and response to IPV, so we can code this outcome when reported in the context of an IPV prevention intervention.

Table 2: Outcome categories

Women-focused outcomes		
F1	Awareness and life skills	Outcomes that allow women to identify IPV as a problem and act upon this understanding and knowledge. An example is negotiation skills that affect women's bargaining power and knowledge of their rights and the services they can access.
F2	Attitudes and self-efficacy or identity	This includes identity formation, perception of gender roles, acceptability of sexist attitudes, acceptability of IPV, intimacy and self-efficacy.
F3	Socio-economic factors	Outcomes considered in the literature as protective factors that reduce the risk of IPV because they generate women's empowerment: education through the completion of secondary school, economic rights, employment outcomes, access and use of assets.
F4	Incidence or reaction to IPV	IPV indicators and reporting would be included here, as well as other outcomes, such as leaving the relationship. We include perpetrating IPV because the study may include cases when the perpetrator is a woman.
F5	Access to/use of response services	The availability and effective use of health, psychological/counselling and legal services.
Men-focused outcomes		
G1	Awareness and life skills	Understanding of IPV as a problem and life skills mainly oriented to self-efficacy and self-control of triggers, particularly in stressful situations. Control of alcohol intake would be included here.
G2	Attitudes towards IPV, perception of gender roles	Acceptability of IPV and perception of gender roles as a risk factor.
G3	Socio-economic factors	The emphasis of this category for men is in the reduction of stress due to lack of economic opportunities that may create stress in the relationship and violent behaviour.
G4	Incidence or reaction to IPV	Studies measuring outcomes for men and boys on attitudes towards IPV could report on men admitting engaging in violence, but mainly we look at proxies of changed behaviour of men.
G5	Access to/use of response services	The availability and effective use of health, psychological/counselling and legal services

Relationship and household outcomes		
H1	Awareness, life skills and attitudes to IPV	A study is categorised here when the change in perception and attitudes toward IPV is observed in the couple or other family members (in-laws, relatives, children, youth).
H2	Incidence and exposure to IPV	Experience and exposure to violence by the couple or other household members. This includes child abuse, other GBV apart from IPV.
H3	Decision-making and gender roles	Identify concrete changes in decision-making power or gender roles due to interventions.
H4	Response to IPV	Response of household members to IPV, including intervening or seeking help.
Community and society-level outcomes		
I1	Attitudes to IPV and perception of gender roles	Community-level measures of IPV acceptability and perceptions of gender role as a risk factor.
I2	Incidence, prevalence and exposure to IPV	Any reports on the percentage of households or of women at the community level suffering or reporting IPV will be included here. It explicitly looks at incidence and reporting. As explained for the individual level, an increased reporting of cases may also be a consequence of programmes in the sense that there is a greater acknowledgement of the problem.
I3	Community/society response to IPV	This category includes legislation, women's quotas in governing bodies, but also reporting/intervening when IPV happens.

2.4.3 Cross-cutting themes

We also code for certain cross-cutting themes and target populations. It is important to understand how the evidence base is answering a wide range of questions around effectiveness, inclusion of vulnerable groups and other subpopulations, or theories of change. Without answering these questions, we are less able to understand how best to use evidence when designing and implementing new programmes. For example, when cost-effectiveness is combined with an understanding of the problem being addressed and with other contextual factors, such as human resource availability, current input prices and local institutions, it can illuminate important insights on a programme's value for money in a defined situation, and identify the factors to which the outcomes of interest are most sensitive (Dhaliwal et al. 2013).

We include these columns so that readers can easily understand the size of the evidence base related to these areas and can find the relevant studies. On 3ie's online platform, the user can filter the map by subpopulation using the population filter.

Table 3: Cross-cutting themes

J1	Cost-effectiveness	If the study has a cost effectiveness analysis for different interventions or combination of interventions, in order to determine which one results in the highest impact for the cost.
J2	Long-term impact	If the study measures impact 24 months or more after baseline or intervention implementation.
J3	Vulnerable populations (other than women)	If the study focuses on indigenous peoples, people living with disabilities, low castes or other vulnerable populations or subpopulations of interest. The intervention should be focused on vulnerability, or the study needs to include a detailed discussion around it; it is not enough to report on a vulnerable population or research-defined group as a heterogeneous effect to be considered in this category.
J4	Focus on men and boys	If the study focuses on men and boys and their attitudes about and perceptions of masculinity, it is included under this category. It is not enough to report results or analyse work with men or boys as part of the analysis. The theory of change of the evaluation should target the transformational effects of focusing an intervention on men or boys.
J5	Focus on alcohol or drug abuse	If the study looks at either alcohol/drug abuse as an outcome, or at populations of those abusing alcohol or drugs, regardless of the focus of the intervention, it is included here.

3. Findings

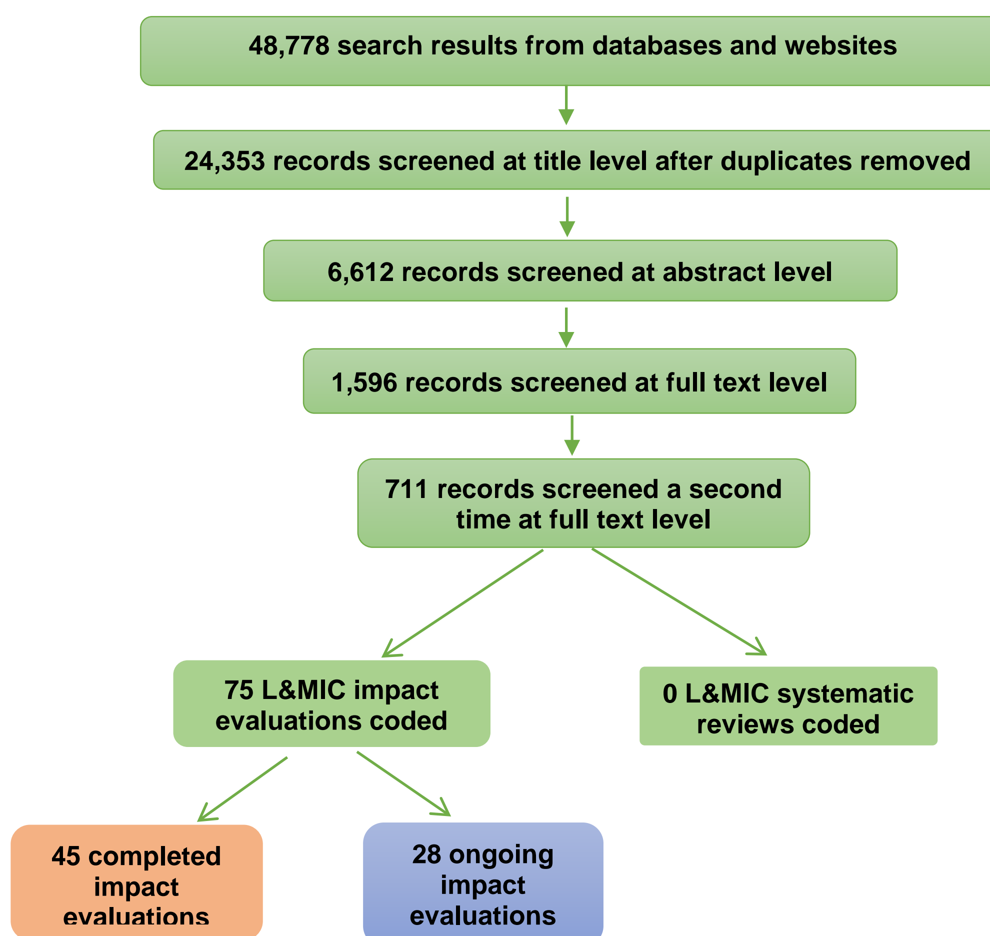
Figure 3 details the results of the search and screening process for qualifying impact evaluations and systematic reviews of evidence from L&MICs. The process resulted in 47 completed[3] impact evaluations, 28 ongoing[4] impact evaluations, and no completed systematic reviews focused on L&MICs that had a high or medium confidence rating based on the 3ie systematic review assessment tool.[5] The 47 completed impact evaluations include 35 journal articles, 5 working papers, 5 project reports and 2 dissertations. A bibliography of all completed and ongoing impact evaluations can be found on Appendix C.

[3] A study is considered complete if it has a report published or in draft form.

[4] The identification of ongoing studies is based on pre-registrations, published protocols or pre-analysis plans. Announcements were also identified on the personal website or CV of the primary authors.

[5] See http://3ieimpact.org/sites/default/files/2019-01/quality_appraisal_checklist_srdatabase.pdf

Figure 3: Search and screening results



After coding all studies identified through the search and screening process, we mapped them under the EGM framework. Figure 4 shows the EGM for completed impact evaluations. On the map, each number indicates how many studies evaluate an intervention category for each outcome category. This generates 159 occurrences of evidence across the map. This happens because each study can be represented in several cells, as studies may evaluate more than one intervention and multiple outcomes. For example, Abeid et al. (2015), which evaluates a community-based intervention in Tanzania, evaluates two different interventions at the community level (a communication campaign using radio and community mobilisation) for three different outcomes focused on women, men and community/society level, generating six occurrences of evidence.

Darker cells on the EGM indicate combinations of interventions and outcomes with more existing evidence. However, it must be stressed that the map only shows where the evidence is, not what the evidence says. In fact, studies under each cell can provide evidence supporting a positive, negative or null effect of the intervention on a given outcome, given the context and implementation specifics. The map provides easy access to this evidence, and a more detailed look at studies included in a cell would allow the reader to better understand the circumstances under which the interventions seems to work better or not.

Figure 4 also maps cross-cutting themes in the far-right panel, with information on 36 impact evaluations that feature at least one of the cross-cutting themes highlighted in the analysis, for a total of 79 occurrences of evidence. Eleven completed impact evaluations featured no discussion whatsoever on any of these special themes.

Using the same framework, we also mapped ongoing impact evaluations yet to be published. Out of 28 ongoing studies, 16 of them are registered as trials either under ClinicalTrials.gov or 3ie's Registry for International Development Impact Evaluations, with the others published as protocols in journals, or with baseline reports already produced. An EGM of ongoing impact evaluations based on available information for them can be found in Appendix B.

Figure 4: Evidence gap map of completed IPV prevention impact evaluations

		OUTCOME CATEGORIES	WOMEN					MEN					COUPLE / HOUSEHOLD MEMBERS				COMMUNITY / SOCIETY			CROSS-CUTTING THEMES				
			F1	F2	F3	F4	F5	G1	G2	G3	G4	G5	H1	H2	H3	H4	I1	I2	I3	J1	J2	J3	J4	J5
INTERVENTION CATEGORIES			Awareness and life skills	Attitudes and self-efficacy/ identity	Socio-economic factors	Incidence or reaction to IPV	Access to/ use of response services	Awareness and life skills	Attitudes to IPV, perception of gender roles	Socio-economic outcomes	Incidence or reaction to IPV	Access to/ use of response services	Awareness, life skills and attitudes to IPV	Incidence, and exposure to IPV	Decision making/ gender roles	Response to IPV	Attitudes to IPV and perception of gender roles	Incidence, prevalence and exposure to IPV	Community/ society response to IPV	Cost-effectiveness	Long-term impact	Vulnerable populations (other than women)	Focus on men and boys	Focus on alcohol and drug abuse
INDIVIDUAL LEVEL	A1	Economic, income generation programs	2	6	6	10		1							7	1	2	1	2	1	7	7		
INDIVIDUAL LEVEL	A2	Social empowerment, skills building, awareness raising	2	3	1	7		1	3		3		1	1	3	1	1	1	1		2	5	4	1
INDIVIDUAL LEVEL	A3	Attention to physical or psychological health	1	1		3								1								2	1	2
INDIVIDUAL LEVEL	A4	Bystander interventions																						
RELATIONSHIP and HOUSEHOLD LEVEL	B1	Counselling , critical awareness of gender roles	1	1	2	4		1	1		1		2	3	3	1	1	1		1		5	2	
RELATIONSHIP and HOUSEHOLD LEVEL	B2	Parenting interventions																						
RELATIONSHIP and HOUSEHOLD LEVEL	B3	Curriculum-based activities at school		1		1	1		1		1	1					1	1						
RELATIONSHIP and HOUSEHOLD LEVEL	B4	Extra-curricular activities for children and adolescents			1	1															1			
COMMUNITY LEVEL	C1	Communication and advocacy campaigns		1		3	1		2		4	1						1			1		1	
COMMUNITY LEVEL	C2	Community-wide mobilisation		2	3	5	1				2				2		2	3	2		6	2		
COMMUNITY LEVEL	C3	Activities and mobilisation through common-interest groups		3	2	3									2				1		2	1		
COMMUNITY LEVEL	C4	Workplace and private sector interventions	1					1	1															1
INSTITUTION/SOCIETY LEVEL	D1	Communication and advocacy focused on authorities																						
INSTITUTION/SOCIETY LEVEL	D2	Promotion of changes in local norms and legislation				1	1														1			
INSTITUTION/SOCIETY LEVEL	D3	Police activities/enforcement of existing laws and regulation				1		1							1			1			2			
EMERGING TRENDS	E1	ICT-based interventions	1			1																1		
EMERGING TRENDS	E2	Using traditions, festivals to channel messages																						
EMERGING TRENDS	E3	Multicomponent Approaches	1	5	6	7	2		2		2	1	2	1	6	1	3	2	3	1	8	5	2	

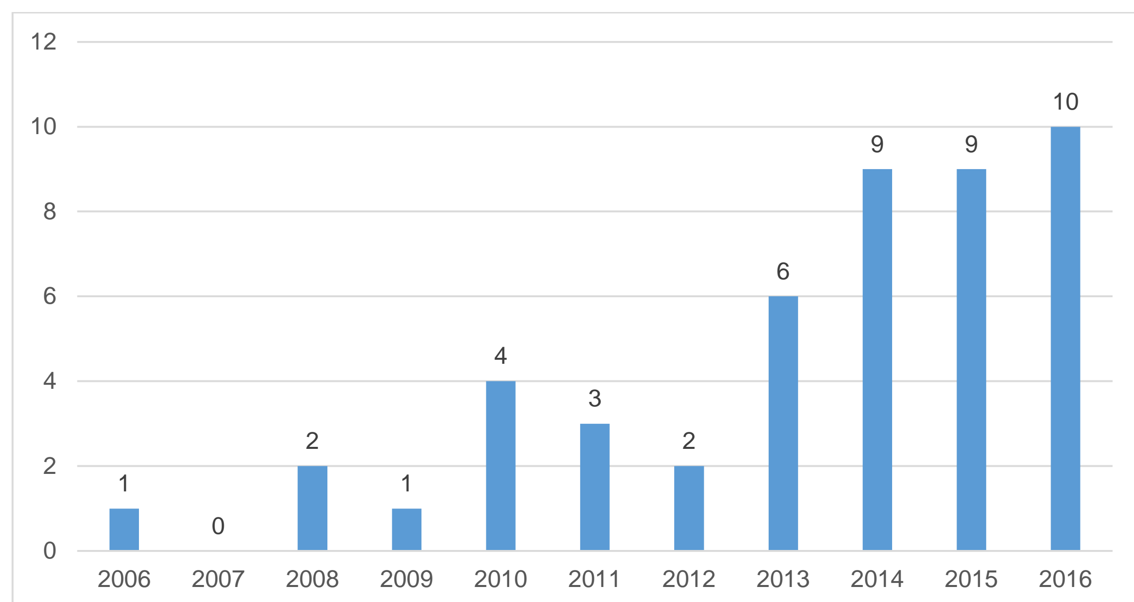
3.1 Features of the impact evaluation evidence base

3.1.1 Impact evaluations by publication year

A key feature of the IPV prevention evidence base in L&MICs is that it is very recent. In fact, the first impact evaluation in an L&MIC identified through the search and screening process was the evaluation of the Intervention with Microfinance for AIDS and Gender Equality (IMAGE) programme in South Africa, using a combination of randomised controlled trials (RCTs) and PSM (Pronyk et al. 2006).

Since then, and by August 2016, 46 additional impact evaluations that focus on IPV prevention have been published. Figure 5 shows the trend in impact evaluation publication, which has particularly picked up since 2012.

Figure 5: Completed impact evaluations by publication year



Ongoing studies

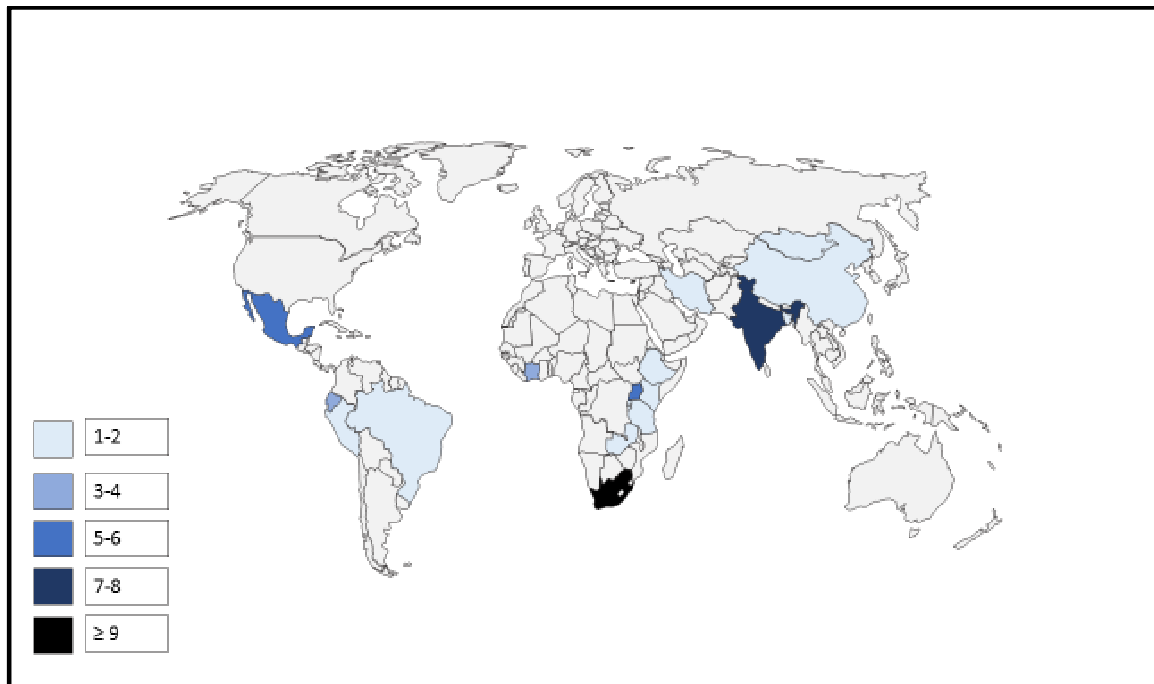
The trend in steady production of impact evaluation research is confirmed when looking at studies underway or not yet published.[6] Of the 28 ongoing studies identified, the oldest were registered in 2012, and 8 were registered in the first 8 months of 2016.

3.1.2 Impact evaluations by geography

Figure 6 shows the distribution of completed impact evaluations by country, while Figure 7 provides details by region. Almost half of the impact evaluations produced to date come from three countries (South Africa, India and Uganda). Only 18 countries around the world have impact evaluations of IPV prevention interventions implemented in them, with 10 countries having only 1 impact evaluation completed.

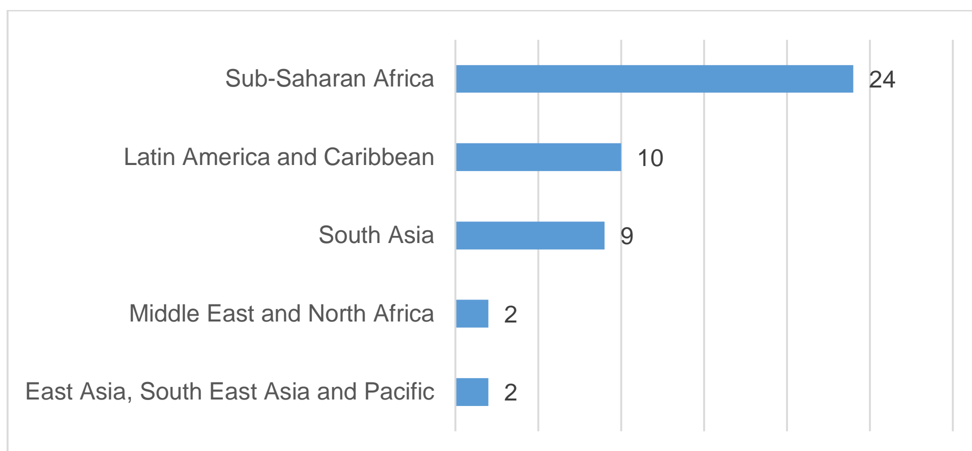
[6] Based on ongoing studies identified by September 2016.

Figure 6: Completed impact evaluations by country



Arguably, the relative novelty in the use of impact evaluation to assess IPV prevention explains, at least in part, the low number of countries and depth of the evidence base in many of them. However, the concentration of studies in a few specific countries also hints at certain favourable conditions within these countries. In South Africa, there are high-profile programmes, such as IMAGE and Stepping Stones, which offer the opportunity and sample sizes for impact evaluation research. Moreover, an established tradition of clinical trials around health and HIV, as well as a strong research community, also facilitate a stream of impact evaluation research in the country. The SASA!, WINGS and SHARE programmes in Uganda present a similar opportunity, while in India there has been increased interest in tackling gender-based violence in the past few years, particularly since the Delhi rape events of late 2012, widely discussed by media, the government and donors.

Figure 7: Completed impact evaluations by region



Regionally, around half (n = 24) of the global impact evaluation evidence base is for interventions implemented in Sub-Saharan Africa. However, given the concentration of impact evaluations in 2 countries in the region, this evidence base represents only 9 of the 50 countries in the region.

The world region with the second largest number of impact evaluations is Latin America and the Caribbean, with 10 impact evaluations. Similar to Sub-Saharan Africa, the evidence base is heavily concentrated in a few countries, in this case Mexico (n=5) and Ecuador (n = 3), with only two other countries represented (Peru and Brazil, each with one completed evaluation). In Mexico, the cluster of studies is explained by the use of the structure and access to beneficiaries of the *Oportunidades* programme for three studies, and the pilot of a school-based intervention called 'True Love' (*Amor, pero del bueno*) with the support of the Inter-American Development Bank.

In the case of South Asia, Bangladesh (n = 2) is the only other country represented in the evidence base besides India. Out of all the L&MICs in Asia and in North Africa, only three countries are represented: Iran, Mongolia and China.

Clearly there are areas of the world with small numbers of impact evaluations but high rates of IPV. For example, the Middle East features only one completed impact evaluation, but according to WHO (2013), the estimated IPV prevalence in that region is as high as the one in Sub-Saharan Africa and South Asia (all of them around 37%). Moreover, while IPV is estimated to be lowest in East Asia and Central Asia, WHO indicates that still about one in four women living there will experience IPV at some point in her lifetime.

Across regions, looking at the evidence from fragile states, only 1 out of 35 countries on the World Bank's harmonised list of fragile states is represented in the evidence base: Côte d'Ivoire, with 3 studies.

Ongoing studies

Studies under preparation confirm a few key trends. First, IPV prevention programming and its evaluation has increased in recent years in India. All except one of the completed impact evaluations in India were published from 2014 onwards; while six new impact evaluations are currently under preparation in the country.

Fourteen new impact evaluations (50% of the ones ongoing) are under preparation in Sub-Saharan Africa, with a better distribution than the current evidence base, and with two new countries represented (Nigeria and the Democratic Republic of the Congo). Among the fragile states, the Democratic Republic of the Congo and Haiti enter the list of countries where impact evaluations of IPV prevention interventions are under preparation.

3.1.3 Impact evaluations by design

As Figure 8 shows, 64 per cent of studies feature an exclusively experimental design, while 23 per cent are quasi-experimental. The other 13 per cent of studies feature a combination of experimental and quasi-experimental designs. The detail on methods used is presented in Figure 9. Apart from RCTs, there appears to be a clear preference for PSM and difference-in-difference estimates as alternative approaches for evaluating IPV prevention interventions. An instrumental variable estimation has only been used

once, and others, such as regression discontinuity design, are not used in any completed studies.

Figure 8: Completed impact evaluations by design

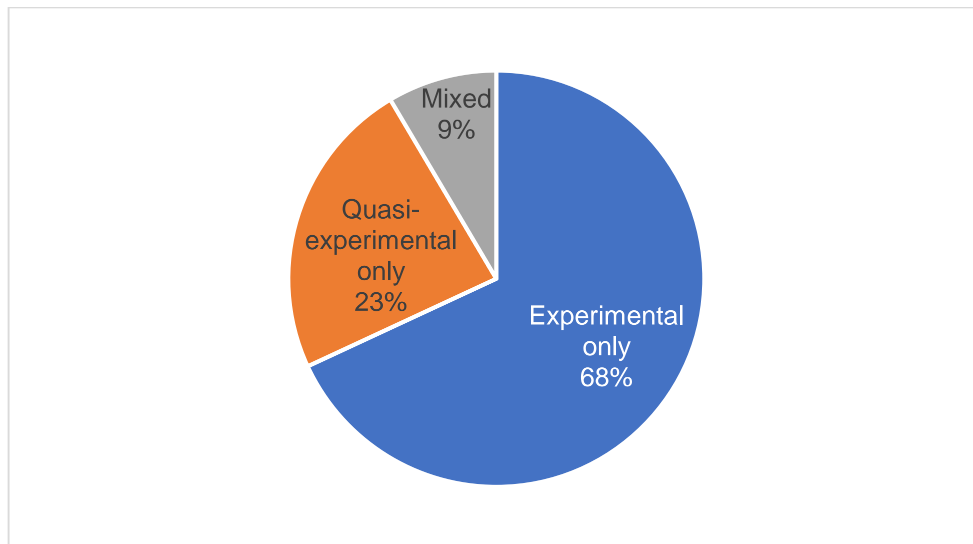
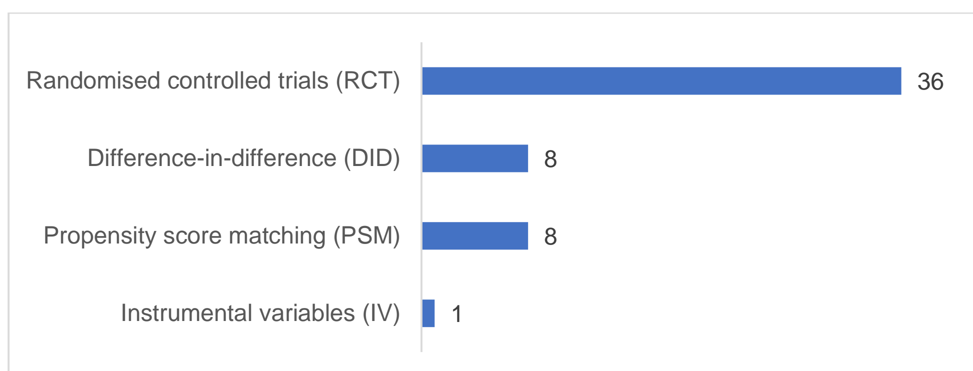


Figure 9: Completed impact evaluations by design



Ongoing studies

Based on available information, the impact evaluations currently under implementation are overwhelmingly registered as RCTs (27 out of 28). Moreover, we could not find information on plans to use quasi-experimental designs combined with an RCT.

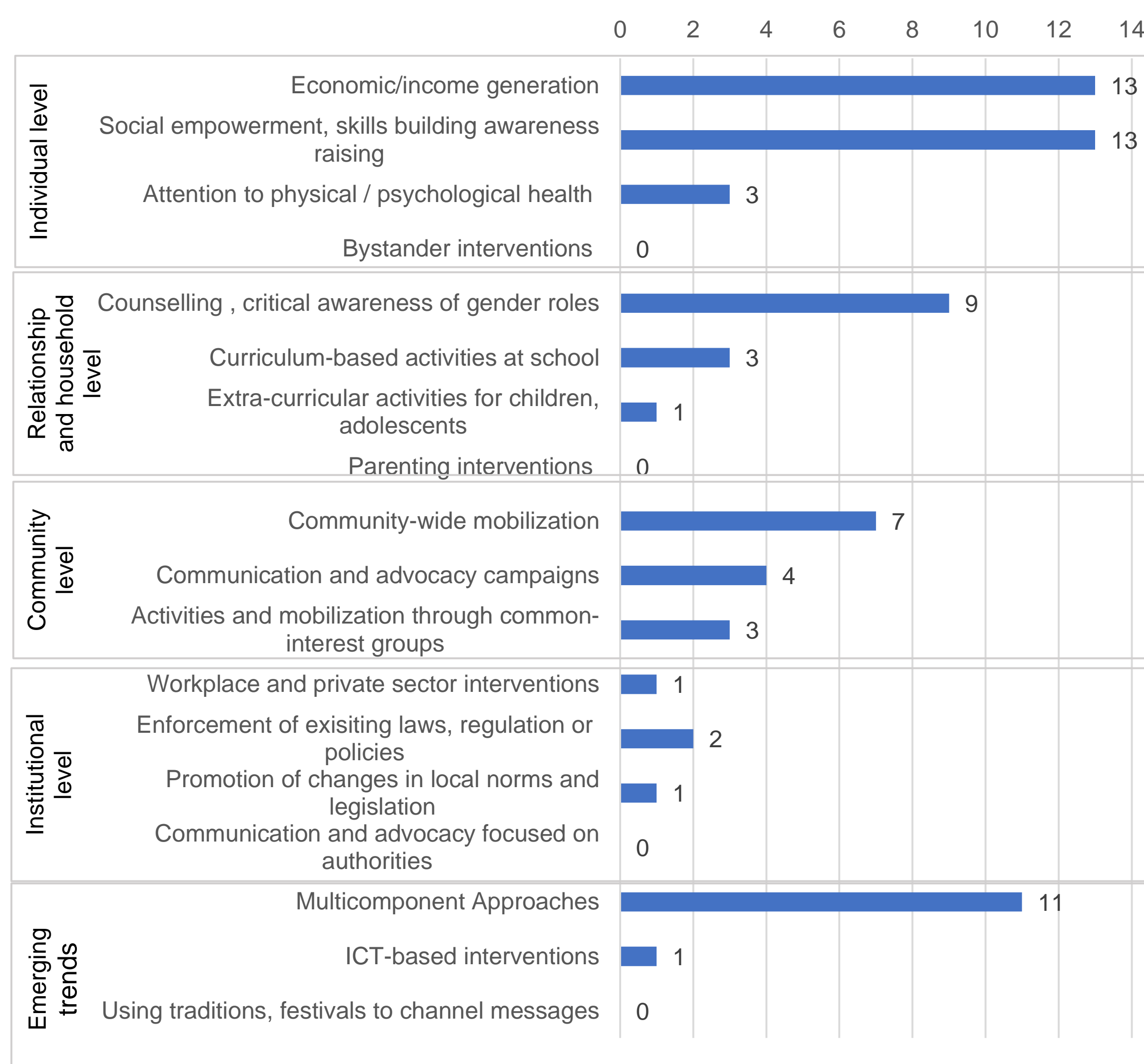
3.1.4 Impact evaluations by intervention category

The previous analysis shows how, in just one decade of impact evaluation evidence, there is a clear preference for RCTs as an evaluation approach, and how impact evaluations in this field are highly concentrated in a few countries.

Figure 10 shows the evidence base for intervention categories. There is a clear concentration of impact evaluations of interventions, policies and programmes designed primarily to target individuals (either men, women or both). Sixty per cent of them assess such interventions, specifically economic (n = 13) and social (n = 13) empowerment. Economic interventions have a theory of change that emphasises the intersection of gender and poverty, and how it increases the likelihood of risk factors that could increase the incidence of IPV.

When targeting women, such interventions make a basic assumption that increased income can reduce gender inequalities. In the case of interventions targeting men, income generated through these interventions reduces economic stress and tensions in the household, which can often lead to partner violence. Social empowerment programmes, on the other hand, are a cornerstone of the violence prevention movement (Fulu and Kerr-Wilson 2015), recognising the role of dependency on men as a source of women's vulnerability. Fulu and Kerr-Wilson's review discusses how there is more overall evidence on the effects of economic interventions than social empowerment activities, particularly when the former are combined with gender transformative approaches.

Figure 10: Completed impact evaluations by intervention category



For other socio-ecological levels, interventions with a large representation of impact evaluations are counselling and critical awareness of gender roles (relationship level) and community-wide mobilisation (community level).

We also coded completed studies evaluating programmes with interventions targeting more than one socio-ecological level, under the label of multicomponent approaches. We identified 11 studies in this group. The literature typically associates multicomponent

programmes with community-based approaches. Here we consider studies evaluating interventions in different combinations of socio-ecological levels, for example individual and household levels.

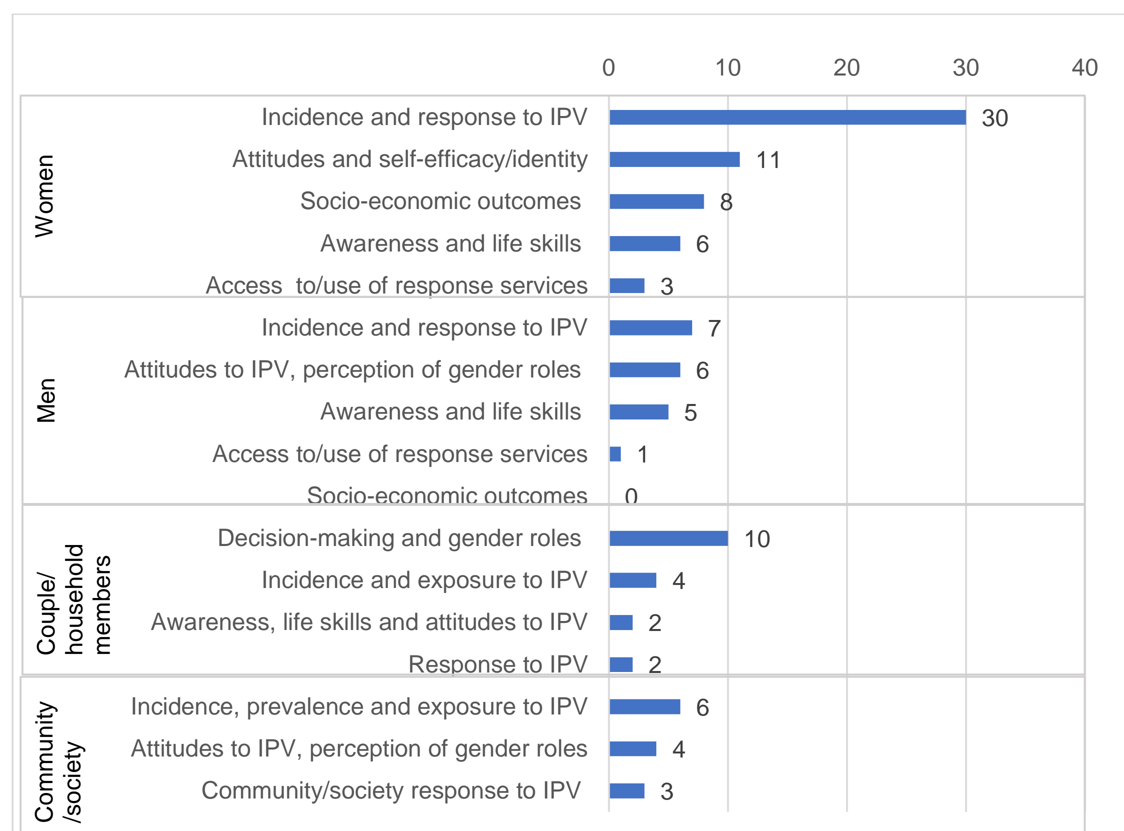
We also identify a number of key gaps in the evidence base. Notably, we did not find any impact evaluations conducted in L&MICs on some widely used or advocated for approaches, such as bystander or parenting interventions. Moreover, there is little evidence on the impact of interventions in the workplace/private sector, extracurricular activities for children, and the promotion of changes in legislation.

3.1.5 Impact evaluations by outcome category

Figure 11 summarises the evidence base in terms of outcomes reported. Over 60 per cent of impact evaluations report results based on an indicator of experience of IPV by women. The specific indicator varies, from self-reported violence to indices designed to get a sense of the level of exposure to violence.

Also for women, 11 studies assessed attitudes, self-efficacy and identity. Most of the indicators under this category focus on attitudes of women towards IPV and the acceptability of partner violence inflicted either on them or around them. A usual question to collect this information is one directly inquiring if the respondent thinks it is justified for a husband to hit his wife under certain circumstances.

Figure 11: Completed impact evaluations by outcome category



Again, we can get as much information about what is out there in the evidence base as of what is absent. Poverty, lack of employment opportunities and food security, among other socio-economic indicators, are regularly mentioned in the literature as risk factors

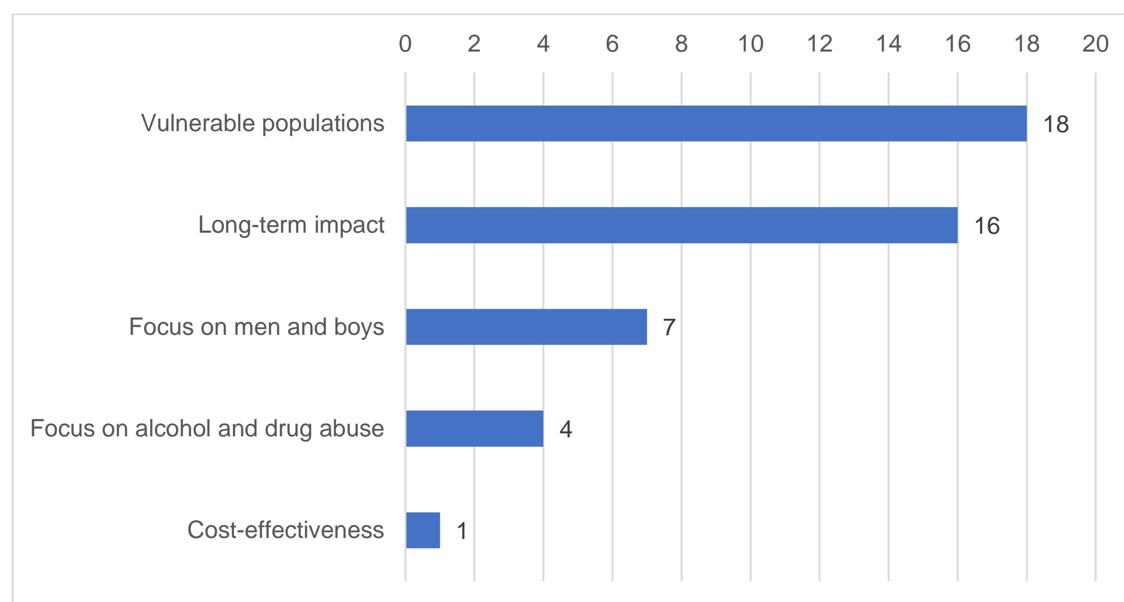
that could lead to increased or sustained partner violence, and treated as outcomes of interest in the IPV prevention literature. Yet, there are no impact evaluations on such risk factors for men that include IPV *prevention* in their theories of change.

Finally, there are only a few studies looking at changes in the reaction and response of households (n=2) or entire communities (n=4) to IPV after the intervention.

3.1.6 Cross-cutting themes

We included five cross-cutting themes in the IPV prevention EGM (Figure 12). Some of them are standard across 3ie EGMs: the identification of studies performing cost-effectiveness analysis of alternative interventions; of studies reporting results in the medium to long term; and of studies reporting effects for vulnerable populations.

Figure 12: Completed impact evaluations by cross-cutting themes



Only one study, which evaluates an income generation support programme in Uganda, includes a cost-effectiveness analysis[7] (Blattman et al. 2013). About a third of studies report results two or more years after programme implementation. Measuring long-term results is particularly important in reducing IPV, given well-established and resilient gendered social norms and the social acceptability of partner violence in many places.

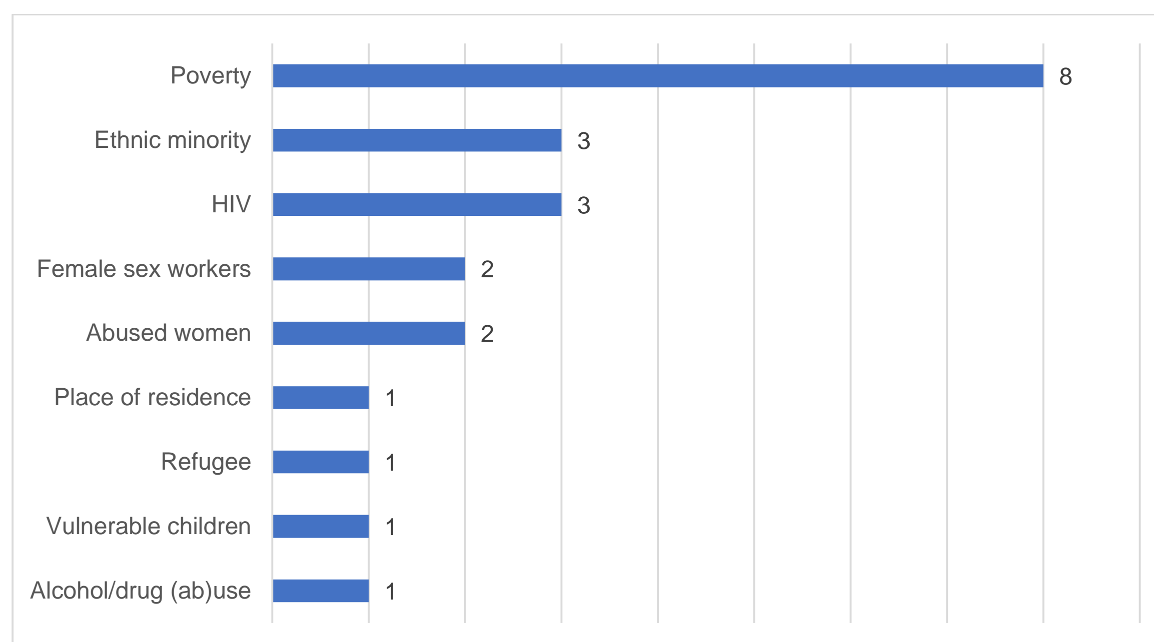
Analysis of vulnerable populations is also a common feature across 3ie EGMs. For this one, we identified relevant vulnerabilities based on suggestions made by experts working in this field (Figure 13). Of the 18 completed impact evaluations discussing the effect of interventions on vulnerable populations, 8 discuss effects on the poor. There is very little disaggregated analysis in the evidence base to identify the effects of a programme on vulnerable people. This includes few studies focused on women that have already been abused in the past (n = 2) but also, for example, on refugees (n = 1) and ethnic minorities (n = 3). Equity analysis is definitely a pending agenda for the IPV prevention evidence base.

[7] We count cost-effectiveness analysis when done as part of the impact evaluation study.

Note that we report on studies reporting on people abusing alcohol or drugs but also on alcohol or drug abuse as a cross-cutting theme. We do this because there may be interventions aimed at reducing alcohol and drug abuse, but not necessarily focused on people suffering such conditions. We identified four studies dealing with this, only one of which specifically targeted people suffering from alcoholism. The other interventions are pre-emptive in nature and delivered at work, at school or at health centres.

Finally, there are only seven impact evaluations that focus on men and boys, many of which centre on awareness raising rather than actual behaviour change. This is despite the fact that a substantial body of literature shows that changing harmful gendered masculinity helps to reduce GBV in general.

Figure 13: Completed impact evaluations by vulnerable population



Note: The number of subpopulations studied is greater than the number of studies because some studies reported on more than one of those listed.

3.1.7 Gender analysis in the evidence base

A gender perspective is a critical element in IPV prevention programming and intervention design, as IPV is closely linked to broadly accepted or established social norms on gender roles and relationships. It is also a factor to consider seriously when doing research around IPV prevention, as it can affect the conclusions of studies.

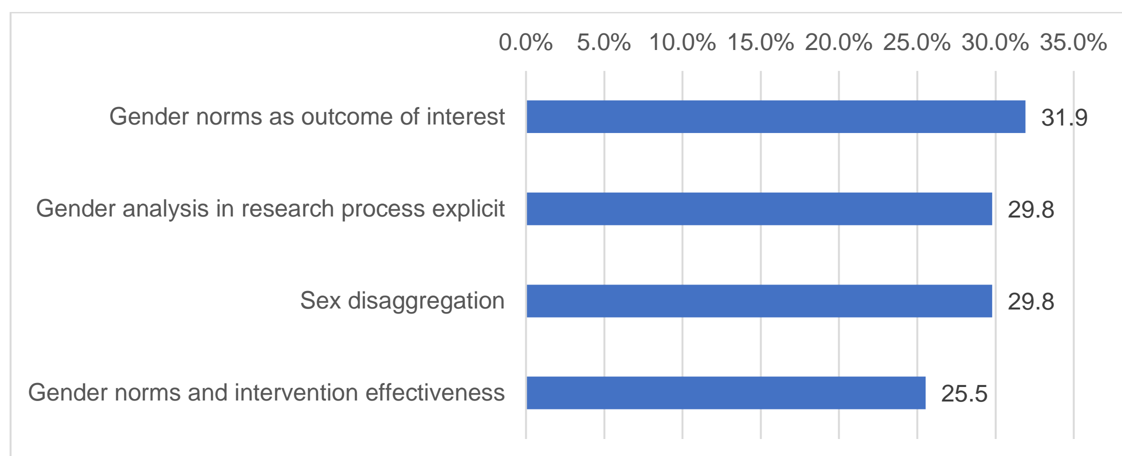
We coded the dimensions of a gender perspective in impact evaluation research, following a simplified appraisal approach proposed by Morgan et al. (2016).

We coded the 47 completed impact evaluations based on four main questions and summarised the results in Figure 14:

1. Does the study disaggregate results by sex?
2. Does the study describe specific considerations of gender in the research process?
3. Is there a discussion in the study on how gender norms affect the effectiveness of the programme evaluated?

4. Are changes in gender power relations or gender norm outcomes investigated in the study?

Figure 14: Gender analysis in the impact evaluation evidence base (by percentage)



Approximately 30 per cent of completed impact evaluations disaggregate results by sex. This number does not include the studies in which information is collected only for men or women. One challenge of evaluations focused in economic and social empowerment is their common failure to include men in their analysis. For example, Buller et al. (2016) only presents outcome data from wives. By contrast, Green et al. (2015) contains gender training for men and women. This intervention and analysis method allows Green and colleagues to measure the impact on men as well as women.

We also looked for explicit references to gender considerations during the research process.[8] In order to do that, coders were asked to look for gender-related information on: who participates as respondents; when data is collected and where; who is present; who collects data; and who analyses the data. We found that 30 per cent of studies discuss at least one of these issues.

Finally, we found that approximately 47 per cent of impact evaluations (n = 22) include some form of gendered power analysis or at least a discussion around gender norms prevailing in the context in which the programme is implemented. In particular, 26 per cent (n = 12) discuss how prevailing gender norms affect programme effectiveness, while 32 per cent (n = 15) have some indicator around changing gender roles considered in the research. For example, studies such as Hossain et al. (2014) attempt to improve relationships by increasing shared decision-making and changing household gender norms. Similarly, Gupta (2014) uses gender dialogue groups to reduce acceptability of IPV. Moreover, some studies focus on younger generations to create more equitable beliefs about gender. Sosa-Rubi (2016), Lazarevich et al. (2015) and Ekhtiari et al. (2014) include school-based interventions to reduce acceptability of IPV and increase gender equity and healthy relationships.

[8] In keeping with 3ie EGM methods, our coding did not attempt to capture implied gender analysis or consideration that researchers undertook but did not report explicitly.

4. Gaps in evidence and opportunities for synthesis

4.1 Gaps in evidence

4.1.1 Interventions

There are noticeable gaps in impact evaluation evidence for several interventions and outcome categories. Going through the EGM by socio-ecological level, even at the individual level, where most of the evidence base seems concentrated, there are intervention categories with scarce impact evaluation evidence attached to them. Economic interventions (most of them not designed for IPV prevention but with studies that assess impacts on IPV outcomes) and social empowerment interventions dominate this section of the EGM.

However, there are no impact evaluations in L&MICs for bystander interventions,[9] a type of intervention strongly grounded on community-based work and the challenge of changing prevailing social norms around gender. By contrast, impact evaluations of bystander interventions have been conducted in high-income countries, with over a dozen completed over the last decade.

Also at the individual level, physical and psychological health in the context of IPV prevention (which includes interventions focused on dealing with alcohol abuse and screening for IPV) has a relatively low presence in the map. This is, in part, because those interventions typically focus on mitigation or response rather than prevention.

At the household level, we could not identify any completed impact evaluations of parenting interventions in L&MICs (there are two ongoing ones in South Africa and Tanzania) and only a few on IPV prevention at school (n=3) and after school (n=1). This is despite the importance placed on the role of relatives and children to reduce IPV prevalence and incidence in the literature.

Interventions targeting the community level, despite being heavily favoured by stakeholders working on IPV prevention programming, have a relatively low number of impact evaluations. Community-based approaches to IPV prevention – particularly, community mobilisation (Fulu et al. 2015) – are considered promising because they can reach multiple levels of society using educational and behavioural change interventions. This helps to foster collective action and potentially change prevailing social norms around gender roles and the acceptability of violence.

Future impact evaluations can shed greater light, not only on the overall effectiveness and understanding of the context in which such community-based approaches work better, but also on understanding how working with specific community groups may improve programme effectiveness. Particularly, impact evaluations related to the private sector or workplace-based interventions have not been generally pursued, except one completed impact evaluation for the garment industry in Bengaluru, India (Krishnan et al. 2016).

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[9] There is, however, an ongoing one in Tanzania, and we received information of another one in the making in India.

Impact evaluations of programmes specifically targeting changes in institutions (both formal and informal) are also under-represented in the evidence base, with only two impact evaluations targeting specific social norms linked to IPV or the enforcement of existing laws that can lead to IPV prevention outcomes. While community-based interventions regularly feature work with local leaders or the promotion of changes in gender norms through advocacy and mobilisation, the specific effectiveness of it is rather absent from the evidence base.

4.1.2 Outcomes

The evidence base is concentrated around outcomes related to women. This focus on women's outcomes across existing impact evaluations is to be expected because women are overwhelmingly the most common victims of IPV. However, the theoretical frameworks for IPV prevention widely acknowledge the need to work with men to change attitudes to IPV in a sustainable manner and to affect prevailing social norms.

All outcome categories for men show low numbers of impact evaluations, but the gap is particularly noticeable for socio-economic triggers that help to reduce the risk of IPV in a given household, as well as access to and use of IPV response services. However, even when we look at other outcome columns with larger numbers of impact evaluations, they are still rather small. There are no studies reporting on male-focused outcomes when the intervention evaluated is attention to physical and psychological support, or bystander interventions. Even when looking at economic interventions, there are virtually no studies (n = 1) reporting on male-focused outcomes.

Similarly, there is a low density of studies measuring household- and community-level outcomes for these categories of intervention. Most of the evidence on community-level indicators comes from interventions focused at the individual level.

4.2 Clusters of evidence

In general, the existing evidence base does not appear ripe for synthesis given the relatively small number of studies and the heterogeneity of outcomes assessed and of interventions evaluated. However, the relatively rapid pace at which the evidence base for L&MICs is growing means that, with additional studies in a few areas that collect similar information, opportunities for synthesis can be generated in the short term.

Whether synthesis and meta-analysis are possible depends on the homogeneity of the studies identified in a cluster, specifically whether the studies evaluate programmes that are relatively similar and measure outcomes in ways that can be standardised and aggregated. We consider here five emerging clusters of impact evaluation:

a. *Impact of economic/income generation programmes on women's experience of or response to IPV*

This cell in the EGM contains 10 studies, representing 8 programmes, which evaluate the effects of economic and income generation interventions (A1) on women's experience of or response to IPV (F4). While we have identified one systematic review in this area (Bourey et al. 2015), that includes all impact evaluations in this cell except two (Iyengar and Ferrari 2011;Bajracharya and Amin 2013), its primary interest is in 'structural interventions' (a broad term that cuts across a set of intervention categories as

defined by our framework), and the heterogeneity of the included studies precluded a meta-analysis. As Bourey and colleagues conclude, more primary studies are required, preferably replicating the same methodology in order to better facilitate future synthesis.

b. *Impact of economic/income generation programmes on decision-making and gender roles at the household or couple level*

An additional cluster of interest is the impact of economic interventions (A1) on household decision-making (H3). The seven impact evaluations in this cell represent five evaluated programmes, including cash transfer programmes in Mexico (Aísa García 2014), Uganda (Blattman et al. 2013; Green et al. 2015) and Ecuador (Buller et al. 2016), and two microfinance interventions in Burundi (Iyengar and Ferrari 2011) and South Africa (Kim et al. 2009; Pronyk et al. 2006). Among the three cash transfer programmes evaluated, outcome indicators vary substantially from composite scores on economic decision-making to decision-making in relation to sexual practices and contraception. Such heterogeneity would therefore make a synthesis difficult, as is the case for the two microfinance studies. It should be noted, however, that the interventions in this cluster are relatively comparable and the studies are focused in two geographic regions (Sub-Saharan Africa and Latin America). Therefore, the priority for further primary research would be on using standardised outcome indicators for household decision-making.

c. *Impact of social empowerment, skills building and awareness raising programmes on women's experience of and response to IPV*

This EGM identifies seven impact evaluations in this cell at the intersection of A2 and F4. The interventions evaluated include training in self-support, negotiation skills, safety skills, gender awareness, community advocacy and substance abuse. The various programmes evaluated in these studies are informed by a number of different theories of change and target a variety of population profiles (such as sex workers, substance abusers, child brides, pregnant women). Therefore, as this cursory examination reveals substantial heterogeneity in terms of intervention type across the seven studies, it is unlikely that an in-depth synthesis or meta-analysis would be possible.

d. *Impact of multicomponent approaches to IPV prevention on women's experience of or response to IPV*

The seven impact evaluations in this cell each evaluate the impacts of different multicomponent programme interventions (E3) on women's experience of or response to IPV (F4). Although the studies in the cluster provide some very useful evidence, we would not recommend that a systematic review be attempted based on the existing evidence base. There are several types of heterogeneity across the studies that make it difficult to perform meta-analysis on them. Namely, of the seven studies, only two evaluate somewhat similar multicomponent approaches (Blattman et al. 2013 and Iyengar and Ferrari 2011). The other five studies evaluate the combination of several different intervention components such as microfinance loans and training for couples of domestic violence (Kim et al. 2009; Pronyk et al. 2006), and combining gender-equity training and family planning services to men and women (Raj et al. 2016).

e. Impact of multicomponent approaches to IPV prevention on decision-making and gender roles at the household or couple level

Finally, we examine the six studies that evaluate the impacts of five different multicomponent programmes (E3) on decision-making and gender roles at the household or couple level (H3). As with the above section, the combination of components evaluated in this cell are too heterogeneous for any synthesis yet.

5. Conclusions

The production of impact evaluations of IPV prevention interventions has steadily increased in recent years, following increased programming in this area, and the interest in adapting experiences that have been deemed promising in preventing IPV. Because conducting an impact evaluation requires time, resources and close coordination with programme-implementing agencies, the evidence base is concentrated in a few countries. The IPV prevention EGM maps impact evaluations that focus on IPV prevention, facilitating access to evidence but also bringing attention to existing gaps in evidence and identifying opportunities for future synthesis.

The intervention and outcome categories on the EGM are the result of discussions with experts working in the area of IPV prevention, in NGOs, donor or research organisations. These categories are relevant because people use them for programming and analysis. The research, analyses and theoretical frameworks developed over the years inform organisations' theories of change. Yet, despite these categories being used for programming, the impact evaluation evidence base for some of them is scarce or non-existent.

We identified 47 completed and 28 ongoing impact evaluations of interventions implemented in L&MICs. The intervention categories with the most impact evaluation studies are economic/income generation and social empowerment (13 studies each), followed by the evaluation of multicomponent interventions (n=11), and most studies focus their report on women's outcomes. Bystander and parenting interventions, and the engagement of local authorities, are all categories with zero completed impact evaluations by the time the search and screening was finished in 2016.

The focus of the impact evaluations published to date has been reporting on women-related outcomes, particularly incidence and response to IPV, attitudes to IPV and socio-economic outcomes. There is a noticeable lack of information on men-related outcomes, which is at odds with the need to work with men and boys that is acknowledged in the IPV prevention literature. In fact, only seven impact evaluations in the evidence base focus on men and boys.

Moreover, for a topic where prevailing gender norms are so important, only around 25 per cent of studies include an explicit discussion on how social norms affect the effectiveness of the intervention evaluated, while about a third of completed impact evaluations report on gender norm changes as an outcome. Sex disaggregation of results is featured in around 30 per cent of studies, in part because many of them focus only on women.

Less than 40 per cent of completed impact evaluations provide information on vulnerable populations, with the poor being the most common subpopulation focus. However, despite several vulnerable populations of interest for programming and intervention design, there is still very limited analysis that specifically focuses on them in existing impact evaluations.

Across outcome levels, there is no impact evaluation evidence yet (as per the search and screening completion date of August 2016) for some important interventions used in programming, such as bystander and parenting interventions, or on the effects of programmes working with local leaders at the institutional level. However, even for those interventions with a relatively large number of studies evaluating them, there is a consistent gap in evidence reporting on men-focused outcomes. Correcting this gap in the evidence base can offer important insights on how to better encourage behavioural change in men and ultimately prevent IPV in a sustainable way.

Additionally, multicomponent interventions offer the opportunity to evaluate the impact of a combination of interventions targeting different levels of the social ecology. Impact evaluations measuring the impact of the overall programme but also of its individual components can also be set up to provide comparative information about interventions, and the opportunity to analyse cost-effectiveness.

While the map shows some apparent clusters of evidence that could be the basis for evidence synthesis, the heterogeneity of interventions under the categories is a challenge when deciding to embark on a systematic review. Once the ongoing impact evaluations (n = 28) are completed, more opportunities for synthesis are likely to open.

The IPV prevention EGM has been structured in such a way that regular updates and new approaches can be considered and added over time. We hope that the IPV prevention community finds this resource useful in their efforts to target programming and prioritise research.

Appendix A: Search and screening tools

Table A1: Search strategy

#	Search syntax
Topical terms	
1	(abus* or assault* or violen* or rape* or beat* or batter* or coerc* or aggress* or ((forc* or unwanted) adj3 (sex* or intercourse)) or harass* or victimi* or ill-treat* or perpetrat* or misogyn*) ti,ab,kw.
2	rape/ or violence/ or coercion/ MeSH
3	1 OR 2
4	(wife or wives or spous* or partner* or girlfriend* or girl-friend* or dating or "go-out-with" or "non-spous*" or husband* or boyfriend* or boy-friend* or couple or couples or family or families or familial or household or fianc* or marital or married or domestic or "co-habit*" or cohabit* or relationship* or intimate) ti,ab,kw.
5	family/ or spouses/ or sexual partners/ MeSH
6	4 OR 5
7	3 AND 6
8	domestic violence/ or spouse abuse/ or intimate partner violence/ MeSH
9	("intimate terrorism" or ("intimate partner*" adj3 violen*) or IPV) ti.ab.kw
10	Battered Women/ MeSH
11	OR/7-10
Impact evaluation and study terms	
12	((match* adj3 (propensity or coarsened or covariate)) or "propensity score" or ("difference in difference*" or "difference-in-difference*" or "differences in difference*" or "differences-in-difference*" or "double difference*") or ("quasi-experimental" or "quasi experimental" or "quasi-experiment" or "quasi experiment") or ((estimator or counterfactual) and evaluation*) or ("instrumental variable*" or (IV adj2 (estimation or approach))) or "regression discontinuity") ti,ab,kw
13	(((experiment or experimental) adj2 (design or study or research or evaluation or evidence)) or (random* adj4 (trial or assignment or treatment or control or intervention* or allocat*))) ti,ab,kw
14	Randomized Controlled Trial/ or random allocation/ or Propensity Score/ or Models, Econometric/ or Quasi-Experimental Studies/ MeSH
15	Program Evaluation/ or Evaluation Studies/ MeSH
16	((impact adj2 (evaluat* or assess* or analy* or estimat* or measure)) or (effectiveness adj2 (evaluat* or assess* or analy* or estimat* or measure))). ti,ab,kw.
17	("program* evaluation" or "project evaluation" or "evaluation research" or "natural experiment*" or "program* effectiveness") ti,ab,kw
18	meta analysis/ MeSH
19	((systematic* adj2 review*) or "meta-analy*" or "meta analy*") ti,ab,kw
20	OR/12-19
	Combination and filtering
21	11 and 20
22	Limit 21 to yr = “1990 –Current”

Table A2: Databases and websites searched

Indexes	Provider
From database providers	
EconLit	EBSCOhost
Criminal Justice Abstracts	
Violence & Abuse Abstracts	
Scopus	
Africa-Wide Information	
Embase	OvidSP
PsycINFO	
Global Health	
CINAHL Plus	
MEDLINE	
ERIC	
International Bibliography of Social Sciences (IBSS)	ProQuest
PILOTS	
Sociological Abstracts (and companion file Social Services Abstracts)	
Criminal Justice Database	
Scopus	Elsevier
Other academic databases	
IDEAS/RePEc	IDEAS
The National Bureau of Economic Research (NBER)	NBER
Social Science Research Network (SSRN)	SSRN
National Criminal Justice Reference Service (NCJRS): NCJRS Abstracts Database	NCJRS
Social Sciences Citation Index (via Web of Science Core Collection)	Thomson Reuters
Contemporary Women's Issues	Gale
Online research libraries	
POPLINE	POPLINE
EPPI-Centre Evaluation Database of Education Research	EPPI-Centre
Trials Register of Promoting Health Interventions (TRoPHI)	EPPI-Centre
Websites	
3ie Impact Evaluation Repository	http://www.3ieimpact.org/evidence-hub/impact-evaluation-repository
Abdul Latif Jameel Poverty Action Lab (J-PAL)	https://www.povertyactionlab.org/evaluations
Innovations for Poverty Action (IPA)	https://www.povertyactionlab.org/evaluations
University of California: Center for Effective Global Action (CEGA)	http://cega.berkeley.edu/evidence/
Overseas Development Institute (ODI)	https://www.odi.org/publications
Governance and Social Development Resource Centre (GSDRC)	http://www.gsdrc.org/document-library/

Health Evidence	http://www.healthevidence.org/
African GBV Prevention Network	http://preventgbvafrica.org/understanding-vaw/vaw-resources/
Interagency Gender Working Group (IGWG)	http://www.igwg.org/
Population Council	http://www.popcouncil.org/
International Center for Research on Women (ICRW)	http://www.icrw.org/
Sexual Violence Research Initiative (South Africa)	http://www.svri.org/documents/svri-publications
BRIDGE Global Resources	http://www.bridge.ids.ac.uk/global-resources?theme_filter=C1672
National Online Resource Centre on Violence Against Women	http://vawnet.org/
Minnesota Center Against Violence and Abuse (MINCAVA)	http://www.mincava.umn.edu/categories/897?type=8
Centre for Court Innovation	http://www.courtinnovation.org/research/7/publication
Social Care Online	http://www.scie-socialcareonline.org.uk/?q=violence+gender+evaluation
Banks	
World Bank topic gender	World Bank
World Bank Working Papers	
enGENDER IMPACT (World Bank)	
Inter-American Development Bank	IDB
UNFPA Evaluation Database	UNFPA
DAC Evaluation Resource Centre (DEReC)	OECD
USAID Development Experience Clearinghouse	USAID DEC
UN Women	UN
WHO IRIS	WHO
UNDP Evaluation Resource Centre	UNDP
Registries	
American Economic Association RCT Registry (AEA)	https://www.socialscienceregistry.org/
3ie Registry for International Development Impact Evaluations (RIDIE)	http://www.3ieimpact.org/evidence-hub/ridie
ClinicalTrials.gov	www.clinicaltrials.gov
Cochrane Central Register of Controlled Trials (CENTRAL)	http://www.cochranelibrary.com/about/central-landing-page.html
Systematic review databases	
3ie Systematic Review Database	http://www.3ieimpact.org/evidence-hub/systematic-review-repository
EPPI-Centre Publications	http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=56
Database of promoting health effectiveness reviews (DoPHER)	https://eppi.ioe.ac.uk/webdatabases4/Intro.aspx?ID=9
ASCOF Interventions Database (AID)	https://eppi.ioe.ac.uk/webdatabases4/Intro.aspx?ID=7

Cochrane Database of Systematic Reviews (CDSR)	http://www.cochranelibrary.com/cochrane-database-of-systematic-reviews/
Campbell Collaboration Library	http://www.campbellcollaboration.org/lib/
Research for Development Outputs	http://r4d.dfid.gov.uk/
Dissertations and theses	
British Library E-Theses Online Service (EThOS)	EThOS
Networked Digital Library of Theses and Dissertations (NDLTD)	NDLTD

Table A3: IPV prevention gap map screening protocol

Instructions

Proceed through the questions in order. Note that an "unclear" answer never excludes a study. The questions are designed to be as objective as possible. The questions are meant to start with those easier to ascertain and progress to those that will be harder to answer based on a quick read. The screener should feel confident of any "yes" or "no" answer used to exclude a study. **If you cannot conclusively say "yes" or "no", please mark the study as unclear and it will move on to the next level of screening.**

Screening questions	No	Yes	Unclear
Title			
1. Was the study conducted in the year 1990 or after?			
IF NO, THEN EXCLUDE			
2. Are data analysed using quantitative methods?			
IF NO, THEN EXCLUDE			
3. Does the study concern a policy, program, or intervention?			
IF NO, THEN EXCLUDE			
4. Is the study a biomedical (efficacy) trial of a product, medication, or procedure? These include medical technologies.			
IF YES, THEN EXCLUDE			
5. Does the study concern a policy, program, or intervention that is CLEARLY NOT concerned with intimate partner violence, GBV, violence against women, domestic abuse or similar topics?			
IF YES, THEN EXCLUDE			
Title and abstract			
Repeat questions 1 – 5.			
6. [Are the methods clearly identified and clearly NOT among the included impact evaluation methodologies? randomized controlled trials (including stratified), difference-in-differences, instrumental variable approaches, propensity score matching (and other matching techniques), regression discontinuity design, synthetic controls. At this level, include all systematic reviews that meet other inclusion criteria.]			
IF YES, THEN EXCLUDE			
7. Does the study measure outcomes for many observations of a relevant unit of analysis? (e.g. individuals, households, firms, communities)? [This question is essentially whether the study is a "large n" study – case studies, for example, should almost always be cut. When in doubt, include]			

IF NO, THEN EXCLUDE			
8. Does the study evaluate a policy, program, or intervention that is clearly NOT concerned with intimate partner violence? ***Intimate partner*** is a person with whom an individual has a close, personal relationship that may be characterized by emotional connectedness, regular contact or sexual behavior, identification as a couple, and cohabitation. Intimate partners may include current or former spouses, boyfriends or girlfriends, dating partners, and ongoing sexual partners (Breiding et al. 2015). ***Intimate partner violence*** is any behavior in an intimate relationship that causes physical, sexual or psychological harm, including aggression, sexual coercion, psychological abuse and controlling behavior (WHO 2005). While typically inflicted on women, men can also be victims of IPV.			
IF YES, THEN EXCLUDE			
9. Does the study evaluate a policy, program, or intervention that is clearly concerned ONLY with the response to or treatment of intimate partner violence and not its prevention? This applies to a policy, program, or intervention without a direct or indirect aim at preventing IPV recurrence. Example: medical attention of victims of abuse without including psychological support would be excluded			
IF YES, THEN EXCLUDE			

Full text			
Repeat questions 1-9.			
10. Does the study use one of the following impact evaluation methodologies: a) Randomized controlled trials (RCT). b) Regression discontinuity design (RDD). c) Propensity score matching (PSM) or other matching methods (as well as synthetic controls). d) Instrumental variable (IV) estimation (or other methods using an instrumental variable such as the Heckman two-step approach). e) Difference-in-differences (DiD), or a fixed or random effects model with an interaction term between time and intervention for baseline and follow-up observations. Note: The study may also use methods in addition to those listed here (such as regression with controls), or may use a primary evaluation methodology not listed (such as in a natural experiment), but must do so in addition to one of the above methods (a–e).			
IF YES, PROCEED TO QUESTION 11 IF NO AND NOT A REVIEW, EXCLUDE IF STUDY IS A REVIEW, PROCEED TO QUESTION 12			
11. Does the study have a sample size of at least 40 observations for RCTs and at least 80 observations for quasi-experimental methods at baseline (control and treatment combined)?			
IF NO, THEN EXCLUDE			
12. Is the study described as a systematic review, synthetic review, and/or meta-analysis? To be a review, the study must meet all five criteria below:			

a) Have a research question or focus on intimate partner violence (a study that examines GBV broadly or GBV only in the public sphere or violence not between intimate partners should be excluded) b) Clearly search for studies that measure the effect of a program, policy, or intervention on outcomes c) Describe methods used for search, screening, data collection, and synthesis d) Concern questions other than those related to treatment efficacy (trials undertaken in closed clinical or laboratory settings) e) Have a publication date of 1990 or later.			
IF STUDY IS A REVIEW, BUT DOES NOT MEET CRITERIA ABOVE, THEN EXCLUDE			
13. Are the evaluated policy or program activities directly or indirectly focused on intimate partner violence prevention? Intimate partner violence prevention activities include: - Those seeking to reduce the overall likelihood that anyone will become a victim or a perpetrator by creating conditions that make violence less likely to occur (examples: awareness and sensitization campaigns, reducing binge drinking); - Efforts to identify and address early signs of abuse or abusiveness (examples: screening, efforts to enhance IPV identification and reporting); and - Those focusing in individuals who are already abused or abusive in order to reduce the recurrence of violence they experience or inflict (examples: psychological support).			
IF YES, INCLUDE IF NOT, EXCLUDE IF UNCLEAR, proceed to question 14			
14. Does the study measure effect sizes for one or more outcome categories in the EGM framework?			
IF NO, EXCLUDE			

Table A4: Coding instructions for included studies

Note: any study for which an intervention or outcome category cannot be identified from the list should be set aside for re-screening.

Basic study information	
Data to be extracted	**Additional instructions to coder**
Study authors	
Study title	
Year of publication/date on document	
Country(ies) where intervention implemented	
Region(s) where intervention implemented	
High-income country or low- & middle-income country	High-income countries and low- and middle-income countries are included in this evidence gap map.
Author email address	Email address by corresponding author; if not indicated use first author.
URL (IER URL if available)	Look up if not indicated in report.
Study publication status	
Program information	
Data to be extracted	**Additional instructions to coder**
Program name (if applicable)	
Methods used (from screening protocol)	If multiple methods were used, please separate with semicolon and space. Remember to consistently use British spelling.
Interventions	
Data to be extracted	**Additional instructions to coder**
Category code(s) of intervention from intervention list	
Intervention activity	
Description of intervention	
Outcomes	
Category code(s) for outcome from outcome list	
Outcome measured	
Description of outcome	
Unit of analysis	

Appendix B: Evidence gap map of ongoing IPV prevention impact evaluations

		OUTCOME CATEGORIES	WOMEN					MEN					COUPLE / HOUSEHOLD MEMBERS				COMMUNITY / SOCIETY			CROSS-CUTTING THEMES				
			F1	F2	F3	F4	F5	G1	G2	G3	G4	G5	H1	H2	H3	H4	I1	I2	I3	J1	J2	J3	J4	J5
INTERVENTION CATEGORIES			Awareness and life skills	Attitudes and self-efficacy/ identity	Socio-economic outcomes	Incidence or response to IPV	Access to/ use of response services	Awareness and life skills	Attitudes to IPV, perception of gender roles	Socio-economic outcomes	Incidence or response to IPV	Access to/ use of response services	Awareness, life skills and attitudes to IPV	Incidence, and exposure to IPV	Decision-making/ gender roles	Response to IPV	Attitudes to IPV and perception of gender roles	Incidence, prevalence and exposure to IPV	Community/ society response to IPV	Cost-effectiveness	Long-term impact	Vulnerable groups (other than women)	Focus on men and boys	Focus on alcohol and drug abuse
INDIVIDUAL LEVEL	A1	Economic, income generation programmes	1	4	3	5	1	1	2		2			1					1	1	2	1	1	
	A2	Social empowerment, skills building, awareness raising	3	6	2	10	1	2	6		5		1	3	1				1	1	4	2	6	
	A3	Attention to physical or psychological health	3	3		5	3	1	1		1			3		1					3		1	1
	A4	Bystander interventions	1	1	1	1		1	1		1			1								1		
RELATIONSHIP and HOUSEHOLD LEVEL	B1	Counselling , critical awareness of gender roles	2	4	1	5	1	1	1		2		1	3	1					1	3			1
	B2	Parenting interventions	1	2		1		1	2		1		1	1										
	B3	Curriculum-based activities at school	2	1		1	1	2	1		1	1					1							
	B4	Extra-curricular activities for children and adolescents																						
COMMUNITY LEVEL	C1	Communication and advocacy campaigns							1								1	1					1	
	C2	Community-wide mobilisation	2	3	1	4		1	2		4			2				1			5	2	2	
	C3	Activities and mobilisation through common-interest groups	1	2	1	3			1		2								1		2		1	
	C4	Workplace and private sector interventions																						
INSTITUTION/SOCIETY LEVEL	D1	Communication and advocacy focused on authorities		1		1															1			
	D2	Police activities/enforcement of existing laws and regulations																						
	D3	Enforcement of exisiting laws, regulation or policies																						
EMERGING TRENDS	E1	ICT-based interventions																						
	E2	Using traditions, festivals to channel messages				1					1			1							1		1	

Appendix C: List of impact evaluations included in the EGM

Completed impact evaluations

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This report outlines the main findings of a gap map that assesses the evidence available on intimate partner violence interventions in low-and middle-income countries. At the moment, the evidence base is concentrated in only eight L&MICs, with the preponderance of them in three: India, South Africa and Uganda. The authors find that a high concentration of interventions target individual men or women, a number of which assess economic and social empowerment programmes. While there is quite a bit of programming aimed at and reporting on women, information on outcomes for men is much more limited. More evidence is needed on interventions that report outcomes for men; that target vulnerable populations, communities and/or institutions; and that report on cost effectiveness.

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