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Intimate partner violence prevention evidence gap map

2018 update

September 2019

Evidence
Gap Map
Report 8

Health



International
Initiative for
Impact Evaluation

About 3ie

The International Initiative for Impact Evaluation (3ie) is an international grant-making NGO promoting evidence-informed development policies and programmes. We are the global leader in funding, producing and synthesising high-quality evidence of what works, for whom, how, why and at what cost. We believe that better and policy-relevant evidence will make development more effective and help improve people's lives.

3ie evidence gap map reports

3ie evidence gap maps are thematic collections of information about impact evaluations or systematic reviews that measure the effects of international development policies and programmes. The maps provide a visual display of completed and ongoing systematic reviews and impact evaluations in a sector or sub-sector, structured around a framework of interventions and outcomes.

The evidence gap map reports provide all the supporting documentation for the maps, including the background information for the theme of the map, the methods and results, protocols, and the analysis of results.

About this evidence gap map report

This report provides the supporting documentation for and complete update of the 3ie evidence gap map on intimate partner violence prevention produced in 2017. When 3ie updates a map, we produce an updated report and brief that replace the previous versions. The older versions are no longer publicly available. The original map and report authors (see the citation) have reviewed this update and remain as authors. Eleanor Dickens and Marie-Eve Augier authored the update. An anonymous donor funded both the original map and this update. 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, Eleanor Dickens, at egdickens@gmail.com.

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3ie Evidence Gap Map Report 8 (updated)

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Acknowledgements

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3ie's original appreciation continues for the more than 30 practitioners and researchers who participated in a consultation webinar for stakeholders in Sub-Saharan Africa, coordinated by Raising Voices in Kampala, Uganda. Also, many thanks go to the participants of a London-based workshop for researchers working on impact evaluations and systematic reviews of interventions to prevent intimate partner violence, and to participants of a donor roundtable meeting hosted by the Inter-American Development Bank in 2015, where the idea of developing an evidence gap map around this topic was originally raised.

Summary

Intimate partner violence (IPV) is a global health problem and a human rights violation. According to the World Health Organization, 30 per cent of women worldwide will suffer some form of partner violence at one point in their lives, and the rate is as high as 37 per cent in some countries. IPV prevention programming has the potential to improve gendered power relations in communities and to positively affect people's lives. From grassroots activists to international donors, stakeholders are devoting 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 interest.

The first IPV prevention gap map was published in 2017. This study provides an update to the map and analysis based on evidence published between August 2016 and July 2018. 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 ecological model that informs most IPV prevention programming.

This update used the same methods and inclusion criteria as the original, including a systematic search, four rounds of screening, metadata extraction and analysis of results. We used an explicit set of inclusion criteria to include completed or ongoing impact evaluations or systematic reviews that focus on activities to prevent primary, secondary or tertiary forms of IPV. The evidence gap map provides a visual display of completed and ongoing systematic reviews and impact evaluations, structured around a framework of interventions and outcomes. It identifies areas where there is little to no evidence, as well as clusters of evidence that could be used for syntheses.

As of this map update, we have identified 141 studies: 95 impact evaluations, 44 ongoing impact evaluations and 2 systematic review protocols. This total represents a significant increase in new completed (48) and ongoing (16) impact evaluations since we first mapped the literature in 2016. Our update includes 8 impact evaluations still in progress from the original map that have since published updates – 6 endline reports and 2 midline reports. Although we did not identify any new completed systematic reviews that met our inclusion criteria, two protocols of ongoing systematic reviews that met our inclusion criteria have been published since our last report.

The evidence base on IPV interventions is barely a decade old. It is highly concentrated in a handful of low- and middle-income countries, particularly South Africa, Uganda and India. Impact evaluations of IPV prevention interventions in conflict-afflicted, post-conflict and humanitarian contexts remains limited, having only increased from 3 to 6 studies since 2016 – 1 systematic review protocol and 5 impact evaluations. The impact evaluations are as follows: 1 in Côte d'Ivoire, 1 in Afghanistan (in progress), 2 in the Democratic Republic of Congo (1 in progress), and 1 in Haiti (in progress). The impact evaluations in Afghanistan and the Democratic Republic of Congo examine the effect of women's economic empowerment – the first on an education and cash transfer programme and the second on a livestock asset transfer programme.

A significant proportion of the included impact evaluations focus on interventions targeted at individuals, particularly economic and social empowerment interventions

targeting women. There has been substantial growth in the evidence base for interventions targeting communities, institutions and relationships/households, particularly in the area of police interventions. Many of these newly published impact evaluations use quasi-experimental designs to evaluate the impact of policies or legislation. For example, one impact evaluation in Turkey examined a legal change in compulsory education to estimate the impact of educational attainment on IPV prevalence. Due to the difficulties of evaluating a public policy through a randomised controlled trial, we encourage more quasi-experimental designs to fill the evidence gap on interventions at the community and institution level.

Shifting the focus to outcomes, there is a clear effort to report on indicators focused on women's actual experiences of IPV. As expected, we find a high concentration of evaluations reporting outcomes on women. Although there are fewer studies measuring outcomes for men, this number has been increasing significantly since 2014. Workplace and private sector interventions that target male outcomes are an important gap that remains to be filled. Finally, 18 per cent of these studies contain substance abuse prevention components and 35 per cent analyse gendered power relations and gendered social norms in measuring male outcomes.

Since 2016, we found more studies reporting outcomes for couples, households, communities and society, in addition to the increases in outcomes measured for men. Previously empty areas on the map, such as parenting and bystander interventions, now reflect newly completed studies, with three and four impact evaluations, respectively. A gender analysis of the evidence base indicates that only a third of studies assess outcomes related to changes in gender norms.

The majority of included impact evaluations use experimental rather than quasi-experimental study designs. In this map, quasi-experimental designs in use were difference-in-difference, instrumental variables, regression discontinuity design and propensity score matching. We have also included studies that used multiple methods (more than one impact evaluation estimation strategy) or mixed methods (an impact evaluation estimation strategy and qualitative methods such as key informant interviews or focus group discussions). Again, there is a notable increase of quasi-experimental studies evaluating the effects of community and institution programmes. Thirty per cent report effects on IPV reductions beyond 24 months after the intervention.

There are clear clusters of evidence around interventions targeted at the individual level and outcomes measuring women. The major evidence gaps are interventions targeting the institution and society level and outcomes measuring effects for couples, households, institutions and societies. We encourage more consideration of gender; equity; and lesbian, gay, bisexual, transgender and queer partners, and measurement of long-term effects. Finally, whilst there are a number of clusters of rigorous evidence, the high variation in the interventions has prevented synthesis. In the short term, we need more rigorous impact evaluations to prepare the evidence base for more systematic reviews in the long term.

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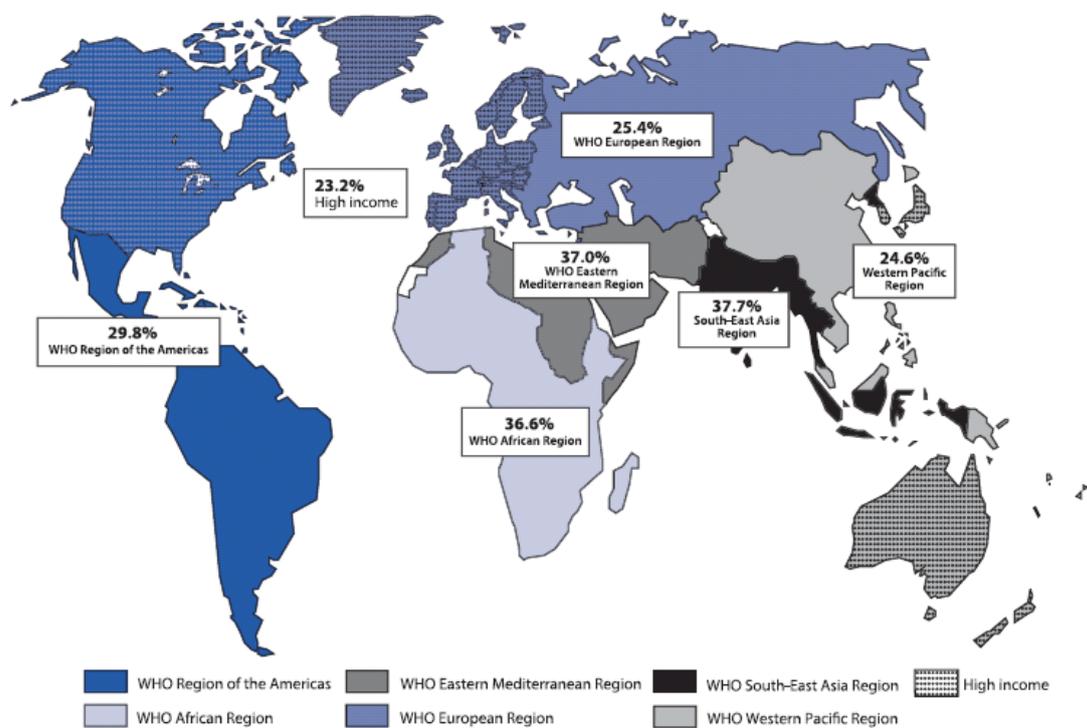
Abbreviations and acronyms

DID	Difference-in-difference
EGM	Evidence gap map
GBV	Gender-based violence
IMAGE	Intervention with Microfinance for AIDS and Gender Equality
IPV	Intimate partner violence
IV	Instrumental variable
L&MICs	Low- and middle-income countries
LGBTQ	Lesbian, gay, bisexual, transgender and queer
PSM	Propensity score matching
RCT	Randomised controlled trial
RDD	Regression discontinuity design
VAWG	Violence against women and girls
WHO	World Health Organization

1. Introduction

In the past decade, there has been a growing recognition of gender-based violence¹ (GBV) and intimate partner violence (IPV) not only as a global health epidemic, but also as human rights violations (Contreras-Urbina et al. 2016; WHO 2013; Heise 2011). According to the World Health Organization's (WHO's) *Global and regional estimates of violence against women*, there is a wide geographical spread of IPV prevalence by region, ranging from 23.2% to 37.7% (Figure 1). This growing recognition is a reflection of the global commitment to documenting the magnitude of the GBV epidemic, as well as the growing body of evidence on the prevalence and consequences of the violence (WHO 2013).

Figure 1: Regional prevalence of IPV by WHO region



Source: WHO (2013)

Recognition of the problem has been spurred by many dedicated professionals, activists and survivors at the grassroots, academic, government and international levels. Media outlets, over time and in more places, are willing to bring this long-standing problem, which is 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 (Barry 2017), was a reflection of this changing environment. It carried repercussions internationally, heightening the attention of other actors in the international development arena, including donors.

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

This increased attention has been matched by increased programming, with more interventions around the world aimed at the prevention or mitigation of violence against women and girls (VAWG). In particular, experience from well-known and researched programmes, such as Intervention with Microfinance for AIDS and Gender Equity (IMAGE) 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, under varying conditions and with varying implementation experiences, becomes ever more important.

In recent years, experts have produced important 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 violence against women. 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 VAWG, Fulu and Heise's (2015) summary of evidence around VAWG, Arango and colleagues' (2014) systematic review of reviews around interventions to prevent or reduce VAWG, *The Lancet's* series on VAWG (Watts et al. 2014) and Heise's (2011) IPV prevention evidence overview.

Donors have also stepped up their efforts in three distinct ways: (1) by assessing their portfolios; (2) by funding global initiatives to build the evidence base and identify successful and promising interventions; and (3) by funding innovative approaches to prevent violence. For example, the United States Agency for International Development evaluated the implementation of its global GBV strategy in 2015. In 2016, UK aid published an independent review of its work in VAWG, and currently funds the five-year, £25 million '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 reasons this evidence gap map (EGM) focuses on IPV, rather than GBV as a whole, are manifold. First, IPV is the most common form of GBV. WHO (2017) estimates that around one third of women who have been in a relationship around the world will suffer violence by a partner at some point in their lifetime. Devries and colleagues (2013) estimate that this ranges from 16 per cent in some countries in East Asia to 66 per cent in some countries of central Sub-Saharan Africa.

Moreover, more research is available on IPV than on other types of GBV, opening more opportunities for review and synthesis. Programmes concentrating on IPV also help 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).

Finally, this EGM is built around IPV prevention, 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 EGMs 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 with data visualisation in an interactive platform. 3ie consults with key stakeholders and uses a theory of change to develop the framework of interventions and outcomes for which we conduct a systematic searching and screening of relevant literature to find evidence to populate that map.

The rows of the gap map framework list relevant intervention categories, whilst the columns represent outcomes pursued by those interventions, typically organised along a causal chain. The same study can evaluate more than one intervention or outcome through a multi-arm randomised controlled trial (RCT), and hence can appear in multiple cells in the EGM.

1.2 Study objectives

The update reflects the objectives of the original IPV prevention EGM: (1) identify and map the evidence base and gaps around IPV prevention in L&MICs; (2) identify existing evidence gaps to better inform future investment in research; (3) identify clusters of impact evaluations that offer opportunities for evidence synthesis; and (4) identify, appraise and summarise existing evidence from systematic reviews of the effects of IPV prevention interventions.

1.3 Methods

3ie produced the first IPV prevention EGM and report in 2017. The newly published map and this report are updates. We used the same framework as the original EGM. That framework was developed in early 2016 from discussions at a gathering of researchers, NGO representatives and donor representatives in London; inputs from 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, the original authors conducted a cursory search and screening of relevant studies found in 3ie's Impact Evaluation Repository. They identified eight studies, which they plotted on a 'teaser map'. This teaser map enabled the team to check for missing categories in the framework and assess how intuitive it was for the coding process, and for fine-tuning category names and definitions. They shared the framework and teaser map with the project's advisory group and incorporated relevant feedback.

For this update, we ran the same search strategy as for the original map, but with a date exclusion for papers that would have been screened for the original map (Table A1 in Appendix A). The team searched 16 indices and database providers, 44 websites, and 4 research registries. We conducted three 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 against women or heterosexual partners. 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 predetermined screening protocol (Table A3 in Appendix A) to screen results by titles, abstracts and then full texts. At least two reviewers screened each study independently. The second round of full-text screening was completed at the same time as metadata extraction (also referred to as coding in this article), wherein we screened at full text and, if determining to include it, extracted metadata. We coded impact evaluations for relevant metadata and populated the EGM. Coding was reviewed by another researcher and the principal investigator. Systematic reviews were assessed against 3ie's rating tool to determine confidence in their findings and to evaluate the risk of bias in each review.

Studies can be represented in several cells on the map, as studies may evaluate more than one intervention and/or outcome. This is common if an RCT has more than one treatment arm, for example. In this map, of the 396 total intersections including cross-cutting themes, 239 intersections have evidence. For example, Abeid and colleagues' (2015) study, which evaluates a community-based intervention in Tanzania, evaluates 2 interventions at the community level (a communication campaign, using radio, and community mobilisation) for 3 different outcomes focused on women, men and the community/society, generating 6 occurrences of evidence.

A key challenge, for this update and the original 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. We trained screeners to be cautious when either of these issues came up; whilst screening in the title and abstract level, screeners included GBV studies unless the authors explicitly disclosed that IPV was out of scope. At the full text screening stage, the principal investigator reviewed these studies to examine the nuanced difference between GBV and IPV and made an inclusion or exclusion decision.

The flow of the screening protocol was written to address this challenge, methodically minimising the risk of missing relevant studies along the process. If the intervention was not focused on IPV prevention but reported effect sizes for IPV prevention outcomes and met all other inclusion criteria, we included it for coding.

1.4 Limitations

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

Halfway through the full text screening process, we conducted a risk assessment of Type I error (falsely excluding studies that should be included) and Type II error (falsely

including studies that should be excluded) associated with one round of full text screening and found a 6.71 per cent risk of total error, all of which was Type II error. The studies under Type II error were for reasons of methodological rigour and nuances between GBV and IPV.

The search was conducted in English only; however, studies published in French, Portuguese and Spanish found opportunistically in the search were screened and accepted if they met all other inclusion criteria. We excluded studies not published in English, French, Portuguese or Spanish.

Finally, the process of developing an EGM framework is always challenging, and the original 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 we felt was consistent with the logic of an EGM, whilst closely considering the end users' point of view.

1.5 Report structure

Section 2 of the report features the scope of this EGM update. 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 discusses gaps and opportunities for synthesis. Section 5 concludes and discusses implications of the EGM. The attached appendixes include information on methodological processes (Appendix A) and a bibliography of included studies from the original and updated EGM (Appendix B).

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 5 cross-cutting themes. These categories are informed by the concepts we define below.

2.1 Definitions

Over the years, the discussion of IPV prevention amongst practitioners, researchers and donors has featured slightly different definitions across countries and amongst different authors. The box below presents the most important working definitions that we use throughout the report. These working definitions allowed us to make clear distinctions between IPV prevention and other related topics during the screening and coding process that guided the inclusion or exclusion of studies when building the EGM.

Key definitions

Intimate partner violence: We use WHO'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: Although 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 characterised 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).

Primary IPV prevention: Activities 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 by pursuing a reduction in binge drinking).

Secondary IPV prevention: Activities 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).

Tertiary IPV prevention: Activities 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, coupled with soft skills and empowerment).

2.1.1 IPV prevention versus IPV mitigation or response

To be included in the map, the evaluated intervention, programme or policy has 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 harmed by an intimate partner. If these interventions are evaluated without a clear argument on how they help *prevent* IPV, or they do not report effect sizes for IPV prevention-specific outcomes, they are not included in the EGM.

2.1.2 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. Some microfinance programmes are examples of the latter type of study.

2.1.3 IPV versus GBV

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 evaluated intervention 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.

2.1.4 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. Most cash transfer programmes are not designed with the explicit goal of preventing 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 is included in this 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. 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 Intervention categories

Table 1 presents the intervention categories² 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 an integrated ecological framework, which is the collection of personal background and personality factors that men and women both bring to their relationships (Heise 1998). This is paired with the context and situational factors that affect their lives, including the prevailing social norms around them that 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).

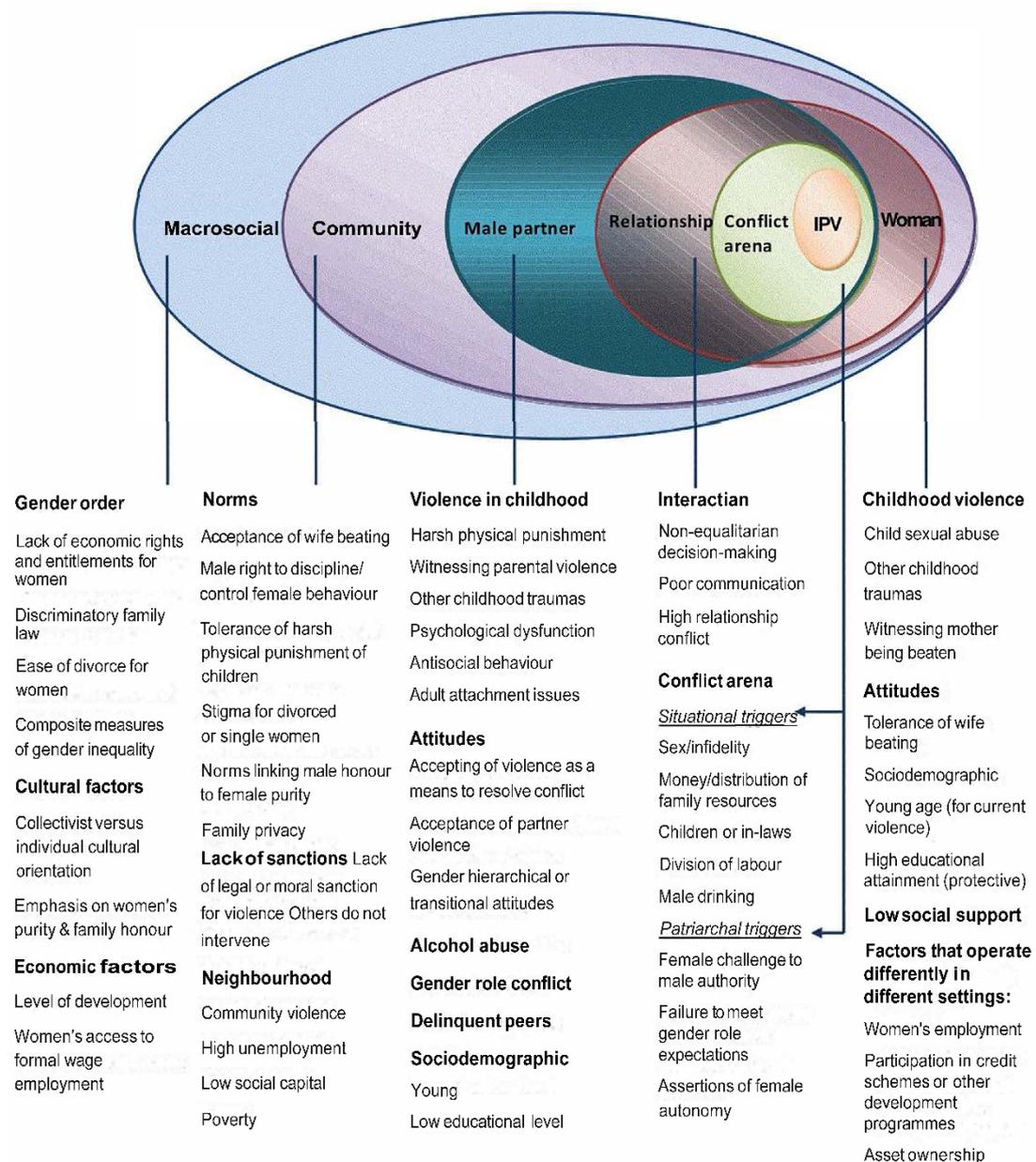
The EGM borrows heavily from ecological models of human development, originally proposed by Bronfenbrenner (1994). Bronfenbrenner argues that we need to consider the entire ecological system in which humans grow in order to understand their development. He conceptualised five subsystems – from the microsystem, or the relationship of an individual with its immediate environment, to the macrosystem, or institutional patterns prevalent in one's society.

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). The intervention typology has not been changed from the original EGM. It remains a combination of specific interventions, intervention goals and intervention targets decided by the advisory group.

Heise (1998) adapts the model to the discussion of VAWG, 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 their own life experience, to a couple's interaction, the household, the community (or communities) to which they belong and their society. The key in 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 there, but not necessarily exclusively there. One example is a communication campaign that reaches an entire community but is intended to reach individuals, or aims at changing the acceptability of IPV at the relationship/household level whilst 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 includes not only 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 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. Therefore, all interventions addressing in-class delivery are under the relationship/household level, whilst the institutional/societal level is reserved for efforts to change laws, regulations and local norms to prevent IPV, and the enforcement of such laws and regulations.

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.

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 and communication 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 again.

Table 1: Intervention categories

<p>Individual level: Studies that focus on interventions targeted at men or women, irrespective of their belonging to a community, interest group or other collective.</p>		
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, and 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, and 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.
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 violence against women to identify, speak out about or seek to engage others in responding to violence. Whilst 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.
<p>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, and parents. This includes heterosexual and LGBTQ partners.</p>		
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.

Relationship and household level (continued): 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, and parents. This includes heterosexual and LGBTQ partners.		
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, amongst others. They can be delivered through home visits, be community based, or be 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	Extracurricular activities for children and/or adolescents	Activities outside school and focused on children (under 13) or adolescents (13–17). Sports, music, theatre and other extracurricular 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.

<p>Institutions and society level: Also known 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.</p>		
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.
<p>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.</p>		
E1	Information and communication technology-based interventions	Includes mobile phones, Internet and hotlines. Whilst 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 the 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, whilst 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!

2.3 Outcome categories

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 are organised as much as possible according to 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 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 on 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 to 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 in which 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 or 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 towards IPV	A study is categorised here when the change in perception and attitudes towards 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 and 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 towards 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 or society response to IPV	This category includes legislation and women's quotas in governing bodies, but also reporting/intervening when IPV happens.

2.4 Populations

We also extracted data on certain 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.

First, we coded the study as including vulnerable populations if the study focused on indigenous peoples, people living with disabilities, people of low castes, LGBTQ people, or other vulnerable populations or subpopulations of interest. The intervention needed to focus on vulnerability or include a detailed discussion around it; it was not enough to report on a vulnerable population or research-defined group as a heterogeneous effect to be considered in this category.

The next population is men and boys. We included a study under this category if the study focuses on men and boys and their attitudes about and perceptions of masculinity. It was not enough to report results or analyse work with men or boys as part of the analysis. The theory of change of the evaluation needed to target the transformational effects of focusing an intervention on men or boys.

Finally, persons abusing alcohol or drugs were included in our third population subgroup. If the study looked at alcohol/drug abuse as an outcome, or at populations of those abusing alcohol or drugs, regardless of the focus of the intervention, we include it here.

2.5 Study types

The IPV prevention EGM primarily includes impact evaluations, which measure the change in the key outcome indicators that occurs because of an intervention, programme or policy. They use 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 to compare the effects of different types of programmes (3ie 2012).

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

- RCT;
- regression discontinuity design (RDD);
- 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 (IV) estimation (or other methods using an instrumental variable, such as the Heckman two-step approach);
 - difference-in-difference (DID); or
 - fixed- or random-effects model with an interaction term between time and intervention for baseline and follow-up observations;
- cross-sectional or panel studies with an intervention and comparison group using methods to control for selection bias and confounding as described above; and
- 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 (Snijlsteit et al. 2013). Systematic reviews also had to be assessed as medium or high confidence in their methods, per 3ie's systematic review assessment tool.

We extracted data on whether studies included a cost-effectiveness analysis or measured long-term impact (24 months or more). Cost-effectiveness is vital to moving an intervention from the proof-of-concept stage to replication and scale-up. Furthermore, it is difficult to build stakeholder momentum around very costly programmes. In order to understand if the programme has lasting effects, it is important to measure long-term impact. Many endline surveys are done within 6 months of completing the intervention; however, it is important to measure effects 24 months or more after the intervention to understand whether the intervention was implemented long enough and whether the effects are lasting. Duration is especially important when trying to change well-established and resilient gendered social norms and the social acceptability of IPV in many places.

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 (such as human resource availability, current input prices and local institutions), it can inform assessments of 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).

2.6 Other inclusion criteria

In addition to the study's topical relevance and the study type, we consider the following characteristics when making inclusionary decisions:

- The study must have been published from 1990 onwards; be an effectiveness study rather than an efficacy study; and study the effects of an intervention, programme or policy; and
- The country must be labelled as a low- or middle-income country by the World Bank at the time of the study's publication.

3. Findings

3.1 Search and screening results

Figure 3 details the results of the search and screening process for impact evaluations and systematic reviews with evidence from L&MICs identified during this update.³ Including what we found in the update, the complete map now contains 141 studies: 95 impact evaluations, 44 ongoing impact evaluations and 2 systematic review protocols. This represents a significant increase in the availability of evidence on IPV interventions since the EGM was first conducted in 2016. Updating the search resulted in the inclusion of 40 newly completed⁴ impact evaluations, 16 newly registered ongoing⁵ impact evaluations and 2 systematic review protocols. We did not identify any completed systematic reviews.

As part of the update, we screened more than 100 new potentially relevant reviews, excluding reviews for two primary reasons – either because they 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 95 completed impact evaluations for L&MICs and nearly 250 for high-income countries, it is not surprising that systematic reviews largely include evidence from high-income countries. However, due to the growth of the evidence base in the past two years, it is unsurprising that two systematic review protocols for L&MICs have been registered since 2016.

Regardless of the location of evidence, the systematic reviews focus more broadly on interventions related to VAWG 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.

Of the ongoing studies identified in the 2017 report, 8 have since published updates – 6 final reports and 2 midline reports. The 95 total completed impact evaluations include 67 journal articles, 13 working papers, 11 project reports and 4 dissertations. A bibliography of all completed and ongoing impact evaluations can be found in Appendix B.

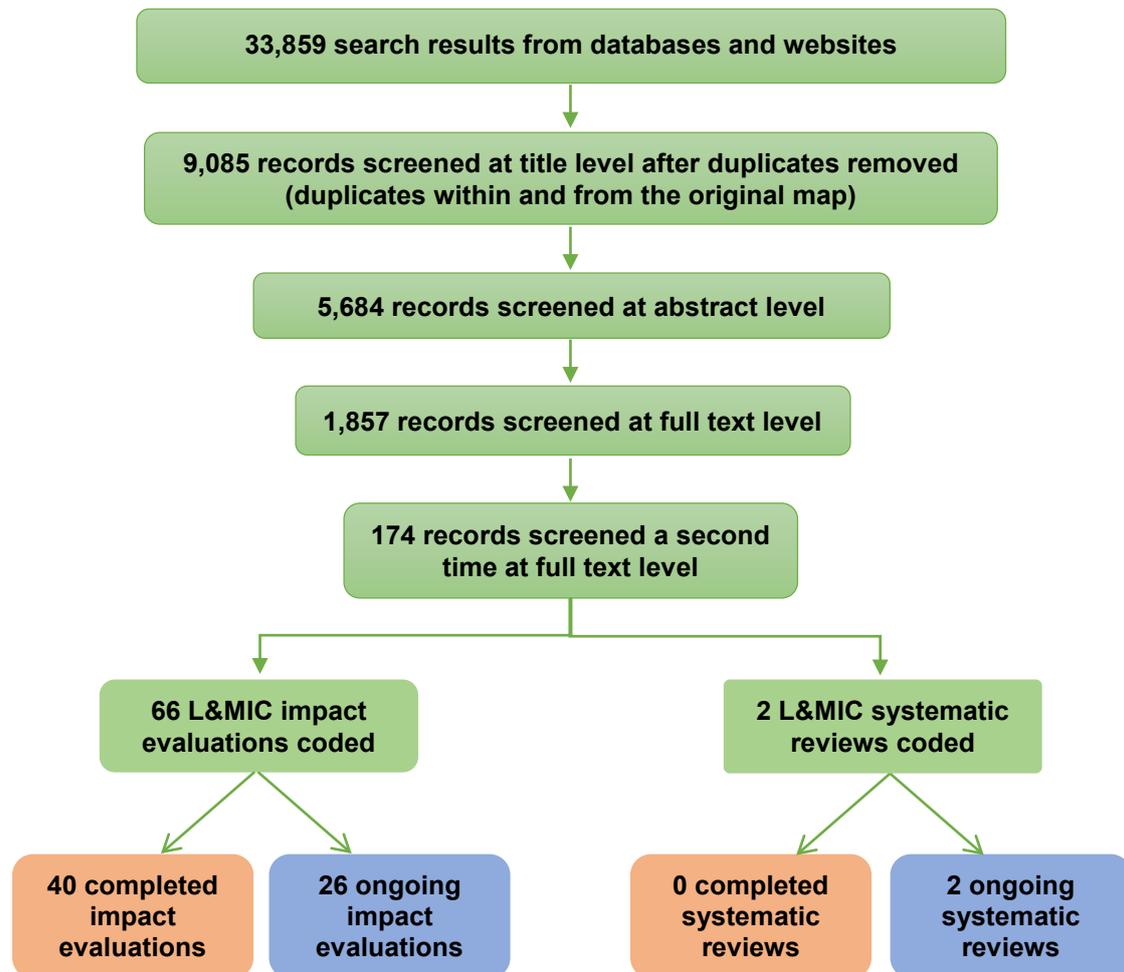
³ For the results of the search and screening process of the original IPV EGM, see Picon and colleagues (2017).

⁴ A study is considered complete if it has a report published or in draft form.

⁵ The identification of ongoing studies is based on preregistrations, published protocols or pre-analysis plans. Announcements were also identified on the personal website or curricula vitae of the primary authors.

After coding all studies identified through the search and screening process, we mapped them under the EGM framework. Figure 13 shows the complete updated EGM, including completed and ongoing impact evaluations and systematic reviews. On the EGM, each number indicates how many studies evaluate category given outcome for that type of intervention.

Figure 3: Search and screening results for the update of the EGM

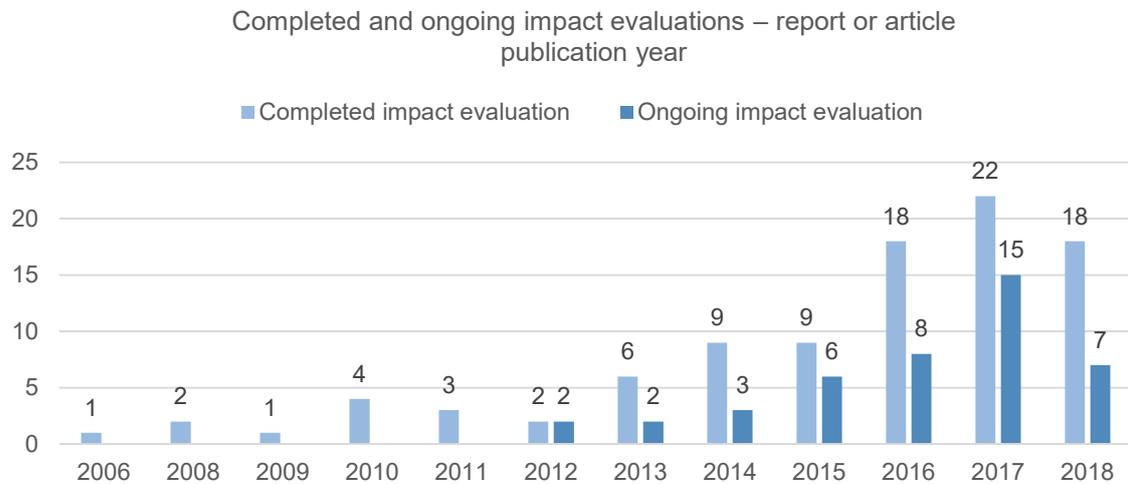


3.2 Publication year

A key feature of the IPV prevention evidence base in L&MICs is that it is very recent. The first published impact evaluation of IPV interventions in an L&MIC was the evaluation of the IMAGE programme in South Africa, using a combination of RCTs and PSM (Pronyk et al. 2006).

By July 2018, 95 impact evaluations that focus on IPV prevention had been published. Figure 4 shows the trend over time in completed impact evaluation and protocol publications, which has particularly picked up since 2012. The trend of steadily increasing research is confirmed when looking at studies underway or not yet published. Of the 44 ongoing impact evaluations and systematic reviews identified, the oldest were registered in 2012, and 8 were registered in the first 7 months of 2018.

Figure 4: Completed and ongoing impact evaluations by publication year through July 2018



Note: There were no included impact evaluations published in 2007.

3.3 Geographical distribution

Figure 5 shows the distribution of completed impact evaluations by country, and Figure 6 provides details by region. Almost half of the impact evaluations produced to date come from three countries – South Africa, India and Uganda. However, 34 countries around the world have had at least 1 study, and 21 countries have more than 1 study.

Thirteen new countries appear on the map in this update, with either published or newly registered impact evaluations: Afghanistan, Burkina Faso, Cameroon, Colombia, El Salvador, Liberia, Malawi, Nepal, the Philippines, South Korea, Sri Lanka, Thailand and Turkey. Six studies in the last two years focus on Bangladesh, ranking it fourth overall behind South Africa, India and Uganda for numbers of IPV studies.

Figure 5: Completed and ongoing impact evaluations by country

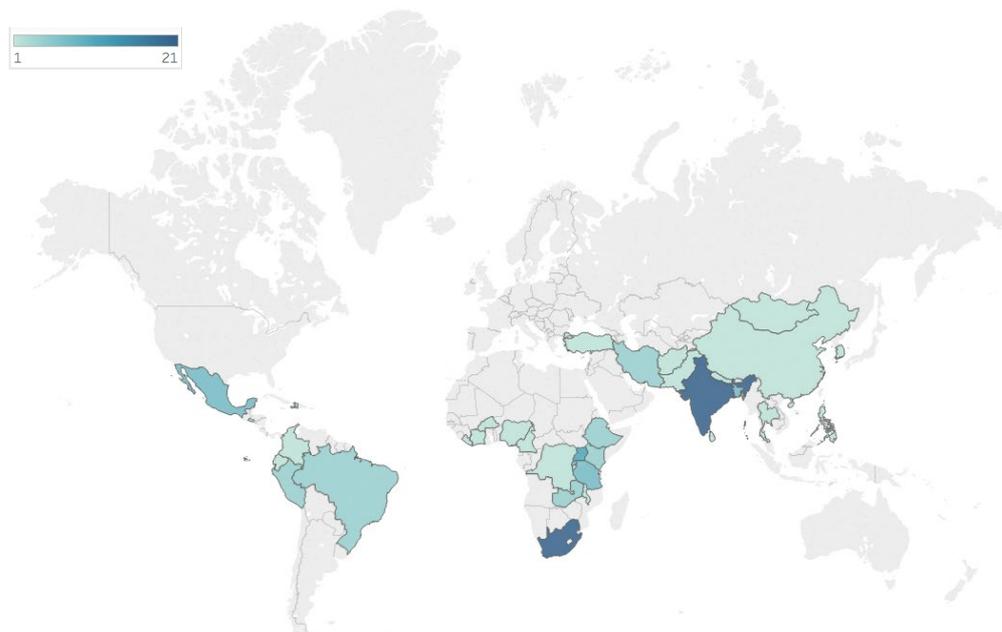
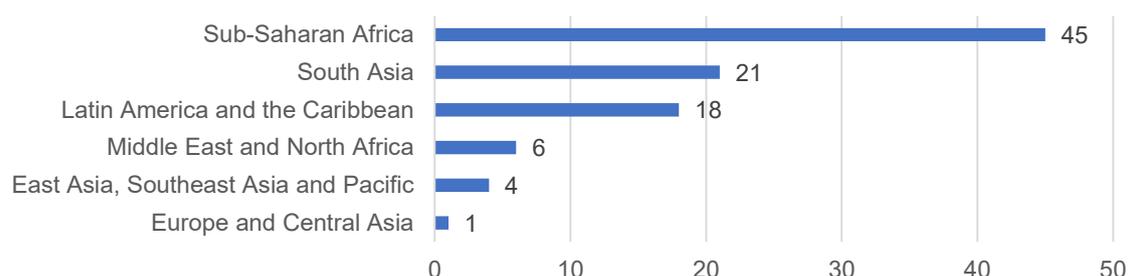


Figure 6: Completed impact evaluations by region



Regionally, around half (45) of the global impact evaluation evidence base is for interventions implemented in Sub-Saharan Africa. However, given the concentration of impact evaluations in South Africa and Uganda, this evidence base represents only 15 of the 46 countries in the region.

The world region with the second-largest number of impact evaluations is South Asia, with 21 impact evaluations. Similar to Sub-Saharan Africa, the evidence base is heavily concentrated in a few countries; in this case, India has 13 and Bangladesh has 6, with Pakistan and Nepal (each with 1 completed evaluation) rounding out the number of countries.

In Latin America and the Caribbean, there are 18 published impact evaluations, with the highest concentration in Mexico (6), followed closely by Brazil, Ecuador and Peru (6 impact evaluations each). 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, 'True Love' (*Amor, pero del bueno*), with the support of the Inter-American Development Bank.

Across regions, looking at the evidence from fragile states, only 3 of 35 countries on the World Bank's harmonised list of fragile states are represented in the evidence base of completed impact evaluations: 3 in Côte d'Ivoire, 2 in the Democratic Republic of Congo and 1 in Liberia.

Ongoing studies

Studies under preparation confirm a few key trends. First, IPV prevention programming and its evaluation have increased in recent years in India. All but one of the completed impact evaluations in India have been published since 2014, whilst six new impact evaluations are under preparation in the country. Impact evaluations are underway in two countries new to the region's evidence base – Afghanistan and Sri Lanka.

Twenty-seven new impact evaluations are under preparation in Sub-Saharan Africa (61% of the ongoing studies), with a better distribution than the current evidence base. Amongst the fragile states, Afghanistan enters the list of countries where impact evaluations of IPV prevention interventions are under preparation.

3.4 Study design

As Figure 7 shows, 64 per cent of studies feature an exclusively experimental design, whilst 23 per cent are exclusively 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 8. Apart from RCTs, there appears to be a clear preference for DID estimation strategies as an alternative approach for evaluating IPV prevention interventions. Use of two quasi-experimental designs has increased significantly since the publication of the original map: Use of RDD rose from 0 to 4 studies and use of IVs rose from just 1 study to 3.

We also extracted data of studies performing cost-effectiveness analysis and of studies reporting results in the medium to long term. Eight studies report cost-effectiveness in their analysis, a significant increase from the sole study found in the original map. About a third of studies report results two or more years after programme implementation.

Figure 7: Completed impact evaluations by design

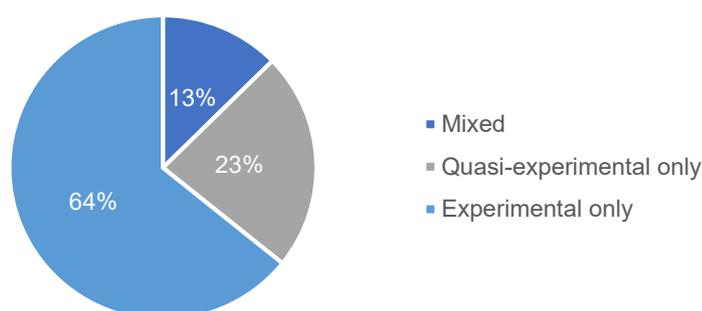
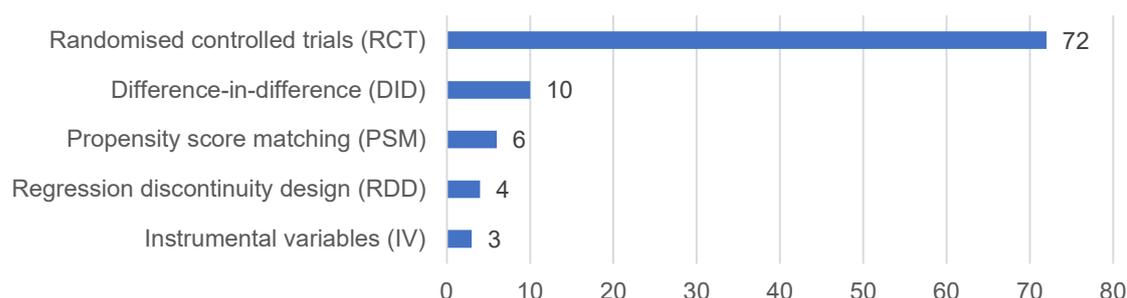


Figure 8: Completed impact evaluations by design



Ongoing studies

Based on available information, the ongoing impact evaluations are overwhelmingly registered as RCTs (42 of 44). The remaining two studies use DID. This is likely due to the lower registration rate of studies that use a quasi-experimental design.

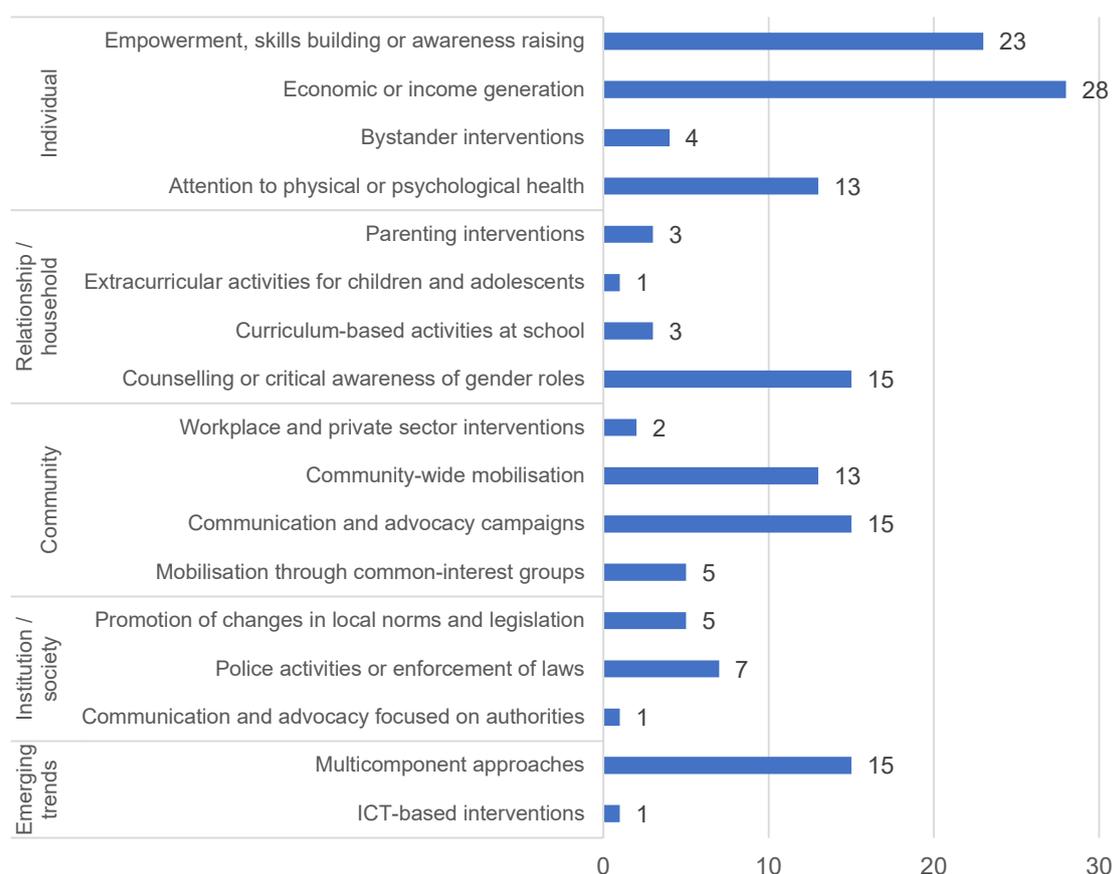
3.5 Intervention categories

Figure 9 shows the distribution of studies across intervention categories. There is a clear concentration of impact evaluations of interventions targeting individuals (men, women or both). More than 50 per cent of the included studies assess such interventions, specifically economic empowerment (28) and social empowerment (23). 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.

For other socio-ecological levels, interventions with a large representation of impact evaluations are counselling and critical awareness of gender roles (relationship/household 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 15 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 relationship/household levels.

Figure 9: Completed impact evaluations by intervention category

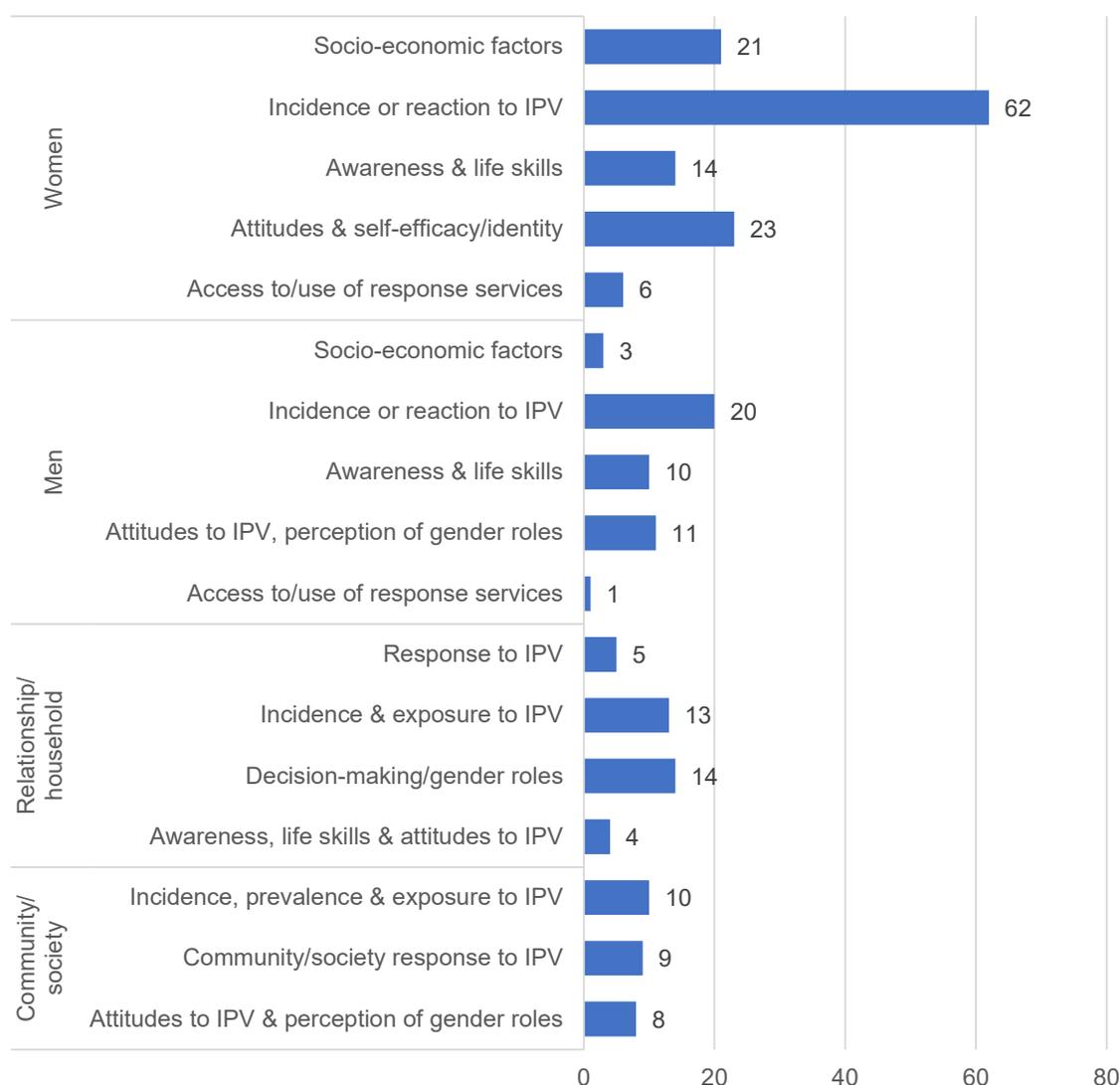


3.6 Outcome categories

Figure 10 summarises the evidence base in terms of outcomes reported. More than 65 per cent of impact evaluations report results based on an indicator of women's experience of IPV. 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, 23 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 typical question to collect this information is one directly inquiring whether the respondent thinks it is justifiable for a husband to hit his wife under certain circumstances.

Figure 10: Completed impact evaluations by outcome category



Poverty, lack of employment opportunities and lack of food security, amongst other socio-economic indicators, are regularly mentioned in the literature as risk factors that could lead to increased or sustained partner violence, and are treated as outcomes of interest in the IPV prevention literature. Yet there are just three impact evaluations, all published since 2016, on such risk factors for men that include IPV *prevention* in their theories of change.

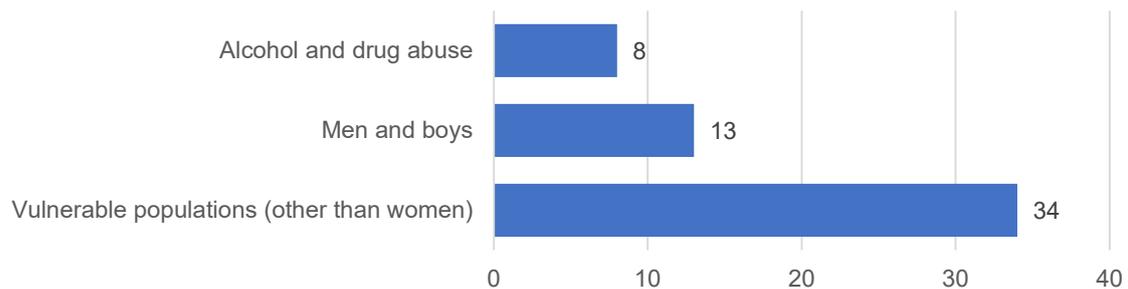
3.7 Populations

Figure 11 summarizes the completed impact evaluations by population. Thirty-four completed impact evaluations focused on vulnerable populations, the majority of which were persons living with HIV and AIDS, sex workers, and refugees or victims of humanitarian crises. We found no studies that explicitly targeted interventions to or measured outcomes for LGBTQ partners. Although being female inherently makes one vulnerable in many contexts, we did not regard studies that focused only on women as a subgroup in this category.

Eight completed impact evaluations looked at either alcohol or drug abuse as an outcome, or at populations of those abusing alcohol or drugs. Only a few of these studies specifically targeted people suffering from alcoholism or drug addiction. The other interventions were pre-emptive and delivered at work, at school or at health centres.

Finally, 13 impact evaluations focused on men and boys, many of which centred 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 11: Completed impact evaluations by population



3.8 Gender analysis in the evidence base

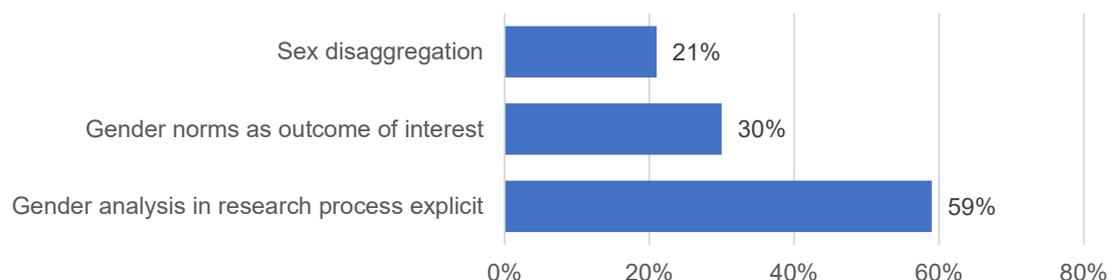
A gender perspective is a critical element in IPV prevention programming and intervention design, as IPV is closely linked to broadly accepted or established social norms on gender roles and relationships. It is also a factor to consider seriously when doing research around IPV prevention, as it can 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 and colleagues (2016). We coded the 95 completed impact evaluations based on three questions:

- Does the study disaggregate results by sex?
- Are changes in gender power relations or gender norm outcomes investigated in the study?
- Does the study describe specific considerations of gender in the research process?

The results are summarised in Figure 12.

Figure 12: Gender analysis in the impact evaluation evidence base (by percentage)



Approximately 21 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 on economic and social empowerment is their common failure to include men in their analysis. For example, Buller and colleagues (2016) only present outcome data from wives. By contrast, Green and colleagues (2015) evaluate gender training for men and women – an intervention and analysis method that allows them to measure the impact on men as well as women.

We also looked for explicit references to gender considerations during the research process.⁶ 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 59 per cent of studies discuss at least one of these issues.

Finally, we found that 30 per cent of impact evaluations 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. For example, interventions used by Hossain and colleagues (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 et al. (2016), Lazarevich and colleagues (2015), and Ekhtiari and colleagues (2014) include school-based interventions to reduce acceptability of IPV and increase gender equity and healthy relationships.

⁶ 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.

Figure 13: Evidence gap map of IPV completed and ongoing impact evaluations and systematic reviews

		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 & life skills	Attitudes & self-efficacy/identity	Socio-economic factors	Incidence or reaction to IPV	Access to/ use of response services	Awareness & 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 & attitudes to IPV	Incidence, and exposure to IPV	Decision making/ gender roles	Response to IPV	Attitudes to IPV & perception of gender roles	Incidence, prevalence & exposure to IPV	Community/ society response to IPV	Cost-effectiveness	Long-term impact	Vulnerable populations (other than women)	Focus on men & boys	Focus on alcohol & drug abuse		
INDIVIDUAL LEVEL	A1	Economic, income generation programs	10	15	21	27	3	2	5	4	4		2	3	9	1	3	2	4	7	14	17	4		
	A2	Social empowerment, skills building, awareness raising	12	16	11	28	3	7	10	1	16		2	2	3	1	2	3	2	8	13	18	12	3	
	A3	Attention to physical or psychological health	5	9	2	17	3	4	4	1	7		4		2		1			6	6	13	8	6	
	A4	Bystander interventions	2	1	2	2		1	1		3		1		1			1		1		1	2		
RELATIONSHIP & HOUSEHOLD LEVEL	B1	Counselling, critical awareness of gender roles	5	7	6	15	2	3	4	1	7		4	10	5	1	1	2		2	4	11	8	3	
	B2	Parenting interventions	1	3		5		2	2		2	1	2	5							1	5	3	4	
	B3	Curriculum-based activities at school	2	2		2	2	2		2	2		1	1		2	1				1	1			
	B4	Extra-curricular activities for children & adolescents			1	1															1				
COMMUNITY LEVEL	C1	Communication & advocacy campaigns	3	8	2	17	3	3	5		11	2	1		1	1	2	5	2		7	8	6	4	
	C2	Community-wide mobilisation	8	10	7	17	4	6	8	1	12		2	2	1	6	7	6	1	15	11	5	2		
	C3	Activities & mobilisation through common-interest groups	2	5	4	7	1		1		2					1	1	2	1	4	3	2			
	C4	Workplace & private sector interventions	1			2	1	1	1							1		1	2	2	2	1		1	
INSTITUTIONAL LEVEL	D1	Communication & advocacy focused on authorities				1										1	1	1		1					
	D2	Promotion of changes in local norms & legislation		1	2	3	1							1			2			2	2	1			
	D3	Police activities/enforcement of existing laws & regulation		2	1	5	3	1	1					1		1	1	2	2	4	4	3			
EMERGING TRENDS	E1	ICT-based interventions	1			1																1			
	E2	Using traditions, festivals to channel messages				1				1			1								1		1		
	E3	Multicomponent Approaches	2	7	8	11	4	1	4		4	1	2	1	6	2	5	3	6	1	6	7	5		

4. Gaps in evidence and opportunities for synthesis

With more than a doubling of the number of studies available, the evidence base has grown significantly since the original EGM was published in 2017. Studies have been conducted in a larger number of countries, covering a broader range of interventions and outcomes and with a greater use of quasi-experimental approaches. As a result, clusters of evidence are starting to emerge around a few intervention areas, giving rise to the potential for systematic reviews. Although this EGM indicates that the evidence base is by and large not synthesised, the two newly published systematic review protocols show that segments of the evidence base are ripening for synthesis. Gaps remain in other sections of the evidence base, which we outline below.

4.1 Gaps

Reviewing 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. Economic interventions (most not designed for IPV prevention, but with studies that assess impacts on IPV outcomes) and social empowerment interventions dominate this section of the EGM.

Evidence at the individual level on bystander interventions is still lacking. We note an increase since 2016 to four studies, including ongoing and completed studies, showing an increased priority to this intervention. Given that this intervention is strongly grounded in community-based work and the challenge of changing prevailing social norms around gender, it can have a magnifying effect on society. Although this remains a gap in the evidence base, researchers can now build on the growing evidence.

Also at the individual level, studies measuring outcomes for men are also lacking, particularly for socio-economic triggers (n = 6) and access to IPV response services (n = 3). Despite these gaps, there have been promising increases for outcomes measuring men; including their awareness and life skills (an increase from 12 to 18), attitudes towards IPV and perception of gender roles (an increase from 12 to 22), and incidence or reaction to IPV (an increase from 16 to 34). Given that men can be both perpetrators and victims of IPV, it is pertinent to increase programming towards, and measure outcomes for, men.

At the relationship or household level, we found gaps in interventions for curriculum-based activities at school (n = 3) and extracurricular activities for children and/or adolescents (n = 1); outcomes at this level measuring changes in attitudes towards IPV (n = 7) and response to IPV (n = 6) are also lacking. Since 2016, there has been no increase in completed impact evaluations for IPV prevention at school or after school. However, three studies are underway for IPV prevention at school in Haiti, Kenya and South Africa.

We found no registered studies for extracurricular activities. Given the importance placed on the role of relatives and children to reduce IPV prevalence and incidence in the literature, we encourage more studies with interventions and outcomes at the relationship/household level.

There are gaps at the community level on workplace and private sector interventions. We identified 4 studies – 2 completed and 2 ongoing. Despite these gaps, there has been increased attention to the other three intervention categories at the community level in both completed and ongoing studies. Communication and advocacy campaigns increased from 7 studies to 24, 3 of which were published impact evaluations from previously ongoing studies in the original map. Community-wide mobilisation interventions increased from 11 to 24 studies.

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 foster collective action and potentially change prevailing social norms around gender roles and the acceptability of violence. There are 16 ongoing impact evaluations for interventions targeting the community level, so we expect more growth in this area.

Moving to the institutional level, there are evidence gaps for awareness focused on authorities and the promotion of changes in local norms. Only 2 studies on awareness focused on authorities, 1 completed in Malawi and 1 under preparation in Peru. Five studies, all of which are completed impact evaluations, promoted changes in local norms. Despite these gaps, there has been small growth in this area over the last 2 years; studies targeting the enforcement of existing laws, regulation or policies increased from 2 to 9. Although community-based interventions regularly feature work with local leaders or the promotion of changes in gender norms through advocacy and mobilisation, the specific effectiveness remains under-studied in the evidence base.

We did not identify any rigorous impact evaluations or systematic reviews with an explicit focus on IPV between LGBTQ partners. We understand the difficulties in directing interventions to or measuring outcomes for LGBTQ persons – both in data collection and research design. There are ethical concerns in collecting data on sexual orientation, given the systematic oppression of LGBTQ populations across societies. Furthermore, given the sensitive nature of this topic, many survey respondents are unwilling to disclose their sexual orientation for fear of retaliation. In countries where non-heterosexuality is illegal, such as Uganda, researchers risk being denied local ethics approval if they consider LGBTQ persons in their research design. Despite the difficulties in researching these diverse and vulnerable populations within the term LGBTQ, we encourage more consideration of LGBTQ people and their intimate partnerships in IPV prevention research, where possible.

Although IPV is the most common form of violence in post-conflict settings (Gibbs et al. 2018), evidence on IPV prevention programming in such settings remains limited, having only increased from 3 studies to 6 (1 systematic review protocol and 5 impact evaluations) since 2016. Women's economic empowerment in post-conflict settings is increasingly being researched. One impact evaluation in Afghanistan and one in the Democratic Republic of Congo examine the effect of women's economic empowerment in post-conflict settings – the first on an education and cash transfer programme (Gibbs et al. 2018) and the second on a livestock asset transfer programme (Glass et al. 2017). One of the new systematic review protocols targets IPV prevention interventions in humanitarian settings.

There are clear regional gaps in the evidence base, particularly for regions with small numbers of impact evaluations but high rates of IPV. For example, the Middle East and North Africa feature only six completed impact evaluations, but according to WHO (2013), the estimated IPV prevalence in that region is as high as that in Sub-Saharan Africa and South Asia (both around 37%). Moreover, although IPV is estimated to be lowest in East Asia and Central Asia, WHO indicates that about one in four women living in those regions will still experience IPV at some point in her lifetime.

The relative recent practice of using 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 countries also suggests favourable conditions within these countries for this type of research. In South Africa, high-profile programmes such as IMAGE and Stepping Stones offer the opportunity, and large enough sample sizes, for impact evaluation research. Moreover, an established tradition of clinical trials around health and HIV, as well as a strong research community, facilitate a stream of impact evaluation research in the country. The WINGS and SHARE and SASA! programmes in Uganda present a similar opportunity. In India, there has been increased interest in tackling IPV prevention in the past few years, particularly since the Delhi rape events of late 2012, widely discussed by the media, government and donors.

4.2 Opportunities for synthesis

In general, the existing evidence has areas that are ripening for synthesis, particularly at the individual level. The strong focus on women's outcomes across existing impact evaluations presents a promising cluster for synthesis. This is to be expected, as women are overwhelmingly the most common victims of IPV. Furthermore, the 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, more 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.

4.2.1 Impact of economic/income-generation programmes on (1) women's experience of or response to IPV, and (2) couple or household decision-making and gender roles

The impact of economic/income-generation programmes on women's experience of or response to IPV contains 27 total studies (20 completed and 7 ongoing). This is an increase from 10 completed impact evaluations from the original EGM. These studies represent eight programmes, including microfinance, asset transfers, conditional and unconditional cash transfers, and entrepreneurship and mentorship programmes. Now that the update has captured 10 newly published impact evaluations, we encourage synthesis in this area.

An additional cluster of interest is the impact of economic interventions on household decision-making. The 9 impact evaluations in this cell represent 5 cash transfer

programmes and 4 microfinance interventions. Amongst the five 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 four microfinance studies. However, the interventions in this cluster are relatively comparable and the studies are focused in two geographic regions (Sub-Saharan Africa and Latin America and the Caribbean). Therefore, the priority for further primary research would be on using standardised outcome indicators for household decision-making.

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

This EGM identifies 28 studies (15 completed and 13 ongoing) in this cell at the intersection of interventions targeting social empowerment, skills building and awareness raising programmes on outcomes related to women's experience of and response to IPV. The interventions evaluated include training in self-support, negotiation skills, safety skills, marital communication, business skills training, gender awareness, community advocacy and substance abuse. The programmes evaluated in these studies are informed by a number of theories of change and target a variety of population profiles (such as sex workers, substance abusers, child brides and pregnant women). Although this cell has increased from 7 to 15 completed studies since the original EGM, the cursory examination still reveals that heterogeneity in intervention types has increased, making it unlikely that an in-depth synthesis or meta-analysis would be possible.

4.2.3 Impact of multicomponent approaches to IPV prevention on women's experience of or response to IPV

The 10 impact evaluations in this cell each evaluate the impacts of different multicomponent programme interventions on women's experience of or response to IPV. 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, including in the three studies captured in the update. Namely, of the 10 studies, only 2 evaluate somewhat similar multicomponent approaches (Blattman et al. 2013; Iyengar and Ferrari 2011). The other eight evaluate the combination of several intervention components, such as microfinance loans and training for couples who had experienced domestic violence in their relationship (Kim et al. 2009; Pronyk et al. 2006), combining gender equity training and family planning services to men and women (Raj et al. 2016), and combining education and entertainment mass media messaging for behavioural and attitudinal change (Green et al. 2018).

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

Finally, we examine six studies that evaluate the impacts of five different multicomponent programmes on decision-making and gender roles at the household or couple level. As with the above section, the combination of components evaluated in this cell are as yet too heterogeneous for any synthesis, and there have been no additional impact evaluations published in this cell since the original map.

5. Conclusions

In this EGM update, we have mapped the current evidence base of IPV prevention in L&MICs and identified 141 studies (95 impact evaluations, 44 ongoing impact evaluations and 2 systematic review protocols). The production of impact evaluations of IPV prevention interventions has increased steadily in recent years, following increased programming in this area and the interest in adapting experiences that hold promise for preventing IPV.

We have several recommendations for researchers, including measuring more male outcomes, measuring gender norms as an outcome, disaggregating results by sex and including vulnerable populations (particularly LGBTQ people) in the sample. Although the update found 12 new impact evaluations on male-related outcomes, this is still a relatively under-studied area of the evidence base. The existing evidence on male outcomes is often in awareness campaigns, counselling programmes and economic interventions; workplace and private sector interventions remain an important gap to fill.

Moreover, for a topic in which understanding and addressing prevailing gender norms are so important, only approximately 30 per cent of completed impact evaluations report on changed gender norms as an outcome. These studies require sufficiently long time frames to capture behaviour change and whether the changes can be sustained. Sex disaggregation of results is featured in around 21 per cent of studies, in part because many of them focus only on women. Barely 35 per cent of completed impact evaluations provide information on vulnerable populations, with the impoverished being the most common subpopulation; no studies focused on LGBTQ partners.

For researchers working in synthesis, we recommend synthesis on the impact of income-generation programmes (such as cash transfer or asset transfer programmes) on women's experience of or response to IPV. Although the map shows some apparent clusters of evidence that could be the basis for synthesis, the heterogeneity of interventions under the categories is a challenge when deciding to embark on a systematic review. Once the 44 ongoing impact evaluations are completed, more opportunities are likely to open.

For implementing organisations, we recommend forging stronger relationships with local governments, educational systems and community-based organisations to enable impact evaluations that evaluate IPV prevention interventions for the populations they serve. Although forming such partnerships can take time, these are important and under-studied areas of the integrated ecological framework. Across intervention categories, there is limited impact evaluation evidence for important interventions used in programming, such as bystander and parenting interventions, before- and after-school programmes, law enforcement programmes, and working with local leaders. Correcting this gap in the evidence base can offer important insights on how to better encourage societal and institutional change to ultimately prevent IPV in a sustainable way.

Funding organisations can direct more funding and strategic priorities to multi-arm RCTs and require their grantees to conduct long-term follow-up surveys and cost-effectiveness analyses. Although they are more expensive and complex, multicomponent interventions offer the opportunity to evaluate the impact of a combination of interventions targeting

different levels of the ecological framework. Impact evaluations measuring the long-term impact and cost-effectiveness of the programme's individual components can also be set up to provide policy-relevant information about interventions.

The IPV prevention EGM has been structured in such a way that regular updates and new approaches can be considered and added over time. This update is part of an ongoing effort in the IPV prevention community to target programming and prioritise research. We will continue to work together in our shared goal of finding the most effective solutions to IPV prevention.

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 perpetr* 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	
Criminal Justice Abstracts	
Violence & Abuse Abstracts	EBSCOhost
Scopus	
Africa-Wide Information	
Embase	
PsycINFO	
Global Health	OvidSP
CINAHL Plus	
MEDLINE	
ERIC	
International Bibliography of Social Sciences (IBSS)	
PILOTS	ProQuest
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/en/evidence/impact-evaluations/impact-evaluation-repository/
Abdul Latif Jameel Poverty Action Lab (J-PAL)	https://www.povertyactionlab.org/evaluations
Innovations for Poverty Action (IPA)	https://www.poverty-action.org/
University of California: Center for Effective Global Action (CEGA)	http://cega.berkeley.edu/evidence/ https://cega.berkeley.edu/
Overseas Development Institute (ODI)	https://www.odi.org/publications
Governance and Social Development Resource Centre (GSDRC)	http://www.gsdr.org/document-library/
Health Evidence	http://www.healthevidence.org/

Indexes	Provider
African GBV Prevention Network	http://preventgbv africa.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 Domestic Violence	http://vawnet.org/
Minnesota Center Against Violence and Abuse (MINCAVA)	https://www.cehd.umn.edu/ssw/centers/mincava/
Center 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 Working Papers	World Bank
enGENDER IMPACT (World Bank)	
Inter-American Development Bank	IDB
UNFPA Evaluation Database	UNFPA
DAC Evaluation Resource Centre (DEReC)	OECD
USAID Development Experience Clearinghouse (DEC)	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)	https://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/en/evidence/systematic-reviews/?q=&title=&author=&published_from=&published_to= https://www.3ieimpact.org/evidence-hub/systematic-review-repository
EPPI-Centre Publications	http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=56

Indexes	Provider
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/ https://www.cochranelibrary.com/cdsr/reviews
Campbell Collaboration Library	http://www.campbellcollaboration.org/lib/ https://campbellcollaboration.org/better-evidence.html
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 that are 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 2016 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 IPV, 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 amongst the included impact evaluation methodologies?			

Screening questions	No	Yes	Unclear
RCTs (including stratified), DID, IV approaches, PSM (and other matching techniques), RDD, 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 IPV? Intimate partner is a person with whom an individual has a close personal relationship that may be characterised by emotional connectedness, regular contact or sexual behaviour, identification as a couple, and cohabitation. Intimate partners may include current or former spouses, boyfriends or girlfriends, dating partners, and ongoing sexual partners (Breiding et al. 2015). IPV is any behaviour in an intimate relationship that causes physical, sexual or psychological harm, including aggression, sexual coercion, psychological abuse and controlling behaviour (WHO 2005). Although it is 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 IPV, and not its prevention? This applies to a policy, programme 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	No	Yes	Unclear
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-difference (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).			

Full text			
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 IPV (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 programme activities directly or indirectly focused on IPV prevention? IPV 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 sensitisation campaigns; reducing binge drinking) - Efforts to identify and address early signs of abuse or abusiveness (examples: screening; efforts to enhance IPV identification and reporting) - Those focusing on individuals who are already abused or abusive in order to reduce the recurrence of violence they experience or inflict (example: 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.

Variable name	Variable description
Coder name	Coder's name
Record number	Autofill
Database source	Select a database source according to 'source' indicated in your spreadsheet.
Study id	Unique id ascribed to each record
IE/SR	Select 'IE' for impact evaluations and SR for systematic reviews.
Title	Use only the English version of the publication's main title. If paper is not written in English and has the title translated, use the translated version of the title. If the publication does not provide an English version, include the title in its original language. Please enter title in sentence case. Ensure there are no line breaks.
Foreign title	When publication is not written in English, code the original title using original accents and special characters. Example: Intervenção educacional em equipes do Programa de Saúde da Família para promoção da amamentação If not applicable, code 'not applicable'.
Language	Select full text language that applies: English, French, Portuguese or Spanish
Author name	Enter all authors one by one. Each cell should contain only one author. The format is 'First name' 'Second name' (if any) and 'Last name/s' Example: Shayda Sabet Shayda M Sabet Shayda Mae Sabet When a publication only provides first name initials and last name, coder will have to perform a cursory online search using the name and paper title to find the author/s' full name. If search is unsuccessful, author/s will be coded following the format: 'First name initial' 'Second name initial' (if any), 'Last name/s'. Example: J Miranda JM Miranda
Author ranking	Rank the authors as they are listed in the article.
Author affiliation (institution)	Code the institution with which the author is affiliated <i>according to what is noted in the article</i> . Code the full name of the institution and its abbreviation (if relevant) in brackets. For example: International Initiative for Impact Evaluation (3ie) If no information is included in the reference output code as 'unidentified'. Do not spend time extracting this manually.
Author affiliation (department)	Code the faculty, department, lab, etc. within the affiliated institution. For example: 'Faculty of Economics'

Variable name	Variable description
Author affiliation (country)	If specified or obvious, select country in which author's institutional affiliation sits. If the institution's headquarters are in one country but the organisation has affiliates or country offices all over the world (such as the World Bank or J-PAL), and the affiliation mentioned does not specify a country office, then select the HQ country. For example, if the affiliate mentioned is simply 'J-PAL', select United States, if it says 'J-PAL Africa', select South Africa.
Publication type	Select from list: <ul style="list-style-type: none"> • Journal article • Working paper (<i>these include discussion papers and technical reports/papers, if they are part of a series</i>) • Report • 3ie series report • Book or book chapter • Draft • Dissertation/thesis • Registered IE • Published protocols
Completed	Select 'yes' if study reports completed (midline or endline) results. Select 'no' for all ongoing studies (registries and published protocols).
DOI	Code the study's DOI. If no information is found, code as 'no DOI'. Example: 10.1007/s11127-017-0452-x
Abstract	Copy and paste study's abstract. If there's no abstract, code as 'no abstract'. If a study is missing an abstract but provides a long executive summary, code as 'no abstract'. Ensure there are no line breaks.
Journal name or registry host	Use full journal name. Do not abbreviate name. Do not include 'The' at the beginning. Example: Journal of Development Effectiveness If publication is a working paper, write the series name. Example: World Bank Policy Research Working Paper If publication is a report, write the publishing institution. Example: USAID If coding a registered IE, code registry host name. Example: ClinicalTrials
Journal volume or registry number	Use Arabic numerals (do not use Roman numerals). For working papers, include series number.
Journal issue	Add journal issue, if any.
Pages	For example: 321-340 If no page numbers given in reference (i.e. working papers that are only online), indicate 'not applicable'.
Publication or registration year	Select the year when the print version of the study was published. The format is YYYY. If only publication online, use this. If study does not have the year information, select 9999. If study registry, select year of registration.

Variable name	Variable description
URL	<p>If study is a journal article enter URL of the landing page from the journal publisher's website.</p> <p>If study is a published working paper or published report, enter URL of the document's landing page from the publishing website.</p> <p>If study is a published working paper or published report and there is not a landing page, provide URL of the full-text PDF.</p> <p>Do not paste hyperlinks.</p>
Open access	<p>If the study's (full-text) content is available, code as 'yes'. If study has paywalls, code as 'no'.</p> <p>Please save the pdf in the Dropbox folder called 'Full Text PDFs' using the following format: Firstauthorsurname_year_record id</p> <p>If study has multiple versions – in other words, if the study has been published as both a journal article and a working paper – both versions may be included in the IER.</p>
Sector name	<p>Select ONE sector that applies according to the intervention evaluation:</p> <ul style="list-style-type: none"> • Agriculture, fishing & forestry • Education • Energy & extractives • Financial sector • Health • Industry, trade & services • Information & communications technologies • Public administration • Social protection • Transportation • Water, sanitation & waste management <p>See World Bank (2016) taxonomy for definitions.</p>
Sub-sector name	<p>Select all sub-sectors that apply according to the sector indicated in previous column. For two or more sub-sectors in one sector, enter in a new row.</p> <p>See World Bank (2016) taxonomy for definitions.</p>
Themes	<p>Select all themes that apply (up to three).</p> <p>See World Bank (2016) taxonomy for definitions.</p> <p>If not applicable, select 'not applicable'.</p>
Sub-themes	<p>Select all sub-themes that apply according to the theme indicated in previous column. For two or more sub-themes for one theme, enter in a new row.</p> <p>See World Bank (2016) taxonomy for definitions.</p> <p>If not applicable, select 'not applicable'.</p>
Other topics	<p>Select one or more other topics that apply:</p> <ul style="list-style-type: none"> • Agricultural technology • Business training • Cash transfers • Community driven development • Cost-benefit/effectiveness analysis • Farmer field schools • Humanitarian aid

Variable name	Variable description
	<ul style="list-style-type: none"> • Microfinance • Payment for ecosystem services • Performance-/results-based financing • Rotating savings and credit associations <p>If not applicable, select 'not applicable'.</p>
Equity focus	<p>How does this study consider gender and/or equity? Choose as many factors as apply from the below list:</p> <ul style="list-style-type: none"> • Sex-disaggregates data • Does not address gender or equity • Gender and/or equity-sensitive analytical frameworks • Theory of change • Subgroup or population analysis by gender and/or equity (trigger) • Gender and/or equity sensitive methodologies – other • Intervention targeting a specific vulnerable population(s) • Measures effects on gender and/or equity outcome • Research process informed by gender and/or equity • Study refers to ethics approval • Approach to ethics informed by gender and/or equity considerations <p>Please see Appendix A for a detailed description of how this gender and equity coding should be applied. If unsure, mark both what you think you are finding and for a senior staff member to review that article.</p>
Equity dimension	<p>Which dimension(s) of gender and/or equity does the intervention target?</p> <p>Please select one or more answer from the following list, as applicable:</p> <ul style="list-style-type: none"> • Place of residence (rural, urban, peri-urban, informal dwellings) • Ethnicity • Culture (includes language) • Sex (includes the use of the term gender meaning the biological sex of a person) • Religion • Education • Socio-economic status (income or poverty status) • Land size • Land ownership • Head of household (female or male) • Social capital • Age • Disability (medical, physical, neurological, mental disorders) • Sexual orientation • Sexual identity • Gendered social norms • Refugees • Conflict-affected • Other (vulnerable group not typified by any of the above) • Power dynamics or relations between the studied population(s) or subpopulation and a power holder(s)

Variable name	Variable description
	<ul style="list-style-type: none"> Not applicable <p>Please see Appendix A for a detailed description of how this gender and equity coding should be applied.</p>
Equity description	Open answer – provide a description of how the study considers gender and equity, and for which population, to corroborate answers above (include page numbers where relevant).
Keywords	Enter all author-provided keywords, one per row. If the author does not provide any, or if you think there are important keywords missing, please add them (maximum 6 in total).
Continent name	<p>Select the continent/region in which the study was conducted:</p> <ul style="list-style-type: none"> East Asia and Pacific Europe and Central Asia Latin America and Caribbean Middle East and North Africa North America South Asia Sub-Saharan Africa <p>If multiple continents, add in new row.</p>
Country name	Select the countries in which the study was conducted (drop-down menu).
Country income level	Autofill
FCV country	Autofill
Region name	Enter all the regions in which the study took place, if provided in the study. This includes both intervention and control groups.
State or province name	Enter all the states/provinces in which the study took place, if provided in the study. This includes both intervention and control groups.
District name	Enter all the districts in which the study took place, if provided in the study. This includes both intervention and control groups.
City or town name	Enter all the cities, towns or villages in which the study took place, if provided in the study. This includes both intervention and control groups.
Location name	<p>Enter any locations in which the study took place. This includes both intervention and control groups.</p> <p>Locations can be broad geographic areas that extend across regions or villages. Locations can also be specific target locations that go beyond the city, town or village level, such as municipality, parish and neighbourhood, amongst others.</p>
Evaluation design	<p>Select one of two options defined as:</p> <p>1. Experimental:</p> <p>a) RCT defined as prospective randomised assignment, where randomisation is implemented by researchers (or by decision makers in the context of an evaluation study)</p> <p>2. Quasi-experimental:</p> <p>a) Quasi-random assignment: i) regression discontinuity design (sharp designs) or ii) natural experiment in which exposure to treatment is random</p> <p>b) Non-random assignment: i) studies that control for unobservables (DID, FE, IV, Fuzzy RDD, ITS) or ii) studies that control for</p>

Variable name	Variable description
	observables only (e.g. statistical matching, synth control, regression adjustment)
Evaluation method	<p>If experimental, then select: Randomised controlled trials</p> <p>If quasi-experimental, then select: Sharp RDD DID FE estimation IV estimation Fuzzy RDD Statistical matching (includes PSM)</p>
Mixed methods	Select 'yes' if the study includes quantitative and qualitative analyses; otherwise, select 'no.'
Additional methods1	Select additional method if any. If none, use 'not applicable'.
Additional methods2	Select additional method if any. If none, use 'not applicable'.
Unit of observation	<p>Enter all the levels of observation of the variables used for the analysis:</p> <ul style="list-style-type: none"> • Country • Community • Village/city • Cohort (includes schools or clinics) • Household • Individual <p>If more than one, include in separate rows.</p>
Project or programme name	Code the name of the project/programme being evaluated (if any).
Programme implementation agency category	<p>Select one of the following:</p> <ul style="list-style-type: none"> • Government agency • International aid agency • International financial institution • Non-profit organisation • For-profit firm • Academic institution • Charitable foundation or private foundation • Not specified <p>See World Bank (2016) taxonomy for definitions.</p>
Programme implementation agency name	Input the name of the agency(ies) implementing the program.
Programme funding agency category	<p>What category of funding agency funded the program? <i>Note: Only code if reported in the study; no need to do additional research to find.</i></p> <p>Select one of the following:</p> <ul style="list-style-type: none"> • Government agency • International aid agency • International financial institution • Non-profit organisation

Variable name	Variable description
	<ul style="list-style-type: none"> • For-profit firm • Academic institution • Charitable foundation or private foundation • Not specified <p>See World Bank (2016) taxonomy for definitions.</p>
Programme funding agency name	Input the name of the agenc(ies) funding the research. (Note: This is not the same as organisations that fund the research of the evaluation.)
Research funding agency category	<p>What category of funding agency funded the research? <i>Note: Only code if reported in the study; no need to do additional research to find.</i></p> <p>Select one of the following:</p> <ul style="list-style-type: none"> • Government agency • International aid agency • International financial institution • Non-profit organisation • For-profit firm • Academic institution • Charitable foundation or private foundation • Not specified <p>See World Bank (2016) taxonomy for definitions.</p>
Research funding agency name	Input the name of the agenc(ies) funding the research. (Note: This is not the same as organisations that fund the program.)
Intervention number	If study interventions fall under more than one category, number each starting with 1.
Intervention group	Select intervention group from list.
Intervention category	Select category from list.
Intervention description	Briefly describe intervention in your own words.
Intervention notes	Add notes if needed.
Outcome number	If study outcomes fall under more than one category, number each starting with 1.
Outcome group	Select outcome group from list.
Outcome category	Select category from list.
Outcome description	Briefly describe outcome in your own words.
Outcome notes	Add notes if needed.
Cost effectiveness	Does the study have a cost-effectiveness analysis for alternative interventions? (yes/no)
Long-term impact	Does the study measure impact 24 months or more after baseline or intervention? (yes/no)
Vulnerable populations	Does the intervention focus on vulnerable groups? (yes/no)
Men and boys	Is the intervention focused on men and boys? (yes/no)

Appendix B: List of studies and reviews included in the EGM

The following list contains all of the included studies and reviews from the 2017 EGM and this update. Additions from the updating process are in **bold**.

B1. Completed impact evaluations

Abeid, M, Muganyizi, P, Mpembeni, R, Darj, E and Axemo, P, 2015. A community-based intervention for improving health-seeking behavior among sexual violence survivors: a controlled before and after design study in rural Tanzania. *Global Health Action*, 8(1), pp.1–9.

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