Uned Atal Trais
Violence Prevention Unit

Ariennir gan
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What Works to Prevent Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV)?

Systematic Evidence Assessment

Authors:
Dr Samia Addis
Samia.addis@wales.nhs.uk
Lara Snowdon
Lara.snowdon@wales.nhs.uk

Uned Atal Trais
Violence Prevention Unit

Wales Violence Prevention Unit
WHO Collaborating Centre for Investment
in Health and Wellbeing,
Public Health Wales
Floor 5
2 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

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Acronyms

VAWDASV	Violence against Women, Domestic Abuse and Sexual Violence
IPV	Intimate Partner Violence
SVA	Sexual Violence and Abuse
DVA	Domestic Violence and Abuse
VAWG	Violence against Women and Girls
GBV	Gender Based Violence
FGM/C	Female Genital Mutilation/cutting
RCT	Randomised Controlled Trial
HBA	So-called Honour Based Abuse
CSEA	Child Sexual Exploitation and Abuse
LGBT	Lesbian, Gay, Bisexual and Transgender
NTE	Night-time Economy
CSA	Child Sexual Abuse
HMPPS	Her Majesty's Prison and Probation Service
CSE	Child Sexual Exploitation
SDV	Sexual and Dating Violence
SV	Sexual Violence

Abstract

Background:

Violence against women domestic abuse and sexual violence (VAWDASV) is a major public health problem, criminal justice and human rights issue, with a range of adverse consequences for health and wellbeing over the life course. In Wales, a key objective of the national VAWDASV strategy is to make early intervention and prevention a priority, in recognition that prevention is vital to breaking the cycle of violence in families and communities. The purpose of this review is to identify effective practice for the prevention of VAWDASV and use the evidence to inform the refresh of the national VAWDASV strategy in Wales in 2021.

Methods:

The systematic evidence assessment was undertaken in two stages; a search of databases to identify reviews of interventions designed to prevent VAWDASV published since 2014 and a supplementary search to identify primary studies published since 2018. Reviews (n=35) and primary studies (n=16), focusing on a range of types of VAWDASV, and types of intervention were identified. An additional grey literature search was undertaken to identify evaluations of VAWDASV prevention programmes in Wales undertaken over the last decade.

Findings:

The socio-ecological model highlights four levels where prevention can occur and acts as a framework for the presentation of findings. At the individual level, effective interventions focus on working with young people to transform harmful gender norms and empowerment approaches. At the relationship level, the focus is on interventions to prevent adolescent violence including promoting healthy relationships and bystander interventions. At the community level a range of interventions, situated in schools, the workplace, and healthcare settings are outlined. Finally, the societal level encompasses interventions such as legislation and alcohol policy. Promising approaches to the prevention of VAWDASV are evident within each level.

Conclusion:

The prevention of VAWDASV is seen as an increasingly critical and feasible component to tackle this major societal issue. This systematic evidence assessment identifies a range of effective practice to prevent VAWDASV that can be considered for implementation as part of the delivery of the national VAWDASV strategy.

Section

1

Background

Section 1: Background

The Nature and Extent of VAWDASV

Violence against women domestic abuse and sexual violence (VAWDASV) is a major public health problem, a criminal justice issue, and a violation of human rights. VAWDASV impacts severely on individuals and families, and harms the health of communities, societies and economies. The National Institute for Health and Care Excellence (NICE, 2014) state that: "The cost, in both human and economic terms, is so significant that even marginally effective interventions are cost effective". A Home Office report estimating the economic and social costs of domestic abuse, placed the annual cost at £66 billion (Oliver et al., 2019), suggesting that the costs of all forms of VAWDASV are considerably higher. Tackling violence and its root causes can improve the health and wellbeing of individuals and communities and have a wider positive impact for the economy and society.

Preventing VAWDASV requires an appreciation that it is part of a social pattern of predominantly male violence towards women (Hester and Lilley, 2014). Whilst boys and men can be victims of VAWDASV, and abuse occurs within same-sex relationships as well as within family relationships and against transgender men and women, in terms of the scale of the problem being addressed by VAWDASV programmes, perpetrators tend overwhelmingly to be male and victims are mainly female. This is reflected in the language of the Istanbul Convention, which is grounded in the understanding that gender inequality is a cause and consequence of violence against women. This means recognising the gendered nature of violence against women as rooted in power imbalances and inequality between women and men (Council of Europe, 2011).

At the same time, sexuality, age, class, race and disability intersect with gender and create differences in lived experience of VAWDASV and outcomes. This means, that while VAWDASV can happen to anyone, anywhere, some women and girls are particularly vulnerable, for example, young women and girls, women who identify as lesbian, bisexual, transgender or intersex, migrants and refugees, indigenous women and ethnic minorities, or women and girls living with HIV and disabilities and those living through humanitarian crises (United Nations, 2021).

The Health Impact of VAWDASV

The short- and long-term health consequences of VAWDASV for women's health are many and significant. Sexual violence can lead to a multitude of health consequences for women, including physical, reproductive and psychological consequences (Jina and Thomas, 2013). Female genital mutilation (FGM) can lead to both immediate health risks as well as a variety of long-term complications which can affect women's physical, mental and sexual health and well-being throughout the life-course (World Health Organisation, 2021a). Women who experience violence are at higher risk of injuries with 42% of women who experience intimate partner violence (IPV) reporting an injury as a consequence of this violence. Women who suffer IPV are twice as likely as women without experience of IPV to experience depression and 1.5 times more likely to acquire a sexually transmitted infection (World Health Organisation, 2018).

Additionally, such violence can have fatal outcomes. Every day, 137 women are killed by a family member and it is estimated of the 87,000 women who were intentionally killed globally in 2017, more than half (50,000) were killed by intimate partners or family members. More than a third (30,000) of the women intentionally killed in 2017 were killed by their current or former intimate partner (United Nations Office on Drugs and Crime, 2019).

These figures reflect the gendered nature of interpersonal violence and abuse with women considerably more likely to experience repeated and severe forms of abuse including sexual violence as well as sustained physical, psychological, or emotional abuse, or violence which results in injury or death. Additionally, women experience higher rates of repeated victimisation and are much more likely to be seriously hurt or killed than male victims of domestic abuse. Data for the year ending March 2016 to the year ending March 2018 indicate that 218 of 270 female domestic homicide victims were killed by a partner or ex-partner compared to 43 male victims who were killed by a partner or ex-partner in the same period (Women's Aid, 2020a).

VAWDASV places a heavy burden on health, economic and social prospects with the adverse psychological, sexual, and reproductive health consequences affecting survivors at all stages of life. In addition, VAWDASV has health consequences for children as well as socio economic impacts of families, communities and societies (World Health Organisation, 2021b).

Defining VAWDASV

A range of forms of violence are recognised within the term VAWDASV, these include gender based violence (GBV); intimate partner violence (IPV); domestic violence and abuse (DVA); sexual violence and abuse (SVA); coercive control; forced marriage; child marriage; so-called honour based abuse (HBA); female genital mutilation (FGM); human trafficking; sexual harassment; cyber harassment and adolescent dating violence (ADV). Many of these terms are used as umbrella terms, and are not mutually exclusive, but are reflected here as they are used in the literature. These will be outlined in turn.

Gender based violence (GBV) constitutes violence that is directed against a person based on gender. It represents a breach of the fundamental right to life, liberty, security, dignity, equality between women and men, non-discrimination and physical and mental integrity (Council of Europe, 2011). Gender based violence is enacted under many different manifestations such as sexual violence, intimate partner violence and so-called honour based abuse, however, these different forms are not mutually exclusive and multiple incidences of violence can happen concurrently and reinforce each other (European Institute for Gender Equality, 2021). Gender based violence is often described as a cause and consequence of gender inequality.

Intimate partner violence (IPV) is behaviour by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, economic abuse and controlling behaviours (World Health Organisation, 2017). Based on data from 2000-2018, the 2018 global estimate of ever married/ partnered women aged 15-49 years who had been subject to IPV at least once in their lifetime since the age of 15 is 27%, equating to up to 753 million women (World Health Organisation, 2021c).

The term domestic violence and abuse (DVA) is used in many countries to refer to violence in a domestic setting, including intimate partner violence, but the term can also encompass child to parent violence or abuse of older people or abuse by any member of a family or household.

Adolescent dating violence (ADV), also called adolescent relationship abuse refers to emotional, physical or sexual abuse of a dating or sexual partner where at least one person is an adolescent. The focus on adolescence rather than teen dating and sexual violence draws attention to the fact that abusive and controlling behaviours can occur in early adolescence (prior to teen years) and extend into adulthood. Sexual violence is also prevalent among adolescents and overlaps with ADV with over half of experiences of sexual violence occurring in the context of a dating or intimate relationship. Sexual violence outside a dating relationship is also common, with 28% to 56% of women in college samples reporting at least one such experience and over 75% of whom who have been sexually assaulted report that the first of such experiences occurred before the age of 25 (Miller et al., 2018).

Sexual violence, sexual assault or harassment involves any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting (World Health Organisation, 2012b). Sexual violent acts can take place in a range of settings and can include rape within marriage or dating relationships; rape by strangers; sexual abuse of children; forced prostitution or the trafficking of people for the purpose of sexual exploitation and sexual harassment (Krug et al., 2002).

Fifteen million adolescent girls worldwide, aged 15-19 years have experienced forced sex, most commonly by a current or former husband, partner or boyfriend (Unicef, 2017). It is also recognised that during times of armed conflict, sexual violence has been used as a strategic and systematic tactic. Whether committed by armed soldiers, gangs or civilians, sexual violence during conflict is intended to weaken the social fabric of families and communities and often the survivors of sexual violence are blamed, rejected by their husbands and severely stigmatised by and isolated from their communities (Stark and Wessells, 2012).

Sexual harassment is defined as unwelcome sexual conduct and studies have consistently shown that a significant number of women and girls have experienced sexual harassment throughout their lives. A recent survey indicates that 71% of women of all ages in the UK have experienced some form of sexual harassment in a public space, and 97% of 18-24 year olds reported having experienced some form of harassment (All Party Parliamentary Group for UN Women, 2021).

In the European Union, one in ten women report having experienced cyber-harassment since the age of 15. This included having received unwanted and or offensive sexually explicit emails or SMS messages, or offensive and/or inappropriate advances on social networking sites. The risk is highest among young women aged 18-29 years (European Union Agency for Fundemental Rights, 2015).

Coercive control is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten the victim. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour (Women's Aid, 2020b). Coercive control often involves physical violence and sexual coercion and there is evidence that cases involving coercive control are more likely to result in serious harm, including domestic homicide, than cases that involve discrete acts of physical violence (Myhill and Hohl, 2019). In the year ending March 2019, there were 17,616 offences of coercive control recorded by the police in England and Wales (Office for National Statistics, 2019).

Forced marriage is where one or both people do not (or in cases of people with some learning disabilities, cannot) consent to the marriage and pressure or abuse is used. It is recognised as a form of violence against women and men, domestic/child abuse, a form of modern slavery, and a serious abuse of human rights (Rights of Women, 2014).

In relation to child marriage, any child (under the age of 18) is considered incapable of freely choosing to marry. Complications arise when there is legal entitlement for a child to marry earlier (from 16 years of age) with parental consent, as in the UK (Girls Not Brides, 2020). In 2019, one in five women, aged 20-24 were married before the age of 18, the highest risk of child marriage currently is in sub-Saharan Africa, where more than one in three women, aged 20-24 were married before the age of 18. Child marriage often results in early pregnancy and social isolation, interrupts schooling and increases a girl's risk of experiencing domestic violence (United Nations, 2020).

For some communities, the concept of 'honour' is deemed to be extremely important, to compromise a family's 'honour' is to bring dishonour and shame and this can have severe consequences. The punishment for bringing dishonour can be emotional abuse, physical abuse, family disownment and in some cases even murder. In most so-called honour based abuse cases there are multiple perpetrators from the

immediate family, sometimes the extended family and occasionally the community at large. Mothers, sisters, aunties and even grandmothers have been known to be involved in the conspiring of so called honour crimes (Karma Nirvana, 2019).

Female genital mutilation (FGM) involves all procedures that involve partial or total removal of the external female genitalia, other injury to, or alteration of the female genital organs for nonmedical reasons (World Health Organisation, 2017). At least 200 million women and girls aged 15-49 years have undergone female genital mutilation and in countries where FGM is almost universal, 9 out of 10 girls and women have been cut (United Nations, 2020). It is estimated that 600,000 women and girls living in Europe have undergone the procedure; the UK and France have the highest numbers (137,000 and 125,000 respectively) followed by Germany and Italy. The practice often happens in the school holidays when girls travel to their family's country of origin despite laws in many countries (including the UK, France and Germany) that allow the prosecution of parents who take their daughters to a foreign country to carry out FGM (Tidey, 2021).

Modern slavery is an umbrella term for activities involved when one person obtains or holds another person in compelled service (Unseen, 2021). Within this, human trafficking involves the forced exploitation of others, typically for sexual or labour purposes, affecting individuals, families, communities, and societies around the world. Victims of human trafficking experience injuries, infections, untreated chronic disease and mental health problems and families of victims are traumatized by separation, social stigma, and lasting multigenerational health effects (Greenbaum et al., 2018). Adult women account for nearly half of all human trafficking victims detected globally (49%). Together, women and girls account for 72% with girls representing more than three out of every four child trafficking victims. Most women and girls are trafficked for the purpose of sexual exploitation (United Nations Office on Drugs and Crime, 2018).

The Impact of COVID-19

Since the outbreak of COVID-19, emerging data and reports from those working in front line services have shown that many types of VAWDASV, particularly domestic violence have intensified. Calls to helplines have increased fivefold in some countries as rates of reported IPV have increased because of the COVID-19 pandemic. This is referred to as the shadow pandemic, as COVID-19 continues to strain health services, and violence is exacerbated in the home, essential services such as domestic violence shelters and helplines have reached capacity (United Nations, 2021).

COVID-19 has further exposed VAWDASV as a global emergency requiring urgent action. The pandemic has exposed the failure of efforts to prevent and respond to violence but also the deeply entrenched and systemic nature of VAWDASV. As the pandemic continues, growing economic and social stress has an impact on everyone, but particularly women who often bear the additional burden of caring responsibilities, are more likely to hold insecure employment, in addition to being at increased risk of violence victimisation in the home. At the same time, restrictions on movement and social isolation measures increase women's vulnerability to violence and since lockdown measures were introduced, restricted access to support services, friends and family reduce survivors' access to support thus increasing the risk of harm (UN General Assembly, 2020).

A Public Health Approach to VAWDASV

The principles of public health provide a useful framework to investigate and understand the causes and consequences of violence and for preventing violence from occurring through primary prevention programmes, policy interventions and advocacy (Violence Prevention Alliance, 2021a). The public health approach is aimed at entire populations and as such, its success depends on action from more than one organisation or group simultaneously, thereby acknowledging the multiple causes of health and social problems (Walden and Wall, 2014), and the value of multi-agency working.

The World Health Organization has adopted a public health approach to violence prevention that aims to promote population level health and well-being by addressing underlying risk factors that increase the likelihood of violence and promoting protective factors. The World Health Organization's Violence Prevention Alliance describes a public health approach to violence prevention as one that 'seeks to improve the health and safety of all individuals by addressing underlying risk factors that increase the likelihood that an individual will become a victim or a perpetrator of violence' (Violence Prevention Alliance, 2021b).

The Alliance further describes four steps of the public health approach to violence prevention, as follows:

Figure 1: *Public Health Approach to Violence Prevention*

1. Definition of the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of violence.
2. Establishment of why violence occurs using research to determine the causes and correlates of violence, the factors that increase or decrease the risk for violence, and the factors that could be modified through interventions.
3. Investigation of what works to prevent violence by designing, implementing and evaluating interventions.
4. Implementation of effective and promising interventions in a wide range of settings, which should include the monitoring of the effects of these interventions on risk factors and the target outcome and evaluation of their impact and cost-effectiveness.

These four steps of a public health approach have been used successfully to implement violence prevention activities across the globe.

Additionally, the WHO's 'ecological framework' for violence prevention (figure 2) presents a model which represents the complex interplay between individual, relationship, community, and societal factors which interact to determine the risk; and experience of violence. Such models are a feature of public health based on the idea that influence and determinants are interrelated, reinforcing the importance of a comprehensive approach in which actions at each level of the social ecology work to support other levels.

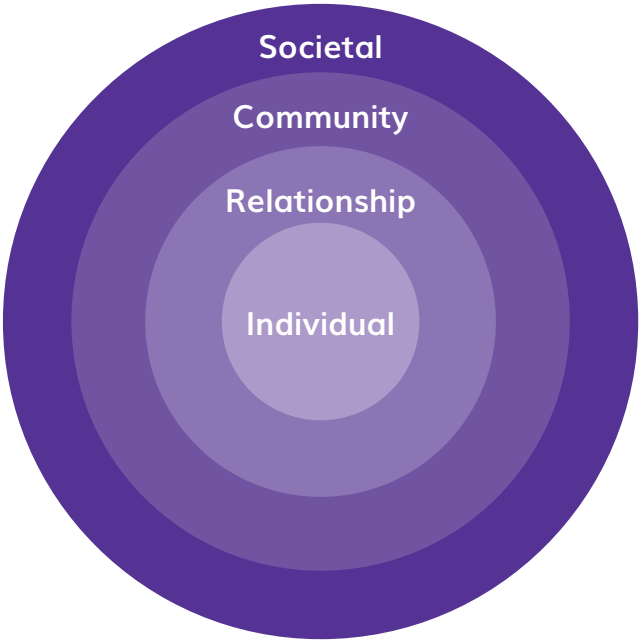

Figure 2: *The Socio-Ecological Model*

Based on this knowledge, violence prevention strategies can function at one or more of these levels, targeting universally or specific populations at higher risk of violence. For example, bystander programmes aim to empower people to challenge attitudes and behaviours that are supportive of violence within their peer group or community. In doing so, they aim to change behaviour and decrease the likelihood of VAWDASV occurring.

Preventing VAWDASV

Public health prevention science identifies three tiers of intervention. Primary prevention aims to prevent violence before it occurs, secondary prevention focuses on the immediate response to violence, and tertiary prevention focuses on long-term care after violence has occurred.

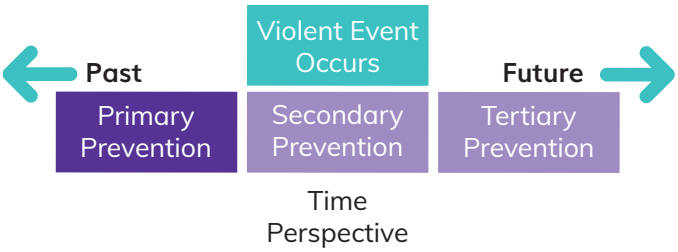

Figure 3: *Tiers of Prevention*

(Krug et al., 2002)

Primary Prevention

Primary prevention strategies include universal interventions directed at the general population as well as selected interventions aimed at those who may be at increased risk for VAWDASV. Primary prevention refers to reducing the number of new instances of violence by intervening before violence takes place. This involves fostering societies, communities, organizations, and relationships in which violence is less likely to occur by challenging attitudes, behaviours, and practices which justify, excuse, or condone violence (Arango et al., 2014). Such strategies for primary prevention include school- or community-based healthy relationship programmes, challenging social norms that support and condone gender based violence, providing skill development for maintaining nonviolent intimate relationships, addressing societal determinants such as laws that discriminate against women, poverty and gender inequality and mass media campaigns that aim to challenge harmful social norms (Anderson et al., 2019, Heard et al., 2020).

Secondary Prevention

Secondary prevention strategies, often referred to as early intervention, are targeted at individuals and groups who exhibit early signs of perpetrating or experiencing VAWDASV. Secondary prevention focuses on early detection after exposure and subsequent treatment and/ or referral to triage any resulting negative health consequences or recurrent exposure. As such, secondary prevention refers to both mitigating the immediate consequences of abuse by providing survivors with services and support as well as preventing recurrence or repeat abuse (Fergus 2012 cited in Arango et al., 2014). Examples of secondary prevention programmes include screening in health-care settings with connection to further services such as counselling, medical treatment, and legal action to prevent future victimization (Thomas et al. 2005 cited in Anderson et al., 2019). Secondary prevention approaches can also include reforms of legislation and the criminal justice sector such as compulsory arrest policies, and early intervention by bystanders witnessing acts of gender-based violence (Heard et al., 2020).

Tertiary Prevention

Tertiary prevention interventions include support, treatment and protection provided to people who have experienced VAWDASV after it has occurred. Interventions aim to respond and prevent recurrence, escalation, and harmful consequences (Welsh Women's Aid, 2020). Approaches to tertiary prevention include emergency shelters and long-term support services for survivors, training professionals to improve services, and strengthening ways in which perpetrators are held accountable.

Applying this framework to VAWDASV has demonstrated its effectiveness as a tool for supporting change across the spectrum of time that violence occurs (Walden and Wall, 2014). However, it is acknowledged that the division between primary, secondary, and tertiary violence prevention is not always clear cut, and that levels of prevention are not mutually exclusive (Heard et al., 2020). Also, since tertiary prevention refers to violence that has already happened, a rapid, well-coordinated response system directed at victims and perpetrators may prevent reoccurrence of violence and/or victimisation (Walden and Wall, 2014).

Section

2

The Welsh Context

Section 2: The Welsh Context

VAWDASV in Wales

Figures indicate that an estimated 5.5% of adults aged 16-74 years (2.3 million people) have experienced domestic abuse in the past year in England and Wales (Office for National Statistics, 2020). Nearly half a million adults are sexually assaulted each year and around 85,000 women and 12,000 men are raped each year in England and Wales (Welsh Government, 2016). In 2015, the Crown Prosecution Service (CPS) reported the highest ever number of cases involving crimes of violence against women and girls in Wales, with 6,878 cases prosecuted by the CPS in 2014-2015. These cases constituted 6.42% of the total number of cases across England and Wales in 2014-2015 (Jurasz, 2018).

In relation to so-called honour based abuse, statistics indicate that there were 2,024 honour based offences in England and Wales in 2019/2020, this includes FGM offences, forced marriage offences and other honour based abuse offences (GOV.UK, 2020). In 2011, an estimated 137,000 girls and women were living with consequences of FGM. In the year ending March 2018 there were 271 newly recorded cases of FGM reported in Wales, although those figures do not indicate that FGM was recent, or that it was carried out in the UK (Public Health Wales, 2018). Additionally, it is estimated that there are up to 100 victims of forced marriage each year in Wales and 80% of cases dealt with by the UK Government's Forced Marriage Unit involved female victims and 20% involved male victims (Welsh Government, 2016).

For the year ending 31st March 2017, estimates put the cost of domestic abuse in England and Wales as £66 billion. These costs are divided into three distinct areas: anticipation (expenditure on protective and preventative measures), consequence (property damage, physical and emotional harms, lost output, health and victim services) and response (police and criminal justice system). Of the £66 billion, the biggest component (£47 billion) was the physical and emotional harms incurred by victims, particularly emotional harms (fear, anxiety and depression experienced by victims as a result of domestic abuse). Additionally, the cost to the economy is considerable, with lost output due to time off work and reduced productivity as a consequence of domestic abuse estimated at £14 billion. In terms of services, costs to the health services are estimated at £2.3 billion, the police, £1.3 billion and housing costs, £550 million. It is also noted that while the £66 billion estimate appears large, it is likely to be an underestimate (Oliver et al., 2019), and does not include the cost of other forms of VAWDASV other than domestic abuse, suggesting that the overall cost of VAWDASV is considerably larger.

The Policy Context in Wales

In 2005, the Welsh Government published its first national strategy 'Tackling Domestic Abuse' (Welsh Government, 2005) which adopted a rights-based framework guaranteeing the right of every citizen to live a life free from violence and abuse (McCarry et al., 2018). This was followed by the 'Right to be Safe Strategy', a six year strategy which focussed on four key areas; prevention and awareness raising, supporting victims, improving the response of criminal justice services as well as health (and related) services (Welsh Government, 2010). In 2012, the Welsh Government white paper set a course for improved education and awareness and more integrated services (Welsh Government, 2012).

In 2015, the Welsh Government passed the 'Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act', the first piece of legislation in the United Kingdom to explicitly address violence against women as opposed to domestic violence generally. The key purpose of the Act was to improve the public sector response in relation to the prevention of acts of gender-based violence, domestic abuse, and sexual violence, the protection of victims and

support for those affected. It is significant for women since it sets out practical steps which national and local government and public sector bodies ought to implement to work together to prevent violence against women. The Act also aims to strengthen the support available to the victims of VAWDASV by improving the public sector response and consistency of service provision by providing a strategic focus with a preventative approach (Price et al., 2020, Jurasz, 2018).

In January 2016, the National Training Framework on Violence against Women, Domestic Abuse and Sexual Violence was issued containing statutory guidance which set the minimum standards of training and professional requirements for public sector services working with the victims of gender-based violence, sexual violence and domestic abuse across Wales. The framework is designed to bring a consistent, gender sensitive and specialist response to gender-based violence and domestic abuse through professional training of relevant authorities (Jurasz, 2018). The Framework refers to the principle of 'Ask and Act', a system of early identification and taking appropriate action for victims of gender-based violence and domestic abuse, which had arisen in recognition of the importance of the role played by public services in identifying and addressing VAWDASV (Jurasz, 2018), with the support of VAWDASV specialist services.

Interventions in the Welsh Context

In the legislative context of the VAWDASV Act 2015, a review of interventions to address domestic abuse and keep people safe found that refuges were highly valued by survivors and practitioners. Also, that there is strong evidence for advocacy services such as independent domestic violence advisors (IDVAs) or other independent advocacy services (Price et al., 2020). In terms of interventions to prevent VAWDASV, a range of interventions have been implemented and evaluated over the last decade in Wales, funded by the Welsh Government, Home Office, Police and Crime Commissioners, Local Authorities and Universities. Examples include: The Bystander Initiative; Ask and Act, Identification and Referral to Improve Safety (IRIS) and Change that Lasts.

The Bystander Initiative was piloted by Welsh Women's Aid in universities across Wales and assessed to determine whether it is effective in addressing sexual violence and domestic abuse in the Welsh student population. Four Welsh universities took part in the pilot which involved training sessions with students. Findings indicate that the Bystander Initiative was effective at increasing the knowledge of students regarding sexual violence and domestic abuse and this knowledge changed their attitudes towards these issues. Findings also showed that following training, students were more aware of strategies to intervene and were more confident in doing so (Welsh Women's Aid, 2018).

Ask and Act (funded by the Welsh Government) aims to equip professionals with the skills and knowledge to identify potential victims of domestic violence and provide appropriate support through referrals and interventions. Ask and Act is currently undergoing an evaluation, due for completion in 2022, to explore the effectiveness of training to date and to assess how successful it is in meeting its aims.

The IRIS initiative is a general practice based domestic abuse and sexual violence training and referral programme, launched by the Police and Crime Commissioner. The evaluation (Feder et al., 2011) tested the effectiveness of a programme of training and support in primary health-care practice to increase identification of women experiencing domestic violence and their referral to specialist advocacy services. The primary outcome was recorded referral of patients to domestic violence advocacy services, and the secondary outcome was recorded identification of domestic violence in the electronic medical records of the general practice. Results found that one year after the second training session, the 24 intervention practices recorded 223 referrals of patients to advocacy and the 24 control practices recorded 12 referrals. Intervention practices recorded 641 disclosures of domestic violence and control practices recorded 236. In conclusion, the training and support targeted at primary care clinicians and administrative staff improved referral to specialist domestic violence agencies and recorded identification of women experiencing domestic violence.

Change that Lasts is a whole systems model which aims to transform the way the communities, trained trusted professionals and specialist services respond to VAWDASV. This model of early intervention to address violence against women has been developed in partnership with services and key stakeholders. It is a needs led strengths-based gender responsive and trauma informed approach and will support survivors and their children to access more effective support early in their help seeking journey, help them build resilience, achieve independence and freedom from abuse. It will maximise safe disclosure points in local communities and create more knowledge, resilient community responses to prevent violence and abuse.

Study Aims

In Wales, the National Strategy for VAWDASV (Welsh Government, 2016) identifies primary prevention as a key commitment. This includes increasing awareness among the Welsh population of VAWDASV and challenging attitudes which condone or legitimise VAWDASV. Additionally, building institutional, organisational and community capacity to identify and respond appropriately to suspected VAWDASV and adequately funding early intervention support services. While the main aim of primary prevention is to prevent VAWDASV before it occurs, it also increases the likelihood of early intervention with survivors and perpetrators of abuse which reduces the harm caused, representing secondary prevention (Welsh Women's Aid, 2020).

Using a systematic evidence assessment approach, this review will identify effective practice for the primary and secondary prevention of VAWDASV using a defined search strategy to address the research question, What Works to Prevent VAWDASV? The intention is that the evidence identified will be used to inform the adoption of evidence-based practice through the refresh of the national VAWDASV strategy in Wales in 2021.

Section

3

Methods

Section 3: Methods

Literature Search

A systematic evidence assessment was undertaken to address the Research Question: What works to prevent VAWDASV? Initially, mapping of the research area was undertaken to ensure that the review included:

a. The range of types of violence encompassed by the term VAWDASV.
b. The range of interventions relating to primary and secondary prevention.
c. The range of potential intervention outcomes.

The following databases were searched: Cochrane Database of Systematic Reviews; Pubmed; DARE; Medline and Google Scholar. Using a defined search strategy, the searches were undertaken in two stages between November 2020 and February 2021. Stage one involved a search of databases to identify systematic reviews of interventions related to the primary or secondary prevention of VAWDASV (published 2014-2020). Stage two was a supplementary search to identify primary studies published more recently (2018-current) and as such may not be included in the systematic reviews identified or to encompass topics where the evidence base may be too limited to be the subject of a systematic review.

The study used a PICO format, search terms included:

Population/ Problem	Partner violence OR partner abuse OR sexual violence OR sexual abuse OR domestic violence OR domestic abuse OR gender-based violence OR violence against women and girls OR sexual exploitation OR coercive control OR forced marriage OR female genital mutilation OR sexual harassment OR slavery OR honour violence OR Honour Abuse
Intervention	Early intervention OR primary prevention OR secondary prevention
Control	Not applicable
Outcome	Behaviour change OR reduction OR what works OR effective*

Table 1: *Search Terms: Search 1*

Additional terms for the supplementary search included:

Population/ Problem	Sexual exploitation OR Night-time economy/sexual violence OR Societal approaches OR Community approaches OR Whole system approaches OR Elder abuse OR Healthcare (including IDVAs) OR UK based evaluations OR Communications/social marketing OR Child sexual exploitation

Table 2: *Search Terms: Search 2*

Child sexual abuse (CSA) was not included in the search. Whilst there are significant links between CSA and VAWDASV, it tends to be deemed as a child protection concern which is outside the scope of the VAWDASV definition.

An additional search of Welsh evaluations of programmes relating to VAWDASV over the last decade was undertaken; these were identified by searches of the grey literature and contact with key stakeholders.

Inclusion/Exclusion Criteria

To be included, for Search 1, papers had to be a systematic review of interventions designed to prevent VAWDASV and published since 2014. For Search 2, papers, had to be published since 2018 and focus on interventions designed to prevent VAWDASV. Across both searches, papers had to focus on primary and secondary prevention strategies, be written in English and review interventions implemented within high income countries with a similar social and cultural context to Wales. (Reviews which considered low and middle income countries in addition to high income were also included).

Selected records were imported into an excel spreadsheet, duplicates were removed, and each record was screened against the inclusion/exclusion criteria by one author. Where there was debate about inclusion, records were assessed by the second author and any differences were resolved through discussion. This resulted in the inclusion of 35 reviews and 16 primary studies (Figure 4: PRISMA Diagram).

Figure 4: PRISMA Diagram

Figure 4: *PRISMA Diagram*

Analysis

For each paper, extracted data included violence type, intervention type, intervention setting, age range and the number and type of studies included (systematic reviews) or type of study (primary study). Due to the diversity of approaches and studies included, this review uses a narrative synthesis, sorting studies into common themes and providing a descriptive summary of each.

Intervention effectiveness was assessed based on positive behaviour change (reduction in perpetration or victimisation of VAWDASV) or positive change in indicators of VAWDASV (including positive changes to attitudes or beliefs concerning VAWDASV or earlier help seeking and harm reduction). Each paper was reviewed independently by both authors and classified according to the categories outlined in Table 3 (reviews) or Table 4 (primary studies); any differences were resolved through discussion. Due to the heterogeneity of the included interventions, this assessment is provided as a guide.

Strong	Positive behaviour change through multiple robust studies
Promising	Positive change on intermediary outcomes demonstrated through robust studies or limited evidence of behaviour change
Mixed	A range of outcomes demonstrating positive or null impact
Limited	Limited evidence of change with limited research
Harmful	Evidence of harmful impact

Table 3: *Criteria for Assessing the Evidence Level (Reviews)*

Strong	Positive behaviour change
Promising	Positive change on intermediary outcomes or limited evidence of behaviour change
Mixed	A range of outcomes demonstrating positive or null impact
Limited	Limited evidence of change with limited research
Harmful	Evidence of harmful impact
No Effect	No evidence of positive change

Table 4: *Criteria for Assessing the Evidence Level (Primary Studies)*

In addition to each individual paper being classified, the evidence was grouped together by intervention type (for example, changing gender norms or bystander interventions) and each category of intervention was given an evidence ranking by the authors, categorised as strong, promising, or limited. Results are presented in Appendix 1.

Section

4

Findings

Section 4: Findings

Key Findings

The reviews and primary studies are presented according to intervention type; each intervention type is placed within the socio-ecological framework which highlights four levels where prevention can occur.

- Individual level (personal beliefs, attitudes, behaviour, and history)
- Relationship level (peers, friends, family)
- Community level (settings such as schools, workplaces, and neighbourhoods)
- Societal level (cultural beliefs or policies)

Where reviews include a range of intervention types but focus on a specific violence type (e.g., IPV), these have been summarised separately. Throughout this section, promising interventions are drawn out in text boxes to highlight examples of good practice.

Individual Level

Changing Gender Norms

The need for work with men and boys in prevention of violence against women and girls is accepted among advocates, educators, and policymakers in recognition that masculinity and gender-related social norms are implicated in violence. As a result, violence prevention practice has evolved over the last few decades from instrumental approaches that target only women, to approaches that seek to transform the relations, norms and systems that sustain gender inequality and violence (Jewkes et al., 2014). Consequently, engaging men and boys as participants and stakeholders in gender-based violence prevention initiatives are an increasing component of efforts to end gender-based violence. As a result, 'men's engagement' has grown to include a broad range of activities and goals including raising men's awareness about gender based violence, fostering the capacity to cultivate respectful and gender equitable relationships and engage men as social change agents (Casey et al., 2018). Three reviews evaluate interventions which focus on changing gender norms (Casey et al., 2018, Jewkes et al., 2014, Graham et al., 2019).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Casey 2018	Review	GBV	Changing Gender Norms		Boys and men	Promising
Jewkes 2014	Review	GBV	Changing gender norms	Range of settings	Boys and men	Mixed
Graham 2019	Review	SV / Dating Violence / IPV	Range of Interventions	Range of Settings (Mainly US Colleges)	Boys and men	Promising

Table 5: *Interventions: Changing Gender Norms*

Casey et al. (2018) included studies of interventions which used a gender transformative approach, or an explicit focus on questioning gender norms and expectations, show particular promise in achieving GBV prevention outcomes. To be included, studies had to describe quantitative and at least quasi experimental evaluation and to assess at least one attitudinal or behavioural change in men related to: an increase in gender equitable attitudes; a decrease in reported IPV perpetration, an increase in care or domestic work and decrease in the social acceptance of IPV. While most studies in this systematic review were undertaken in Africa, one US based study 'Real Consent' showed statistically significant increases in terms of gender equitable attitudes as well as documenting a significant decrease in reported IPV over time. Overall, this review concluded that the developing evidence base for a "gender transformative" approach show promise in achieving GBV prevention outcomes.

Real Consent

The Real Consent Programme works with male undergraduate students drawing on Social Norms and Social Cognitive Theory as well as bystander approaches to support participants in critically examining masculine gender roles and building skills related to respectful sexual negotiation and intervening in situations that could lead to sexual assault. The programme is delivered in six, 30-minute modules. The modules communicate key themes using definitions, scenarios, survivor stories portrayed by actors, expert testimony, advice from peers, and interactive quizzes and games.

Figure 5: *Real Consent*

Jewkes et al. (2014) focussed on interventions implemented under the rubric of 'working with men and boys'. These included workshop interventions, bystander interventions, school and dating interventions, perpetrator programmes, social norm change interventions including men, and multi-component interventions to review effectiveness in the reduction of violence and its risk factors. This review drew on systematic and comprehensive reviews and meta-analyses in addition to interventions. Most studies (85%) took place in high income countries and 90% in school settings. This review finds that evidence of the effectiveness of interventions involving men and boys to reduce the use of violence, or its risk factors, is limited; Only five of 12 moderate or strong evaluations of interventions that sought to change gender roles had positive findings; Bystander interventions (those aimed at engaging non-violent men or women in challenging tacit acceptance of behaviour of others) did not fare well. Overall, two of three moderate or strong evaluations have had any significant findings, but there have been serious limitations in many of the evaluations and so these cannot be considered to have shown the interventions 'worked', and there are no better results for bystander attitude interventions.

Graham et al. (2019) reviewed randomized controlled studies that evaluated SV/DV/IPV perpetration prevention programme for boys and men and have measured changes in perpetration behaviours longitudinally. The available research was conducted primarily in the US in colleges and university settings. This review found that significant effects on SV/DV/IPV perpetration were found for five programmes: Real Consent, Coaching Boys into Men (CBIM), The Men's Programme, The Men's Project and the Video Programme. However, Real Consent was the only programme found to significantly decrease SV perpetration among a universal population (i.e., college men broadly). CBIM had significant effects on overall DV perpetration (i.e., not reported individually for physical, psychological, or sexual DV) at 12-month follow-up specifically among male high-school athletes, a high-risk population. One of the two studies of The Men's Programme found significant programme effects on SV perpetration only among participants who joined a fraternity, whereas the other study did not find effects on SV perpetration. The evaluation of The Men's Project indicated a lack of persistent effects on SV perpetration, and the evaluation of the Video Programme showed that as compared with high-risk comparison group participants, a higher percentage of high-risk

programme participants reported perpetrating SV after watching the video. This mix of findings, paired with the heterogeneity in intervention approaches, suggests that there is insufficient evidence available to describe with certainty what works to prevent SV/DV/IPV perpetration in male-focused programme.

Coaching Boys into Men (CBIM)

Coaching Boys into Men is based on Social Norms Change Theory and is a participatory 12-week programme delivered to boys by sports coaches who have received training from violence prevention advocates. Athletic coaches play an extremely influential and unique role in the lives of young men. Because of these relationships, coaches are poised to positively influence how young men think and behave, both on and off the field. Coaching Boys into Men is the only evidence-based prevention programme that trains and motivates high school coaches to teach their young male athletes healthy relationship skills and that violence never equals strength.

Figure 6: *Coaching Boys into Men*

Empowerment

Two primary studies focussed on empowerment to prevent VAWDASV (Jordan and Mossman, 2018, Rothman et al., 2019).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Jordan 2018	Primary Study	GBV	Empowerment	Schools (New Zealand)	Girls	Promising
Rothman 2019	Primary Study	CSE	Empowerment (My Life My Choice)	Community (US)	Teenage Girls	Promising

Table 6: *Interventions: Empowerment*

Jordan and Mossman (2018) present the findings from a large-scale evaluation of self-defence programmes provided to three different age groups of schoolgirls from diverse backgrounds in New Zealand. The intervention focussed on awareness raising, recognising inappropriate behaviour by others, learning ways to keep safe and keep friends safe, feeling empowered and enhancing self-esteem. Data were collected by a survey of participants, supplemented by qualitative data provided by key informant interviews with their school and self-defence teachers. Positive and statistically significant shifts were evident for all three age groups related to their understanding of what inappropriate touching is, and what constitutes a healthy relationship. Girls in all age groups showed significant improvements in understanding the importance of help seeking for themselves and others, with a high proportion (95%) of girls reporting their intention to do this if required. Overall, the findings provide clear evidence of the many positive benefits that can result for girls of all ages who participate in feminist self-defence courses taught by carefully trained instructors with a strong empowerment focus.

Rothman et al., (2019) evaluated the Boston based My Life My Choice (MLMC) programme which offers a multi-session psychoeducation group to girls who are identified as at disproportional risk for CSE victimisation. The programme has a mission of combatting CSE through survivor empowerment, training and advocacy and prevention solutions. Using a one-group longitudinal design, changes in participant behaviour and CSE knowledge were measured at baseline, upon group completion, and three months after. Participants in the MLMC prevention groups demonstrated changes in knowledge, attitudes and behaviour from the start of the programme to its end at three months, and for many outcomes, the changes persisted an additional three months after the programme had ended. Of particular note, the incidence of self-reported sexually explicit behaviours was reduced by half over time. Dating abuse victimization also decreased. Trust in the police increased substantially over the course of the programme and was sustained, as was knowledge about CSE, feeling like one would be able to tell a friend about helping resources, and actually giving help or information about CSE to a friend. Participants' sense of control over the conditions of their lives increased.

Interventions to Prevent FGM

Three studies reviewed interventions to prevent FGM (Baillot et al., 2018, Njue et al., 2019, Balfour et al., 2016).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Baillot 2018	Review	FGM	Range of Interventions	Range of Settings	Girls and Women	Limited
Njue 2019	Review	FGM	Range of Interventions	Range of settings	Girls and Women	Limited
Balfour 2016	Review	FGM	Education (Health Professionals)	Healthcare (US)	Midwives	Promising

Table 7: *Interventions: FGM*

Baillot et al. (2018) undertook a scoping study design of FGM prevention aimed to explore FGM prevention and response interventions in Europe, using literature and interview sources. The objectives of the study were to describe EU interventions, assess whether interventions that appeared successful might be replicable, and propose promising interventions that could be implemented more widely. Of the 70 literature sources included, the UK was best represented (22 sources), France (9), Sweden (6), Norway (4), Spain (3), Italy, Netherlands and Switzerland (2) and Belgium, Finland, and Germany (1). This review found preventive interventions aim to create and sustain behavioural and attitudinal change within affected communities; two prevention themes emerged, awareness-raising and the professionals' role. Participants stressed the need for concerted efforts to tackle FGM across multiple public-facing bodies encompassing the entire political spectrum, so awareness-raising could reach the public, service providers, and policymakers. Multi-level approaches were considered beneficial, with UK participants reporting collaborative awareness-raising had pushed Government to respond to FGM. Additionally, professionals can play a key role in longer-term FGM prevention as affected women and girls contact services. Opportunities in health, education, social-work, and policing were highlighted. Many participants discussed the preventive role of health professionals, particularly midwives, obstetricians, paediatricians, general practitioners (GPs), and school doctors.

Njue et al. (2019) analysed peer-reviewed and grey literature to extract the evidence for FGM prevention interventions from a public health perspective in high income countries. All documents included described primary prevention activities that seek to increase individual professional and community awareness and understanding of FGM. Study types are largely process evaluations that include measures of short-term outcomes (pre- and post-changes in attitude, knowledge and confidence or audits of practices). Five reports discuss FGM programmes in the UK, three in EU member states and two in Canada and Australia. The studies used qualitative and quantitative methods with six judged to be of high quality, five of moderate quality and one judged to be of low quality. This review found that there is a dearth of evaluative research focused on empowerment-oriented preventative activities that involve individual women and girls who are affected by FGM. High income countries have given attention to legislative action and bureaucratic interventions to address social injustice and protect those at risk of FGM, alongside prevention activities that favour health persuasion, foster engagement with the local community through outreach and the involvement of community champions, healthcare professional training and capacity strengthening. Most of the reports included described primary prevention activities in the UK and across Europe that are largely prescriptive or top-down forms of social intervention as compared with participative or 'bottom-up' forms.

Finally, Balfour et al. (2016) undertook a systematic review of the published and grey literature on interventions aimed at improving healthcare providers' capacities of prevention and treatment of FGM. Outcomes observed were knowledge and attitudes about FGM, medicalisation, and prevention. Only two studies met the inclusion criteria, one in Mali and one in the US which was conducted with 11 certified nurse-midwives. In the US study, midwives reported feeling more confident in the clinical and obstetric management of women with FGM. The level of self-confidence in the recognition of the four types of FGM (1-4) and the management of each type improved from an average 2.36 to 4.18, with 5 being most confident. Their confidence in their ability to counsel women with type 3 went from 2.00 to 4.09. Their confidence in cultural competence increased from 2.36 to 4.09 and in performing defibrillation (reversal) from 1.54 to 3.54. Their ability to identify factors that are contraindications for defibrillation went from 1.63 to 4.27 and to understand the historical, cultural, legal, and ethical considerations of FGM from 2.64 to 4.09. However, it is noted that the review was limited due to lack of available evidence.

Relationship Level

Preventing Adolescent Violence

Estimates suggest between 10% and 25% of adolescents have experienced some form of physical violence within a dating relationship, and one in four college-age women experiences attempted or completed sexual violence on campus (Storer et al., 2016). Two reviews focussed on a range of interventions aimed at tackling VAWDASV in the adolescent age range (De Koker et al., 2014, Lundgren and Amin, 2015).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
De Koker 2014	Review	IPV	Range of Interventions	Range of Settings	Adolescents	Strong
Lundgren 2015	Review	IPV/SV	Range of Interventions	Range of Settings	Adolescents and young people	Promising

Table 8: *Interventions: Preventing Adolescent Violence*

De Koker et al. (2014) reviewed randomised controlled trials of interventions to reduce physical, sexual, and psychological violence perpetration and victimization among adolescents, seeking to evaluate the effects of interventions aimed at primary and secondary prevention. Included trials predominantly focussed on physical IPV perpetration and victimization, with two studies focussing on emotional/psychological abuse. Eight articles reporting on six randomised controlled trials were retrieved; four trials were conducted in America (Shifting Boundaries, Safe Dates, Ending Violence, Coaching boys into Men), one in Canada (Fourth-R) and one in South Africa (Stepping Stones). Of the six randomised controlled trials, four interventions contained both school and community components. All trials were cluster RCTs however, there were quality issues in all six trials.

This review suggests that comprehensive IPV prevention interventions based in both school and community are effective in preventing IPV perpetration and victimisation among adolescents. Three studies (Safe Dates, Fourth R and Shifting Boundaries) found positive intervention effects on IPV perpetration and on IPV victimisation. Compared with the studies with no effects on IPV, the effective interventions were of longer duration, and were implemented in more than one setting. Additionally, Stepping Stones led to fewer males (but not females) in the intervention arm who reported perpetrating physical/sexual IPV although differences were not statistically significant. Two interventions were not as effective as preventing IPV; Ending Violence and Coaching Boys, these programmes were of shorter duration compared with those that were effective.

The Fourth R

Fourth R: Skills for Youth Relationship is based on Skills-Based Learning taught in secondary schools in sex segregated classes. Topics covered include personal safety, injury prevention; dating violence responsibilities and consequences related to IPV and sexual decision making.

Figure 7: *The Fourth R*

In Lundgren and Amin (2015), the aim was to identify effective approaches to prevent adolescent IPV and SV and to identify critical knowledge gaps. A review of 142 articles and documents yielded 61 interventions, which aimed to prevent IPV and SV among adolescents. Studies reviewed were categorised as parenting programmes (8), targeted interventions for children and adolescents subjected to maltreatment (3), school based (31), community based (16), and economic empowerment (2). Programmes were classified as "effective," "emerging," "ineffective," or "unclear" based on the strength of evidence. The rigour of the evaluations varies greatly, a good number had relatively weak research designs, short follow-up periods, and low or unreported retention rates. Only six of the evaluations were randomised controlled trials and eight used quasi-experimental designs. Overall, there is a lack of robust standardized measures for behavioural outcomes.

Of the programmes reviewed, 17 were implemented in developing countries. From this review, three promising approaches emerged, first, school-based dating violence interventions show considerable success; second, community-based interventions to form gender-equitable attitudes among boys and girls, either by working only with boys and young men or simultaneously with separate groups of boys and girls, have successfully prevented IPV or SV. Third, evidence suggests that parenting interventions and interventions with children and adolescents subjected to maltreatment hold promise in preventing IPV or SV by addressing child maltreatment, which is a risk factor for later perpetration or experience of IPV or SV. Results suggest that programmes with longer term investments and repeated exposure to ideas delivered in different settings over time have better results than single awareness-raising or discussion sessions.

Community

Theatre Interventions

Applied theatre projects use a wide range of techniques and approaches that are generally participatory in nature and share the goal of creating social awareness and change with the audience. Such interventions can involve role-plays, playmaking with audiences, interactive workshops and talk back sessions. Research investigating precisely how applied theatre works as a vehicle for change highlights the creation of a safe space that allows for reflection and examination of complex human phenomena and an opportunity for embodied learning where new approaches to social and personal oppressions can be trialled and practiced (Heard et al., 2020).

One review (Heard et al., 2020) and one primary study (May et al., 2020) focussed on theatre interventions.

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Heard 2020	Review	IPV	Drama /Theatre	Community	13-40 years	Promising
May 2020	Primary Study	CSE	Theatre Programme	School (UK)	Young People	Limited

Table 9: *Interventions: Theatre Interventions*

Heard et al. (2020) provides a synthesis of applied theatre interventions which address primary, secondary and tertiary IPV prevention. Specific strategies used in the studies included healthy relationship training, rising awareness and community advocacy, service provider training, bystander training, and working with survivors. Research involving a range of methodologies were included and interventions were conducted in three countries, United States, United Kingdom, and Australia. Four interventions were conducted with ethnic minority groups (Indian, Latino, Asian), six with young people (school and university/college based), two with survivors of IPV, and two with service providers. The outcomes of this review indicate some potential for applied theatre to have positive outcomes at primary and secondary levels of IPV prevention. In terms of primary prevention, two U.S.-based school interventions assessed as moderate and high quality demonstrated significant decreases in participants' acceptance of IPV as well as increased confidence and intention to act non-violently in intimate relationships. Two interventions used interactive applied theatre as a tool for exploration and advocacy regarding the experiences of IPV for minority groups in the United States and Australia. These moderate- and low-quality studies focused on primary prevention by identifying the needs, current knowledge, and skill sets of specific groups to inform the development of effective prevention strategies. Finally, a high-quality U.S.-based study indicated positive outcomes relating to increased knowledge of IPV and decreased acceptance of common myths related to IPV.

In terms of secondary prevention, the focus was on service provider training and building effective bystanders. Two interventions (articles of moderate and high quality) reported advancing secondary IPV prevention through improved service provision by building empathy and awareness of client needs and increasing multidisciplinary collaboration. Focussing on bystander training, two U.S.-based interventions engaged university students in applied theatre interventions to build knowledge, skills, and confidence to intervene when witnessing IPV.

May et al. (2020) explored young people's experiences of attending a school based theatre-in education programme and the impact this had on their awareness and understanding of Child Sexual Exploitation and Abuse (CSEA). Focus groups were undertaken in two schools in the UK. Participants reported that the theatre performance/live element of the programme was particularly impactful, feeling that this was delivered to them at the right time, but suggesting that younger people would also benefit from the important messages. The results suggest that participants gained new awareness and understanding of aspects related to CSEA, including other forms of (criminal) exploitation, as well as how to avoid harm and what to do "if bad things happen", however, unfortunately, it was not possible to determine whether this increased awareness translated into reduced risk of CSEA.

School Based Interventions

School based interventions which aim to prevent VAWDASV can be delivered on a large scale to a captive audience who have yet to experience or are just embarking on their own intimate relationships. Generally, programme theories include some version of behavioural change, with the intention being to change knowledge and/or attitudes towards specific social norms (usually, but not always, gender norms) with the assumption that this would change behavioural intention, and, eventually, actual behaviour, with a resulting effect on the incidence of perpetration and/or victimisation (Stanley et al., 2015a).

Four reviews focussed on school-based interventions, two to prevent domestic abuse (Stanley et al., 2015a, Stanley et al., 2015b), and two to prevent IPV (Lester et al., 2017, Ellsberg et al., 2015).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Stanley 2015a	Review	DVA	Education (School children)	Schools	Under 18 years	Promising
Stanley 2015b	Review	DVA	Education (School Children)	Schools	Under 18 years	Promising
Lester 2017	Review	IPV	Changing Gender Norms	Schools	Adolescents	Mixed
Ellsberg 2015	Review	GBV	Range of Interventions	Range of Settings	Range of Ages	Mixed

Table 10: *Interventions: School Setting*

Stanley et al. (2015a; 2015b) report on a mixed method realist review of studies reporting preventive interventions in domestic abuse for children and young people. Studies using a wide range of methods were included, 13 papers reported on controlled trials which involved nine different programmes and 15 papers reported on 14 programmes which included various types of cohort or case control study. Studies were based predominantly in USA but also, Canada, UK and India. All were school based except for Families for Safe Dates and three made explicit reference to bystander theory. Programme outcomes were identified as changes in young people's knowledge, attitudes behaviours as well as incidence of victimisation or perpetration. Stanley (2015b) found that the largest effect sizes were found in measures of knowledge, although the differences in these tended to decrease over time. The only relatively large and statistically significant finding in a well-designed study in terms of incidence of perpetration or victimisations was found in an evaluation of the Fourth R Programme where perpetration of physical dating violence by boys was found to have decreased 2.5 years after the programme (Wolfe et al., 2009). Most of the papers included in the systematic review failed to provide robust evidence of behaviour change however, it was acknowledged that using behaviour as a primary outcome of an intervention which is targeting social norms may be problematic.

Ellsberg et al., (2015) undertook a broad review of evidence of interventions to reduce the prevalence and incidence of violence against women and girls. This review encompassed a broad range of intervention models in high, middle and low income countries and primary, secondary and tertiary prevention. In relation to school based interventions, this review found that most prevention programmes for IPV and non-partner sexual assault in high-income countries are school-based group training interventions. However, while evidence from these programmes has not been encouraging, there have been a few exceptions. The Healthy Relationships programme in Canada was tested in two settings: one with male and female high school students and the other in the community with male and female young people. Both studies showed significant reductions in both perpetration and victimisation of dating violence in both boys and girls in the intervention groups compared with the control groups. Additionally, studies of two well-known interventions, Shifting Boundaries and Safe Dates, reported a reduction in dating violence in adolescents.

Lester et al. (2017) completed a systematic review of reviews of interventions to reduce IPV undertaken within the school setting mainly in the US. A handful of programmes demonstrated promise in preventing IPV. Safe Dates, the Fourth R, Stepping Stones and Shifting Boundaries stand out as programmes that

achieved positive effects. Safe Dates, the Fourth R and Stepping Stones are conspicuous as having been studied in trials with the strongest methods for determining evidence of effect in that they have the longest follow-up periods (three, two and a half and two years respectively). The Safe Dates trial was also strong in that it measured the widest range of forms of dating violence and was able to show that effects for several forms of violence persisted over time. Moderation effects are also key in understanding programmes. Safe Dates has produced evidence that there is no difference in effectiveness by gender, by white vs. other ethnicity, or by whether students had previous experience of dating violence; but the trial of the Fourth R showed that the effect was present only for boys. Safe Dates thus appears to be the most effective school-based program for preventing dating violence, but the evidence base in general needs much more development. Despite these limitations, it is clear that a number of violence prevention initiatives have been successfully delivered at school.

Safe Dates

Safe Dates is a programme of school and community activities to promote primary and secondary prevention of dating violence by changing norms associated with partner violence, decrease gender stereotyping and improving conflict management skills. Activities in schools include a theatre production, a 10-session curriculum, and a poster contest while activities in the community include services for adolescents in abusive relationships and community service provider training.

Figure 8: *Safe Dates*

Changing Gender Norms in the Community Setting

Two primary studies evaluate interventions which focus on changing gender norms in the community setting Banyard et al. (2019) and Miller et al., (2019).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Banyard 2019	Primary Study	SDV	Changing Gender Norms Reducing Sexism & Violence Programme – Middle School Programme (RSVP-MSP)	Middle School (US)	Boys	Promising
Miller 2020	Primary Study	GBV	Changing gender norms (Manhood 2.0)	US Community	High school age males	No effect

Table 11: *Interventions: Changing Gender Norms in a Community Setting*

Banyard et al. (2019) reviewed a pilot evaluation of a new gender-transformative prevention programme for middle school boys in the US. The Reducing Sexism and Violence Programme – Middle School Programme (RSVP-MSP) is theoretically grounded and includes four, one-hour sessions that explore the normalization, pervasiveness, and harmful nature of rigid gender role assumptions with the goal of reducing sexual and dating violence (SDV). The programme includes both reduction of violence-related risk factors and promotion of positive youth development variables. A quasi-experimental design was used, 292 boys took surveys at two time points, three months apart. Findings suggest that the programme improved attitudes related to use of coercion and violence in relationships. All boys improved on measures of gender equality in relationships and perceptions of male power and showed decreased support for the use of violence in relationships. Both groups, control and treatment groups, showed significant improvement over time in diminished support for male power and increased support for gender equity among couples. These findings suggest that education for middle school boys can be successful at changing violence related beliefs that are risk factors for the perpetration of harassment and SDV. Findings also revealed that while the programme is designed for universal or primary violence prevention, many boys reported being the victim of peer bullying and harassment prior to being part of this programme. The programme's focus on healthy masculinity may serve both a primary and secondary prevention function for middle school boys.

Miller et al. (2020) evaluated the effectiveness of a community-based, gender-transformative programme (Manhood 2.0) on perpetration of gender-based violence by adolescent boys and young men. Manhood 2.0, an international programme adapted for adolescent boys and young men in US urban communities, encourages individuals to challenge gender norms that foster violence against women and unhealthy sexual relationships. Each programme was 18 hours long and individuals in the control population received job-readiness training instead. It was hypothesised that Manhood 2.0 would result in a greater decrease in any sexual violence (SV) or adolescent relationship abuse (ARA) perpetration compared with job-readiness training with secondary outcomes including gender-equitable attitudes, recognition of abusive behaviours, intentions to intervene with peers, condom self-efficacy and contraceptive use attitudes, and positive and negative bystander behaviour. However, there was no evidence of an intervention effect for the primary outcome and findings did not show a significant intervention effect in reducing SV or ARA perpetration between Manhood 2.0 and a job-readiness control programme.

Bystander Programmes

Bystander programmes focus on equipping people with the skills to safely intervene when they witness behaviours that can result in VAWDASV. Most bystander programmes attempt to influence attitudes and beliefs about gender, violence, and bystander roles in recognition that helpful bystander behaviour is dependent upon a belief and confidence in one's ability to act in a prosocial way. The bystander approach is based on the premise that both men and women collectively have the capability (and responsibility) to prevent and intervene as prosocial bystanders when they witness behaviours related to sexual and dating violence. Although most programmes are intended to prevent the victimization of young women by men, some programmes are "gender neutral" in that they position men and women equally as potential perpetrators and victims (Katz et al., 2011).

Bystander programmes were the focus of seven reviews (Jouriles et al., 2018, Kettrey and Marx, 2019a, Kettrey and Marx, 2019b, Kovalenko et al., 2020, Mujal et al., 2019, Storer et al., 2016, Fenton et al., 2016). All the reviews focus on adolescents or young people in educational settings, mainly college settings, although bystander programmes are also delivered in school settings.

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Jouriles 2008	Review	SVA	Bystander Programmes	College Campus	Young adults	Promising
Kettrey 2019a	Review	SVA	Bystander Programmes	College Campus	Young adults	Promising
Kettrey 2019b	Review	SVA	Bystander Programmes	College Campus	Young adults	Promising
Kovalenko 2020	Review	Dating Violence	Bystander Programmes	Range	15-30 years	Promising
Mujal 2019	Review	SVA	Bystander Programmes	Range of Settings	Range	Promising
Storer 2016	Review	Dating Violence	Bystander Programmes	College	Adolescents and young people	Mixed
Fenton 2016	Review	SVA and DVA	Bystander Programmes	University (UK)	Students	Promising

Table 12: *Interventions: Bystander Programmes (Reviews)*

Jouriles et al. (2018) undertook a systematic review and meta-analysis to evaluate the effectiveness of bystander programme that address sexual violence on college campuses. Programmes effects on student attitudes, beliefs and bystander behaviour were examined. To be included, studies must have included a control group and evaluated a bystander programme to reduce dating violence, sexual assault, or both. This review found that students who participated in a bystander programme, compared to those who had not, had more pro-social attitudes/beliefs about sexual violence and intervening to prevent it, and engaged in more bystander behaviours. However, the positive effects of bystander programmes on attitudes and beliefs as well as bystander behaviour were small in magnitude. While programme effects diminished over time, meaningful changes persisted for at least three months following programme delivery with longer programmes having greater effects than shorter programmes on attitudes/beliefs.

Kettrey and Marx (2019a) undertook a systematic review and meta-analysis which synthesized high-quality research examining the effects of bystander programmes on both bystander intervention and self-reported perpetration of sexual assault. This study paid attention to a gendered approach as a moderator of programme effects. Of the 14 studies synthesised, 12 were RCTs and two used a high quality quasi experimental design. To be included, studies had to assess the effects of a bystander sexual assault prevention programme on bystander intervention and/or sexual assault perpetration among adolescents or college students in the US. This review found that bystander programmes have a significant, desirable effect on bystander intervention with adolescents and college students. However, there was no support for the effectiveness of these programmes in preventing sexual assault. Additionally, no evidence was found that gendered framing of sexual assault moderated the effect of a bystander programme. Findings from this systematic review and meta-analysis suggest there is a fairly strong body of high-quality research assessing the effects of bystander programme on behaviours.

Kettrey and Marx (2019b) undertook a systematic review and meta-analysis which synthesised data from 15 high quality studies and examined the effects of sexual assault prevention bystander programme on (i) bystander efficacy, (ii) intentions, and (iii) interventions across the college years in the US. The aim was to identify any differential effects of bystander programmes between the early and late college years to identify the best timing for implementing bystander programmes with college students in the US. Only studies using an experimental or controlled quasi-experimental research design to compare an intervention group with a comparison group were included. This review found that bystander programmes have a significant, desirable effect on all three outcomes. The moderator analyses reported indicate programme effects on bystander intentions are stronger in the early college years than in the later college years. However, effects on bystander efficacy and intervention are similar between these contexts.

Kovalenko et al. (2020) identified 40 reviews and meta-analyses reporting on the effectiveness of violence prevention programme among young people (age 15–30) in educational institutions, mainly in Europe and North America. The focus was programmes designed to reduce dating and relationship violence and sexual assault and only evaluations that reported on behavioural outcomes such as perpetration, victimization, and bystander behaviour were included. Of the 40 reviews, one was considered high quality, one medium, one low, and 37 (92.5%) of critically low quality. This review found that most studies found small effects on violence reduction and victimization and increases in self-reported bystander behaviour. As a result, although most studies found significant beneficial outcomes, for the most part, the practical effect of these benefits is not certain. Programmes proved to be effective for the improvement of knowledge and attitudes, less often for behaviour, and the effect decreased over time. Effective programmes involved peer education, use of drama and poster activities as well as education on legislation, personal safety, consequences, health and sexuality, gender roles, healthy relationships, and the role of bystanders. Reviewers conclude that programme content should be underpinned by evidence-based theories and appropriately tailored to the culture and needs of target audiences. The lack of rigorous longitudinal evaluation design and moderator analyses limited the ability to draw conclusions about specific programme features that enhance the effectiveness of violence prevention programmes.

Mujal et al. (2019) summarised bystander intervention training approaches for the primary prevention of sexual violence and assault, predominantly in college students but also adults in America and Canada. Of the studies, nearly 40% employed an RCT design, 36% were one-group designs and 25% a quasi-experimental design. For inclusion, studies had to address the topic of sexual assault, sexual violence, dating violence, sexual harassment, gender-based violence, or interpersonal violence and collect one of the following outcome measures; attitudes, knowledge, behaviours, efficacy, or incidence/rate of sexual violence. This review found that the use of in-person bystander training can make positive changes in attitudes and behaviours by increasing awareness of a problem and responsibility to solve it. Thirty-two percent of studies analysed bystander behaviour postintervention, and most found significant beneficial outcomes. However, knowledge of the effectiveness of bystander interventions for the prevention of sexual violence is still small due to the rarity of RCT and quasi-experimental designs testing such programmes and the lack of any effectiveness tests beyond 12 months after programme conclusion.

Storer et al. (2016) examined the content and programme components of bystander based dating and sexual violence prevention programmes across adolescent and college-age audiences. The inclusion criteria comprised postintervention outcomes related to bystander behaviour and an evaluation of bystander programmes designed to impact bystander behaviour related to sexual assault and/or dating violence. This review found that bystander programmes are promising from the standpoint of increasing young adults' willingness to intervene and confidence in their ability to intervene when they witness dating or sexual violence. However, although bystander programmes show promise and have an intuitive

appeal, the current research base is mixed and unable to conclusively articulate which programme design and components may impact desired outcomes. Further, the current state of the evaluation literature renders it premature to draw definitive conclusions about whether bystander-based prevention programmes have an impact on general rates of sexual or dating violence perpetration or on campus or community climates. Given mixed findings related to programmes' impact on bystander behaviour, practitioners may need to assess factors within their local context or community that could support or constrain bystander behaviour and tailor interventions to include attention to those factors.

Fenton et al. (2016) undertook a narrative literature review of primary research publications concerning the efficacy of bystander programmes to prevent violence against women in university settings in the UK. This review found that rigorous evidence is limited and as an outcome, violence reduction was difficult to measure. However, the review found evidence for positive changes in bystander behaviour as well as risk factors for sexual violence perpetration and victimisation as well as other outcomes. Statistically significant changes were reported for participants in bystander intervention programmes across a range of measures including decreased perpetration and victimisation of violence; decreased likelihood of perpetrating violence; increased bystander interventions; increased confidence to intervene and decreased sexist attitudes and rape myth acceptance. This review also found that a gendered understanding of sexual and domestic violence in universities is necessary for effective prevention. Also, that the research base indicates that a bystander intervention approach shows aptitude for addressing the primary prevention of sexual and domestic violence in university settings, having the potential to engage men as well as women.

Seven primary studies evaluated interventions which focussed on Bystander Programmes (Borsky et al., 2018, Carlyle et al., 2020, Coker et al., 2019, Edwards et al., 2019, Fenton and Mott, 2019, Gainsbury et al., 2020, McMahon and Seabrook, 2019).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Borsky 2018	Primary Study	Dating Violence	Bystander (The Red Flag campaign)	University (US)	Students	Promising
Carlyle 2020	Primary Study	SDV	Bystander (The Red Flag Campaign)	University (US)	Students	Promising
Coker 2019	Primary Study	Dating Violence	Bystander (Green Dot)	School (US)	Male and female students	Strong
Edwards 2019	Primary Study	GBV	Bystander (Bringing in the Bystander – High School Curriculum)	School (US)	Students	Mixed
Fenton 2019	Primary Study	GBV	Bystander (The Intervention Initiative)	University (UK)	Students	Promising
Gainsbury 2020	Primary Study	DVA	Bystander (Active Bystander)	Community (UK)		Promising
McMahon 2019	Primary Study	SV	Bystander	University (UK)	Students	Promising

Table 13: *Interventions: Bystander Programmes (Reviews)*

Borsky et al. (2018) used a quasi-experimental design to evaluate a low-resource, low intensity intervention aimed at preventing dating violence among college students in the US. The intervention consists of a 30-minute presentation on dating violence at new student orientation as well as a social marketing campaign, the Red Flag Campaign (RFC) which lasts one week. Results show an increase in bystander behaviours before and after implementation in the intervention group, however, no significant changes were found for bystander intentions, self-efficacy, social norms or attitudes related to dating violence from pre to post intervention. Results suggest that low resource interventions have a modest effect on increasing bystander behaviours, however higher resources are probably needed for a larger impact. Carlyle et al. (2020) also evaluated the Red Flag Campaign (RFC), a state-wide public awareness campaign to promote the prevention of SV/DV in college campuses in the US. Informed by the bystander approach, the RFC employs a variety of techniques to engage campus community members and empower them to say something when they see warning signs or 'red flags' for SV/DV. This evaluation tested the hypothesis that college students who are exposed to the RFC will report a greater likelihood of, and efficacy toward, intervening as a bystander as compared to those who are not exposed to the RFC. Data were collected using an online survey and found that college students who had been exposed to the RFC reported greater efficacy for intervening as a bystander compared to those students who had not been exposed. This evaluation offers preliminary evidence that the RFC is effective at increasing determinants of prosocial bystander behaviour, the enactment of which could reduce SV/DV on college campuses.

Coker et al. (2019) undertook a rigorous cluster-randomised controlled trial to evaluate the effectiveness of Green Dot presentations and bystander trainings at both school and individual levels in the US. The purpose of Green Dot is to change violence acceptance of trained students and to engage students as potential bystanders to safely and effectively act to reduce the risk of interpersonal violence within their social network or community. Through Green Dot bystander training, male and female students are taught to recognise situations and behaviours that could lead to violence or abuse. The primary outcomes were sexual violence perpetration and victimisation, and secondary or intermediate outcomes were intervention-associated changes in a violence acceptance and bystander behaviours. This RCT finds evidence that the Green Dot works as hypothesised and as implemented, to reduce acceptance of dating violence and sexual violence at the school and individual levels.

Green Dot

Through bystander training the Green Dot programme engages witnesses to interrupt situations that are imminently or potentially high risk for violence, increases self-efficacy and provides skill building and specific strategies to increase the likelihood that trained individuals will intervene. Green Dot attempts to change violence acceptance of trained students and to engage students as potential bystanders to act safely and effectively to reduce the risk of interpersonal violence within their social network or community. Through training, students are taught to recognise situations and behaviours that could lead to violence or abuse. Programmes are tailored for a range of ages from Kindergarten, through high school and college and into the community.

Figure 9: *Green Dot*

Edwards et al. (2019) evaluated the effectiveness of a seven session, bystander focused classroom delivered curriculum, Bringing in the Bystander – High School Curriculum (BITB-HSC) in reducing rates of interpersonal violence among high school students in the US. The primary outcomes were reducing interpersonal violence perpetration and victimisation and intermediate outcomes included bystander readiness and rape myth acceptance. This study found evidence that the BITB-HSC may reduce some forms of interpersonal violence, specifically stalking and

sexual harassment. Percent reductions for sexual and dating violence were larger among youth in the BITB-HSC than other conditions. Thus, the intervention was more effective for sexual harassment and stalking. These behaviours may be easier to change than sexual assault and dating violence. Overall, the findings were mixed, the BITB-HSC led to some long-term changes (e.g., increases in media literacy, reductions in bystander denial), but other positive outcomes were only short-lived (e.g., decreases in rape myths, increases in victim empathy). Overall, the BITB-HSC had little long-term impact on actual bystander behaviour, there were reductions in some forms of violence among students in the BITB-HSC condition relative to the control condition.

Fenton and Mott, (2019) evaluated The Intervention Initiative (TII), which is a facilitated bystander intervention education programme commissioned by Public Health England for use in English universities to prevent violence, abuse and coercion. The programme was evaluated through course evaluation feedback and in a questionnaire study. The programme significantly decreased participants' rape and domestic abuse myth acceptance, and significantly increased their bystander efficacy and readiness and intent to help. All significant results also showed effect sizes indicating meaningful change with the highest effect sizes for myth acceptance and readiness to help, followed by efficacy and finally, intent to help. The findings were that prosocial bystander behaviour did not increase significantly immediately after taking part in the programme. Rape myth acceptance, domestic abuse myth acceptance and denial decreased significantly and intent to help increased significantly. Exposure to a concurrent social marketing campaign on campus had a significant strengthening effect on improvement of attitudes to rape myths but not any other outcomes.

Gainsbury et al. (2020) evaluated the feasibility and potential for effectiveness of a domestic violence and abuse bystander intervention within UK communities. Active Bystander Communities (ABC) is structurally and theoretically like The Intervention Initiative (TII) with participants attending a three-session programme facilitated by experts. Myth acceptance, bystander efficacy, behavioural intent and bystander behaviours were assessed using validated scales at baseline, post intervention and four months follow up. Significant change was observed in the desired direction across myth acceptance, bystander efficacy, behavioural intent. Significance was maintained at four months with the exception of myth acceptance. Findings are promising and indicate the translatability of the bystander approach to domestic violence and abuse prevention as well as community contexts in the UK.

Active Bystander Communities (ABC)

Active Bystander Communities (ABC) is a domestic abuse primary prevention programme, co-produced by academics and public health and domestic abuse practitioners designed for communities in the UK. The purpose is to engage those outside the victim/perpetrator relationship in violence prevention. ABC is a six hour intervention delivered over three weekly sessions. Session one and two correspond with the first three stages for intervention (noticing to responsibility) and session three corresponds with the skills training in stage four (I have the skills to do something). A variety of methods are used including presentation, media, active learning exercises, group work and role play vignettes.

Figure 10: *Active Bystander Communities*

McMahon and Seabrook. (2019) investigated the impact of receiving varied prevention messages throughout adolescence and into early adulthood to determine whether it influences college students' awareness of sexual violence, willingness to intervene as a helpful bystander, and actual prosocial bystander behaviour. The findings from this study are consistent with the "dose–response" model, suggesting that greater exposure to information and messages about sexual violence is associated with a greater willingness to intervene as a prosocial bystander as well as greater actual prosocial bystander behaviour in college. An important finding was that the addition of exposure to information prior to coming to the university was related to greater willingness to intervene and actual bystander behaviour even after accounting for information about sexual violence that is delivered from the university.

Marketing

One primary study focussed on the use of a sexual violence prevention marketing campaign (Mennicke et al., 2018).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Mennicke 2018	Primary Study	SV	Marketing Campaign	University (US)	Male Students	Promising

Table 14: *Interventions: Marketing*

Mennicke et al. (2018) evaluates the effectiveness of a five-year social norms sexual violence prevention marketing campaign designed specifically for men at a large university in the US. In a cross-sectional survey design, data about self-reported and perception of peers' attitudes, beliefs, and behaviours were collected from male students for five years. Each year the social norms marketing campaign focused on four overarching themes: consent, bystander, rape myths, and sexual activity. Results suggest that the social norms marketing campaign intervention was successful. Over five years of data collection, men's perception of their peer's attitudes and beliefs improved, the discrepancy between perceptions and self-report decreased, and their own beliefs (more so than attitudes) improved. In addition to gains on measures of both self-reported beliefs and perception of peer attitudes and beliefs, men's self-reported behaviour also improved throughout the course of the intervention. Men reported sexually aggressive behaviour less frequently during later years of the intervention and indicated that they engaged in bystander intervention behaviour more frequently. Results from this research suggests that social norms marketing campaigns can be used to positively engage men in violence prevention.

Education and Screening within Health Care Settings

It is recognised that health professionals are ideally placed to identify VAWDASV through screening and well placed to provide advice and support and to signpost patients to further resources. Routine screening of people without signs or symptoms of abuse could identify abuse not otherwise disclosed, providing opportunities for interventions that may reduce future abuse as well as short and long-term adverse health consequences (Feltner et al., 2018). Screening is defined as any of a range of methods (face to face, written or computerised survey) involving specific inquiry about VAWDASV that aimed for all women patients in a healthcare setting to be asked about their experience of such violence.

Five reviews focus on prevention of VAWDASV in various healthcare settings. One focussed on the primary care setting (Bair-Merritt et al., 2014), one on the emergency department setting (Ansari and Boyle, 2017). Two reviews looked at a range of healthcare settings (O'Doherty et al., 2014, Feltner et al., 2018) while the fifth study looked at allied health professionals (Sawyer et al., 2016).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Bair-Merritt 2014	Review	IPV	Education (Health Professionals	Healthcare (Primary Care)	Adults	Promising
Ansari 2017	Review	DVA	Education (Health Professionals	Healthcare (Emergency Departments)	Adults	Limited
O'Doherty 2014	Review	IPV	Education (Health Care Professionals)	Health care	Women	Mixed (some promising)
Feltner 2018	Review	IPV	Range of Interventions	Range of settings	Range of Ages	Limited
Sawyer 2016	Review	IPV	Education (Allied Health Care Professionals)	Health care	Adults	Promising

Table 15: *Interventions: Healthcare Settings (Reviews)*

Bair-Merritt et al., (2014) undertook a systematic review which summarised primary care based interventions for patients experiencing IPV. Eligible studies included articles that assessed patient-level impact of IPV interventions that originated from patients' visits to a primary care provider. The focus of the interventions was on empowerment, empathetic listening, discussion of the cycle of violence and safety and referral to community-based resources within the primary care setting. Studies investigated a variety of outcomes, including reduction in IPV, improvement in physical and emotional health, safety-promoting behaviours, and use of IPV and community-based resources/referrals. Included studies were global but the majority were based in the US. Eleven studies used randomized designs, two used pre– post- test designs, two were prospective cohorts with a nonrandomized control group, and two were descriptive studies. This review found of the 17 studies reviewed, 13 demonstrated at least one intervention-related benefit. Six of 11 articles measuring IPV persistence found reductions in future violence; two of five measuring safety-promoting behaviours found increases; and six of 10 measuring IPV/community resource referrals found enhanced use. Some studies also documented health improvements. Most studies demonstrated patient-level benefit subsequent to primary care IPV interventions, with IPV/community referrals the most common positively affected outcome.

Ansari and Boyle (2017) examined interventional studies to evaluate the effectiveness of emergency department (ED) based interventions in reducing domestic abuse-related morbidity. Nine studies were eligible for review, of which four focused on the effects of ED staff training interventions alone. The reviewed studies were based in USA (4), New Zealand (3), Australia (1) and UK (1). This review found that interventions involving training of healthcare providers demonstrated benefits in subjective measures such as staff knowledge regarding abuse. However, small improvements were seen in clinical practice based on detection and referral rates. Where staff training was implemented in conjunction with supporting system changes, for example standardized documentation for assessment and referral, clinical improvements were noted. They conclude that emergency department-based interventions centred on staff training are insufficient to bring about improvements in the management and thus, outcome of patients suffering abuse. Instead, system changes, such as standardized documentation and referral pathways, supported by training may bring about beneficial changes. The main findings from this review suggest that one-off instructional training in isolation, despite improvements in staff awareness, has a limited impact on clinical practice and where improvements are noted they are not sustained in the long-term.

O'Doherty et al., (2014) examined the effectiveness of screening for intimate partner violence conducted within healthcare settings to determine whether or not screening increases identification and referral to support agencies, improves women's wellbeing, decreases further violence, or causes harm. Included studies were randomised or quasi-randomised trials of screening programme for intimate partner violence involving all women aged ≥16 attending a healthcare setting. It was hypothesised that screening can, as a first step, lead to improved identification, information giving, and referral to support services (primary outcomes), which in turn might lead to a reduction in abuse and an improvement in health and wellbeing (secondary outcomes) in the longer term. This review assessed the results of 11 eligible trials. In six pooled studies screening increased the identification of intimate partner violence, particularly in antenatal settings. Based on three studies, no evidence that screening increases referrals to domestic violence support services was detected. Only two studies measured women's experience of violence after screening (three to 18 months after screening) and found no reduction in intimate partner violence. One study reported that screening does not cause harm. Further, this review found little evidence that screening increases referrals to support services. Furthermore, though not meta-analysed, the trials did not find an impact of screening on improved outcomes for women. Only two studies measured the impact of screening on re-exposure to intimate partner violence and did not find that screening alone reduces abuse. Thus, weighing up the limited evidence of benefit beyond identification and the fact that most studies do not measure the risks of screening, O'Doherty et al. (2014) maintains that the current evidence does not support screening programmes for intimate partner violence in healthcare settings.

Feltner et al., (2018) reviewed the evidence on screening and interventions for IPV, the abuse of older people, and abuse of vulnerable adults. Included studies were randomised clinical trials, studies evaluating test accuracy and cohort studies with a concurrent control group assessing harms. Outcomes measures included abuse or neglect, morbidity caused by abuse, test accuracy and harms. This review found three RCTs compared IPV screening with no screening and none found significant improvements in outcomes. Nine studies assessed tools to detect any past-year or current IPV in women. For past-year IPV, in five studies, sensitivity of 5 tools ranged from 65% to 87% and specificity ranged from 80% to 95%. For detecting current abuse, the accuracy of 5 tools varied widely and sensitivity ranged from 46% to 94% and specificity ranged from 38% to 95%. Eleven RCTs evaluated interventions for women with screen detected IPV, two enrolling pregnant women found significantly less IPV among women in the intervention group. Although available screening tools may reasonably identify women experiencing IPV, trials of IPV screening in adult women did not show a reduction in IPV or improvement in quality of life over three to 18 months. Limited evidence suggested that home visiting and behavioural counselling interventions that address multiple risk factors may lead to reduced IPV among pregnant or postpartum women. No studies assessed screening or treatment for elder abuse and abuse of vulnerable adults.

Finally, Sawyer et al., (2016) undertook a review which examined the effects of IPV educational interventions on the knowledge, attitudes, skills and behaviours of allied health care practitioners (AHCPs) such as nurses, dentists, social workers and paramedics. The majority of studies used a single-sample pre and post-test design; there were two non-randomised two-group and two randomised controlled trials. Most studies were conducted in the USA with others in Turkey, UK, Australia, Canada and Sri Lanka. Findings suggest that IPV educational interventions delivered to allied health care practitioners (AHCPs) are associated with improvements in some aspects of knowledge, attitudes, skills, and behaviours (KASB). However, results were inconsistent, and the limitations of the studies included mean that no firm conclusions can be drawn. Nonetheless, the included studies demonstrate a positive association between educational interventions and improved KASB in AHCPs, which is supported by other reviews. The review concludes that there is a clear need to generate further high-quality research on educational effectiveness before any firm conclusions can be made.

Two primary studies focussed on interventions in health care settings; one within a paediatric spina bifida clinic (Levin-Decanini et al., 2019) and one study which evaluated a home visiting programme (Jack et al., 2019).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Levin-Decanini 2019	Primary Study	IPV	Education (Patients)	Health Care Clinic (US)	Adolescents	Promising
Jack 2019	Primary Study	IPV	Healthcare/ Home visiting	Community (US)	Pregnant low-income women	No effect

Table 16: *Interventions: Healthcare Settings (Primary Studies)*

One primary study evaluated the feasibility of implementing a brief educational training programme based on an evidence based IPV intervention in a paediatric spina bifida clinic (Levin-Decanini et al., 2019). Frequency of IPV discussion was assessed through evaluation of patient feedback and provider surveys. Primary outcomes included frequency of provider discussion about IPV and receipt of patient safety cards. Chi-square tests compared patient feedback prior to and two months following the education session. Provider knowledge and attitude changes were assessed with pre-post surveys. The adapted IPV intervention increased discussion between providers and patients about relationships and IPV. In addition, providers noted increased comfort with the subject matter, how to respond to disclosure, and referring individuals to partner organisations.

Jack et al. (2019) evaluated the effect on maternal quality of life of a nurse home visitation programme augmented by an IPV intervention, compared with the nurse home visitation programme alone. This was a cluster-based single blind randomized clinical trial in eight US states with socially disadvantaged pregnant women. Nurses received intensive IPV education and delivered an IPV intervention that included a clinical pathway to guide assessment and tailor care focused on safety planning, violence awareness, self-efficacy and referral to social supports. In this trial, augmenting a nurse home visitation programme with a complex, multicomponent IPV intervention did not lead to additional benefits in the primary outcome or any of the secondary outcomes. Among pregnant women experiencing social and economic disadvantage and preparing to parent for the first time, augmentation of a nurse home visitation programme with a comprehensive IPV intervention, compared with the home visitation programme alone, did not significantly improve quality of life at 24 months after delivery. The author concludes that the findings do not support the use of this intervention.

Web and ICT Based Interventions

It is recognised that a barrier to IPV prevention can be related to the mode of delivery which can reduce the likelihood of uptake or impact. Common barriers for victims wishing to inititate services include a lack of knoweldge of community resources and fears about privacy (Anderson et al., 2019). Connection to the Internet provides immediate and confidential access to both local and Internet community resources, increases privacy and anonymity, and connects providers to patients via various telehealth or mHealth mechanisms. Mobile health (mHealth) technologies (defined as Internet or technology mediated approaches to provision of health resources or interventions) are increasingly used across health programmes including intimate partner violence prevention to optimize screening, educational outreach, and linkages to care via telehealth.

Three reviews considered the use of technology (ICT or mobile phone) to prevent IPV (Anderson et al., 2019, El Morr and Layal, 2019, El Morr and Layal, 2020).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Anderson 2019	Review	IPV	Web based or mobile	Healthcare Settings	Adults	Promising
El Morr 2019	Review	IPV	ICT	Healthcare Settings	Adults	Promising
El Morr 2020	Review	IPV	ICT	Healthcare Settings	Adults	Promising

Table 17: *Interventions: ICT in Healthcare settings*

Anderson et al., (2019) evaluated web-based and mobile health (mHealth) interventions which includes web or mobile based delivery methods for primary, secondary and tertiary IPV victim prevention. This review identified studies that used mHealth to screen, assess risk, deliver support or education, or facilitate psychotherapy. Computer based screening with or without integrated education was the most common mHealth approach, followed by safety decision aids. The purpose of the review was to identify and critically evaluate what, if any, benefits exist for participants. For inclusion, studies needed to consider empirical data, participants in adult romantic relationships, IPV as a primary or secondary outcome and an mHealth component. Of the 31 studies included, three used primary prevention approaches, 18 secondary and 10 tertiary; 21 studies were RCTs or RCT protocols, three quantitive non randomised, five quantitative descriptive, one qualitative and three mixed methods. The majority of studies (23) were undertaken in the US. This review found that web-based approaches to IPV prevention have the capacity to reduce risk and studies demonstrate effective web-mediated access to telehealth services such as CBT, online support groups for victims, and changing behaviour expectations through educational programming.

In El Morr and Layal (2019) the focus was to summarize studies in different settings that used Information and Communication Technologies (ICT) to address IPV. Twenty-one studies were identified in which ICT was found to be a suitable low-cost option for screening and disclosure of IPV, as well as for preventing IPV. This review found IPV screening equally effective using ICT or face to-face/paper method with high disclosure of IPV using computers. ICT was found suitable, in terms of confidentially, usefulness, and satisfaction in three studies however, in one study, some participants expressed scepticism about the ability of ICT-based interventions to empathize, retain privacy, provide support, and deliver meaningful feedback. In terms of IPV prevention, one study showed that most participating women were less likely to report experiencing physical IPV at follow-up (12 months), less likely to report IPV with injury and less likely to report severe sexual IPV.

El Morr and Layal (2020) reviewed evidence on ICT-based interventions which address IPV, evaluating the effectiveness, acceptability, and suitability of ICT for addressing awareness, screening and prevention. The study objectives were to examine whether ICT could become acceptable for effective IPV interventions. Studies were included if they described an intervention that used some form of ICT, and if the recipients were women who experienced intimate partner violence or domestic violence. The 25 studies included 16 RCTs, four pre-post designs, two cross-sectional studies, two prospective studies, and one diagnostic case-control study. ICT was used for screening and disclosure (13 studies); IPV prevention (5 studies); to address mental health (4 studies) and to provide support for decision aid (2 studies). Only one study assessed the suitability of ICT for use in an IPV context. Most studies were in the US (20), with three in Canada and two elsewhere. This review suggests that ICT-based interventions have the potential to be effective in spreading awareness

about and screening for IPV. ICT use shows promise for reducing decisional conflict, improving knowledge and risk assessments, and motivating women to disclose, discuss, and leave their abusive relationships. However, there is lack of homogeneity among the studies' outcome measurements, and the sample sizes, the control groups used (if any), the type of interventions and the study recruitment space. The use of ICT-based interventions seems to be an attractive option for disseminating awareness and prevention information, due to the wide availability of ICT (including simple mobile phones) in both high-income and low- and middle-income countries. ICT may also present an opportunity to deliver culturally sensitive multilingual interventions using consumer health informatics.

Education within Workplace Settings

One review, Adhia et al. (2019) undertook a systematic review to summarise existing studies evaluating workplace interventions for IPV prevention.

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Adhia 2019	Review	IPV	Education (co-workers)	Workplace (US)	Adults	Promising

Table 18: *Interventions: Workplace*

The review included six studies evaluating five interventions, one of which used a randomised design and two studies measured whether outcomes were sustained over time. The interventions focussed on recognising signs of abuse, responding to victims, and providing referrals to community-based resources. Five of the studies were from the US and one from India. The themes of the interventions included recognising signs of abuse, responding to victims and providing victims with resources. Findings included improved awareness of IPV, increased provision of information to victims, and greater willingness to intervene if an employee may be experiencing IPV. The studies investigated a variety of outcomes, including improvement in knowledge, willingness to intervene, and likelihood of providing information or resources. Nearly every study reported a significant increase in at least one outcome. This systematic review indicates that there may be benefits to workplace interventions for IPV in terms of increased knowledge and provision of information and resources, but strong evidence of effective information is limited.

Night-time Economy

One review (Quigg et al., 2020) and one primary study (Quigg and Bigland, 2020) focussed on interventions within nightlife settings.

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Quigg 2020	Review	SV	Education (workers in the night time economy)	Night-time economy		Mixed
Quigg & Bigland 2020	Primary Study	SV	Education/awareness/ bystander (The Good Night Out campaign)	Night-time economy (UK)	NTE Workers	Promising

Table 19: *Interventions: Night-time Economy*

Quigg et al. (2020) focussed on nightlife related sexual violence. Nineteen studies focussed on prevention and response to nightlife-related sexual violence but only two studies evaluated the impact of prevention and response approaches designed to target nightlife-related sexual violence directly. All were in high income countries. Five articles highlighted ways in which individuals (primarily women) may monitor or alter their behaviours to reduce their level of vulnerability when frequenting nightlife settings. Five articles explored bystander opportunities or approaches to preventing and responding to sexual violence. Other studies in this review explored awareness raising/media campaigns and the role of alcohol legislation/policies, finding that the sexualised nature of nightlife settings, including alcohol advertisements, conflicts with sexual violence prevention activity and limiting effective communication of prevention messages (Gunby et al., 2017 cited in Quigg et al., 2020). This review concludes that preventing sexual violence should form part of a suite of programmes that aim to prevent harms in nightlife settings more broadly, including those to reduce excessive alcohol consumption, modify the drinking environment to make it safer, and the implementation of laws to ensure inappropriate sexual behaviour specific to sexual violence is both discouraged and addressed. Further, programmes are needed that aim to promote gender equality and address norms that promote sexual violence at a societal level.

Quigg and Bigland (2020) evaluated The Good Night Out Campaign (GNOC), a UK programme developed for licenced premises which aims to support those who work in nightlife settings to better understand, respond to and prevent sexual violence. GNOC facilitators worked with 11 nightlife venues to engage them in the GNOC, providing guidance on preventing and responding to sexual violence, training for over 150 nightlife workers, and materials to display in venues to raise awareness of the GNOC and encourage nightlife patrons to report incidents. Data were collected by a survey of trainees and findings suggest that the GNOC training programme is associated with improvements in knowledge; improved attitudes towards sexual violence; and, greater readiness and confidence to intervene in sexual violence, amongst nightlife workers.

The Good Night Out Campaign

Good Night Out Campaign began in 2014, initially in London. The programme helps licensed spaces to upskill their teams and deliver specialist interactive workshops to bar staff, managers, and security. The Campaign also work with Local Authorities to develop sexual violence prevention and response campaigns and partner frontline support services. The core training session is 2.5 hours long, for up to 20 participants (currently delivered by zoom) – Understanding and Responding to Sexual Harassment and Assault in Licensed Premises. The training session covers a range of topics to promote sexual violence prevention.

Figure 11: *The Good Night Out Campaign*

Multi Agency Approaches

The review by Cleaver et al., (2019) aims to identify existing good practice in multi-agency, early intervention approaches to domestic abuse in the UK.

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Cleaver 2019	Review	DVA	Multi-agency	Range	Range	Mixed

Table 20: *Interventions: Multi Agency Approaches*

In relation to primary prevention, this review includes school-based interventions; these projects employed different approaches including drama, the development of a teaching package and delivery of teaching sessions developed as part of schools' personal, social and health education (PSHE) curriculum. Evidence supports the suggestion that intervention programmes designed with the involvement of children and teachers are more successful (Stanley et al, 2015; Hale et al, 2012). However, there is little evidence-based guidance available to help schools determine what works best and for whom. In terms of secondary prevention, this review identified a range of initiatives and found that multi-agency working provided both benefits and challenges for the early identification and prevention of domestic abuse. Programmes included information sharing; routine enquiry by health professionals; routine enquiry and co-location of services; partnership projects and advocacy. Multiple partnerships were shown to be effective in building a coordinated community response to domestic abuse, the most significant element of which was the comprehensive early intervention outreach/advocacy service. This service incorporated a wide range of community-based and women-centred interventions, as did other advocacy interventions that tended to adopt a more holistic approach. Overall, interventions that adopt an advocacy approach appear to have more impact and are more sustainable, and, that when co-located with statutory or voluntary services, multi-agency working is enhanced.

Societal

Alcohol Policy

Alcohol use is widely identified as a risk factor for sexual violence perpetration and numerous studies have found a direct association between alcohol use and sexual violence perpetration with roughly half of all sexual assaults involving the consumption of alcohol by the perpetrator, victim or both. The literature suggests that between 34% and 74% of sexual violence perpetrators used alcohol at the time of assault, and men who drank 'heavily' on their last date were more likely to report committing sexual assault on that date than men who did not (Abbey et al cited in Lippy and DeGue, 2016). As a result, alcohol policy has the potential to impact sexual violence perpetration through the direct effects of excessive alcohol consumption on behaviour or through the impact of alcohol and alcohol outlets on social organisation within communities (Lippy and DeGue, 2016). An ecological framework for violence prevention suggests alcohol interventions relevant to alcohol related IPV can occur at the community level and the population level, as well as at the individual/relationship level (Wilson et al., 2014).

Two studies reviewed alcohol policy as a means of preventing sexual violence (Lippy and DeGue, 2016, Wilson et al., 2014).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Lippy 2016	Review	SVA	Alcohol Policy	Range of Settings	Range	Promising
Wilson 2014	Review	IPV	Alcohol Policy	Range	Adults	Limited

Table 21: *Interventions: Alcohol Policy*

Lippy and DeGue (2016) reviewed alcohol policy affecting alcohol pricing, sale time, outlet density, drinking environment, marketing, and college environment to identify existing evidence of impact on rates of sexual violence or related outcomes, including risk factors and related health behaviours. The review included primary empirical research, systematic reviews, and meta-analyses from the peer-reviewed literature as well as reports by governmental and nongovernmental agencies. This review found that despite the breadth of alcohol policy research available, there is limited direct evidence of the impact of these policies on sexual violence outcomes. Therefore, the current review considered not only evidence on sexual violence outcomes but also evidence of the impact on related outcomes and potential mediators of sexual violence. Research suggests that policies which increase alcohol prices through taxation may have beneficial effects on the rates of sexual violence perpetration. Higher prices are also associated with lower rates of alcohol consumption, general violence and crime, and related health outcomes (e.g., STIs, risky sexual behaviour) at the population level. However, the effects of pricing policies vary by the size of the price increase, the type of beverage, and differences in price elasticities, that is, the extent to which changes in alcohol price correlate with changes in demand and consumption of alcohol. Overall, the evidence in this area supports a consistent link between policies that increase price through taxation or prevent large decreases in price through drink promotions and relevant health outcomes, including sexual violence perpetration.

Wilson et al. (2014) examined interventions to reduce alcohol use at the individual, relationship, community and/or population level. Included studies investigated whether an intervention or policy to reduce alcohol consumption was directly or indirectly associated with a change in any form of IPV as a primary or secondary outcome. Studies included randomized controlled trials, longitudinal studies that measured IPV over multiple time points before and after the intervention, included multiple replications or used an interrupted time series design; all the included studies were conducted in the USA. This review found that the small literature available suggested little or weak evidence of an effect of alcohol pricing on IPV, possibly hampered by most studies evaluating very small changes in taxation over time and using a measure of IPV that included both alcohol related IPV and IPV that was not related to alcohol. While all the reviewed studies were based on the theoretical assumption that changes in price influence consumption, only one study included alcohol consumption measures in their design, and it failed to find a strong enough link to demonstrate that alcohol tax changes can reduce violence against women, with this effect mediated through a reduction in alcohol consumption. Studies of community-level policies or interventions (e.g., hours of sale, alcohol outlet density) showed weak evidence of an association with IPV. Couples-based and individual alcohol treatment studies found a relationship between reductions in alcohol consumption and reductions in IPV but their designs precluded attributing changes to treatment. Randomized controlled trials of combined alcohol and violence treatment programme found some positive effects of brief alcohol intervention as an adjunct to batterer treatment for hazardous drinking IPV perpetrators, and of brief interventions with non-dependent younger populations, but effects were often not sustained (Wilson et al., 2014).

Legislative Reform

Two studies already outlined reference the impact of legislation on IPV (Ellsberg et al., 2015, DeGue et al., 2014). Ellsberg et al., (2015) notes that according to the US Bureau of Justice, the rate of IPV in the USA fell by 53% between 1993 and 2008 and the number of intimate partner homicides of women decreased by 26%. Many experts attribute this decline to the Violence against Women Act (VAWA), first authorised by Congress in 1994, which provides funding for many programmes. The Act originally authorised US$1·6 billion in funding in 5 years and has been reauthorised three more times since then. A study of more than 10,000 jurisdictions between 1996 and 2002 showed that jurisdictions that received VAWA grants had significant reductions in the numbers of sexual and aggravated assaults compared with

jurisdictions that did not received VAWA grants. De Gue et al., (2014) notes that the U.S. Violence Against Women Act of 1994 (VAWA) aimed to increase the prosecution and penalties associated with sexual assault, stalking, intimate partner violence and other forms of violence against women, as well as to fund research, education and awareness programme, prevention activities, and victim services. Results of a rigorous, controlled quasi-experimental evaluation suggest that VAWA-related grant funding through the U.S. Department of Justice for criminal justice-related activities was associated with a .066% annual reduction in rapes reported to the police, as well as reductions in aggravated assault.

Preventing VAWDASV – Range of Interventions

Two reviews included a wide range of interventions focussed on a wide range of violence (Arango et al., 2014, DeGue et al., 2014).

Author/ Year	Study Type	Violence Type	Intervention Type	Setting	Population	Evidence
Arango 2014	Review	GBV	Range of Interventions	Range of Settings	Range	Mixed
DeGue 2014	Review	GBV	Range of Interventions	Range of Settings	Range	Strong

Table 22: *Interventions – Range*

Arango et al., (2014) presents a review of reviews of evidence on reducing the victimisation or perpetration of a range of types of Violence against Women and Girls (VAWG). Also, where available, this paper reviews findings on impacts of interventions on changing norms and attitudes that underlie VAWG. Eligible interventions included empirical results from two or more impact evaluations, experimental designs, or quasi-experimental designs with well-defined comparison groups. Most of the evaluations identified (70%) were conducted in seven high-income countries comprising 6% of the world's population (Australia, Canada, Denmark, Hong Kong, New Zealand, the United Kingdom and the United States). This review finds that, in relation to primary prevention of IPV in high income countries only four evaluations with positive findings were identified. These included the Hawaii Health Start Programme and a reproductive coercion evaluation in California. The other two evaluations assessed group training programmes on 'Healthy Relationships' to reduce dating violence among adolescents in Canada (also detailed in Ellsberg et al., (2015). Both programmes, one conducted with male and female high school students, and the other, a community-based intervention with male and female at risk youth, found significant reductions in perpetration of dating violence in the intervention arm compared to the control groups. This review also found that home visiting programme have the potential to reduce IPV, however, three comprehensive reviews assessed the effectiveness of perinatal and maternal and child health (MCH) home visitations and found limited evidence supporting the use of this type of intervention to prevent or reduce IPV.

Evaluations of screening programmes have found statistically significant positive results for identifying survivors of IPV, and recurrent screening throughout the pregnancy has further increased identification rates, however, there is no evidence that screening alone increased referrals to support agencies. The few screening evaluations that reported decreases in violence usually combined screening with psychosocial support or another type of survivor service. Other frequently studied interventions are "women-centred" programmes that target known survivors or women newly identified through screening. These interventions use a combination of strategies, including survivor advocacy and

psychosocial support to provide women with resources to reduce their future risk of violence, as well as to improve their health status. Basic psychosocial counselling may include providing danger assessments, safety planning, and referrals to specialized services. Providing screening alone has not been found to decrease IPV, although several of the screening evaluations report positive outcomes for both women and their children, such as decreased depression, lower stress, and greater knowledge and use of services (Arango et al., 2014). Reviews of sexual assault prevention programme, particularly among North American university-level students, were the most numerous. While numerous impact evaluations found significant average effect sizes for improving rape-related knowledge and attitudes, only two impact evaluations reported positive findings of decreased non-partner sexual assault.

Interventions Group training for women: Of 17 included intervention evaluations, only two reported significantly positive results in reducing non-partner sexual assault. They were both conducted in the United States among female students and consisted of university-based sexual assault prevention programme. It is not clear to what extent these programmes could be meaningfully applied to other settings or populations. Lessons highlighted in reviews of these interventions are that longer interventions are more likely to yield positive results than brief interventions, as are risk reducing versus empathy focused programmes. The same review also highlighted the scarcity of evaluations focusing on culturally and racially focused sexual assault education programme (Anderson & Whiston, 2005) cited in (Arango et al., 2014).

De Gue et al., (2014) undertook a systematic review which examined outcome evaluations of primary prevention strategies for sexual violence perpetration. Only studies that compared one intervention condition to a no-treatment or waitlist control group (i.e., experimental, and quasi experimental designs) or that utilized a single-group pre–post design were included in this review, as the goal was to ascertain changes or differences in the outcomes following exposure to a specific treatment programme. This review finds that most sexual violence prevention strategies in the evaluation literature are brief, psycho-educational programmes focused on increasing knowledge or changing attitudes, none of which have shown evidence of effectiveness on sexually violent behaviour using a rigorous evaluation design. Further, only three primary prevention strategies demonstrated significant effects on sexually violent behaviour in a rigorous outcome evaluation: Safe Dates; Shifting Boundaries and funding associated with the 1994 U.S. Violence Against Women Act (VAWA) (included in Section 12).

The best available evidence suggests that these strategies, if well-implemented with an appropriate population, may be effective in preventing sexually violent behaviour. Safe Dates is a universal dating violence prevention programme for middle- and high-school students, results from one rigorous evaluation using an RCT design showed that four years after receiving the programme, students in the intervention group were significantly less likely to be victims or perpetrators of self-reported sexual violence involving a dating partner relative to students in the control group. Shifting Boundaries is a universal, school-based dating violence prevention programme for middle school students, results from one rigorous evaluation indicated that the building-level intervention, but not the curriculum alone, was effective in reducing self-reported perpetration and victimization of sexual harassment and peer sexual violence, as well as sexual violence victimization (but not perpetration) by a dating partner.

Section

5

Discussion

Section 5: Discussion

In Wales, a key objective in the National VAWDASV Strategy is to make early intervention and prevention a priority, in recognition that intervening early is vital to stop violence from escalating and reduce harm to victims and children (Welsh Government, 2016). Further, it is noted that identifying and providing an appropriate response to VAWDASV, at the earliest opportunity to minimise impact and harm is critical to achieving prevention and protection. The purpose of this review is to identify effective practice for the prevention of VAWDASV with the intention that the evidence identified is used to inform the adoption of evidence based practice through the refresh of the national VAWDASV strategy in Wales in 2021.
The focus of this systematic evidence review was to address the research question, What Works to Prevent VAWDASV? The review was undertaken in two stages, a systematic evidence assessment of reviews of interventions designed to prevent VAWDASV and a supplementary search to identify primary studies, published more recently and to encompass topics where the evidence base may be too limited to be the subject of a systematic review. Reviews (n=35) and primary studies (n=16) focussing on a range of types of violence and types of intervention were identified.

Using a socio-ecological model as a framework, this section provides a summary of the key findings, in order to address the question what works to prevent VAWDASV? The section then outlines implications for policy and practice and explores the impact of COVID-19, then considers the strengths and limitations of the review and finally highlights areas where there is a need for further research. The findings are also presented in a summary table in Appendix 1 with interventions categorised according to level of evidence.

What Works to Prevent VAWDASV?

The findings indicate that there is a wealth of literature in terms of the prevention of VAWDASV, including several high-quality studies undertaken recently. The number of studies acknowledges the necessity of prioritising the prevention of VAWDASV and demonstrates the feasibility of research in this field as well as the interest from researchers and funding bodies. In addition to the prevention of the perpetration and victimisation of VAWDASV, the included studies incorporate a range of outcomes in recognition that measuring changes in violence is challenging, especially over the short time periods of most projects. As a result, many studies assess attitudinal and behaviour change as outcomes, as part of a broader theory of a change.

Individual Level

Overall, the findings for gender transformative approaches were strong with some presenting promising evidence of change. One intervention, 'Real Consent', showed statistically significant increases in terms of gender equitable attitudes as well as documenting a significant decrease in reported IPV over time (Casey et al., 2018, Graham et al., 2019). Another promising intervention, Coaching Boys into Men had significant effects on DV perpetration at 12 months follow up (Graham et al., 2019).

One primary study focussed on empowerment of girls found promising evidence in terms of improvements in awareness raising, recognising inappropriate behaviour, and learning ways to keep yourself and friends safe (Jordan and Mossman, 2018). Another reported a reduction in the incidence of dating abuse victimisation and self-reported sexually explicit behaviour as a result of survivor empowerment training, advocacy and prevention solutions to combat CSE (Rothman et al., 2019).

In relation to the prevention of FGM, common themes that appeared to underlie successful approaches included recognition of FGM as gender-based violence, providing clear preventive roles for frontline professionals, clear protection and prosecution approaches, and participation of affected communities (Baillot et al., 2018). It was also acknowledged that there is a dearth of evaluative research focused on preventative activities that involved women and girls who are affected by FGM.

Relationship Level

Three interventions, Safe Dates, Fourth R and Shifting Boundaries were found to have positive intervention effects suggesting that comprehensive IPV prevention (including adolescent dating violence) interventions in both school and the community are effective in preventing IPV perpetration and victimisation among adolescents (De Koker et al., 2014, Lundgren and Amin, 2015). These finding are echoed in a further review programmes for middle school boys, such as The Reducing Sexism and Violence Programme which found that students in the intervention group of the Safe Dates study were less likely to be victims or perpetrators of self-reported sexual violence and Shifting Boundaries was effective in reducing self-reported perpetration and victimisation (DeGue et al., 2014).

Community Level

Reviews of interventions undertaken in the school setting also highlighted the Fourth R programme as resulting in a decrease in the perpetration of physical dating violence (Woolfe et al. 2009 cited in Stanley et al. 2015b). Also, the Healthy Relationships programme resulted in significant reductions in both perpetration and victimisation of dating violence (Ellsberg et al., 2015). Two other interventions, Shifting Boundaries and Safe Dates reported a reduction in adolescent dating violence (Ellsberg et al., 2015). These findings are supported by a further review which found that Safe Dates, the Fourth R programme and Stepping Stones were studies in trials with the strongest evidence of effect in that they have the longest follow-up periods (between 2-3 years). Safe Dates was also strong in that it measured the widest range of forms of dating violence and was able to show effects for several forms of violence which persisted over time (Lester et al., 2017).

Theatre interventions, reported positive outcomes in relation to creating awareness of IPV, reducing gender stereotyping and encouraging engagement in nonviolent conflict resolution. A primary study also found that participants gained new awareness and understanding in relation to CSEA as a result of a school-based theatre programme (May et al., 2020).

Gender transformative approaches in the community suggest that programmes for middle school boys including The Reducing Sexism and Violence Programme – Middle School Programme can be successful at changing violence related beliefs that are risk factors for the perpetration of harassment and SDV at the community (Banyard et al., 2019).

In university settings, bystander programmes were overwhelmingly found to be promising, with evidence of a positive impact on changing attitudes and beliefs, however, the impact on behaviour was less clear cut. Interventions include Red Flag Campaign (Borsky et al., 2018, Carlyle et al., 2020), Green Dot (Coker et al., 2019), Bringing in the Bystander (Edwards et al., 2019), and The Intervention Initiative (Fenton and Mott, 2019). One study evaluating Active Bystander Communities indicates that the bystander approach can be transferred from student population to general communities and from sexual violence to DVA in the UK (Gainsbury et al., 2020). Also, within a university setting, one primary study evaluated the effectiveness of a five-year social norms sexual violence prevention marketing campaign. Results suggest the campaign was successful, resulting in reporting of less sexually aggressive behaviour and increased frequency of engaging in bystander interventions (Mennicke et al., 2018).

For interventions undertaken in healthcare settings, evidence was mixed. In the primary care setting, most studies demonstrated patient-level benefit with IPV/community referrals the most common, positively affected outcome (Bair-Merritt et al., 2014). In the

Emergency Department, it was found that one off training in isolation, may improve staff awareness but has limited impact on clinical practice (Ansari and Boyle, 2017). Where interventions across a range of settings were considered, findings were mixed with one review finding no evidence that screening increases referrals or reduction in IPV (O'Doherty et al., 2014); another that women did not show a reduction in IPV or improvement in quality of life (Feltner et al., 2018). In a further study, educational interventions were associated with improvement in knowledge and behaviours of healthcare workers despite inconsistent results (Sawyer et al., 2016). In one primary study based in the US, no benefits were found for a home visiting programme (Jack et al., 2019).

In the healthcare setting, web based approaches were found to demonstrate effective web-mediated access to telehealth services such as online support groups for victims and changing behaviour expectations through educational programming (Anderson et al., 2019). Another review suggests that ICT interventions had the potential to be effective in spreading awareness and in terms of IPV prevention (El Morr and Layal, 2020), also that participants were less likely to report experiencing physical IPV at follow up (El Morr and Layal, 2019). Data suggests that ICT-based screening tools are best used as a supplement to face-to-face screening, allowing for more in-depth and tailored advice from healthcare providers. Also, that mHealth tools are especially acceptable in health-care settings, on mobile phone platforms, or when connecting victims to health care (Anderson et al., 2019).

In relation to interventions to prevent IPV within the workplace setting, findings indicate that there may be benefits in terms of increased knowledge and provision of information and resources, but strong evidence of effective interventions is limited at this time and further research is required (Adhia et al., 2019).

In the night-time environment, studies focussed on bystander interventions, awareness raising campaigns and the role of alcohol legislation. It was concluded that a broad suite of programmes is necessary to prevent sexual violence in night-time environment (Quigg et al., 2020). A primary study evaluated The Good Night Out Campaign which provided guidance to workers on preventing and responding to sexual violence and found that awareness raising was associated with greater readiness and confidence to intervene (Quigg and Bigland, 2020).

Finally, working across agencies, multiple partnerships were shown to be effective in building a coordinated community response to VAWDASV, the most significant element of which was the comprehensive early intervention outreach/advocacy service. This service incorporated a wide range of community-based and women-centred interventions, as did other advocacy interventions that tended to adopt a more holistic approach. Overall, interventions that adopt an advocacy approach appear to have more impact and are more sustainable, and, that when co-located with statutory or voluntary services, multi-agency working is enhanced (Cleaver et al., 2019).

Societal Level

It was found that despite the breadth of alcohol policy research available, there is limited direct evidence of the impact of these policies on VAWDASV outcomes. Rather, the focus was on the impact of alcohol policy on related outcomes and potential mediators of VAWDASV. Overall the evidence supports a consistent link between policies which increase price (or prevent low prices) and relevant health outcomes including prevention of sexual violence perpetration (Lippy and DeGue, 2016). Several policy areas demonstrate initial evidence of a direct association with sexual violence, including those affecting price, outlet density, bar management, sexist alcohol marketing content, and alcohol bans on college campus and in substance-free dorms. This evidence points to the potential utility of these approaches as part of a comprehensive sexual violence prevention strategy targeting individual and community-level risk factors for perpetration. However, more research is needed to better understand the nature of association between those factors and sexual violence

perpetration risk as well as the effects of specific policies on VAWDASV and sexual violence outcomes (Lippy and DeGue, 2016).

Two studies reference the impact of legislation on IPV, specifically the Violence against Women Act (VAWA) introduced in the US in 1994. Findings indicate that areas which had received VAWA grants had significant reductions in the numbers of sexual and aggravated assaults compared with areas that did not (Ellsberg et al., 2015, DeGue et al., 2014).

Implications for Policy and Practice

The studies highlight a number of factors which contribute to the success of interventions, these include, intervention duration, socio-cultural relevance and mode of implementation.

In the case of changing gender norms, the evidence indicates that the more successful violence prevention programmes had a relatively long participant engagement time and that brief interventions may not be as successful (Jewkes et al., 2014). For interventions in school settings, it was also found that longer interventions delivered by appropriately trained staff appeared more likely to be effective and that teachers are well placed to embed interventions in schools, with appropriate training and support (Stanley et al., 2015b). In relation to bystander programmes, results suggest that low resource interventions have a modest effect on increasing bystander behaviour and higher resources were needed for a bigger impact (Borsky et al., 2018). The most effective strategy was found to be a multidose, multimode approach, tapping into various ecological levels as greater exposure to information and education yields better outcomes (Banyard, 2014, McMahon and Seabrook, 2019).

Interventions need to be socio-culturally relevant to be effective (Nation et al., 2003). The evidence from this review found that for school-based interventions, a key ingredient was found to be involving young people in the design and delivery of programmes as part of a whole school approach (Stanley et al., 2015b). While off the shelf programmes were influential, including local elements in programme design and content would ensure those delivering and receiving the intervention contribute to its development and the evidence suggests that interventions programmes designed with the involvement of children and teachers are more successful (Stanley et al., 2015b, Cleaver et al., 2019). However, it was noted that schools need evidence based guidance to help them determine what works best and for whom (Cleaver et al., 2019). It was also found to be important that interventions addressed the specific requirements of participants from a range of backgrounds with one study highlighting a lack of materials designed for some groups of young people, especially LGBT young people (Stanley et al., 2015b).

In terms of implementation, the use of online and social media platforms in violence prevention might resonate with younger audiences in countries with high internet usage particularly (Graham et al., 2019). In the health care setting, the use of ICT-based interventions seems to be an attractive option for disseminating awareness and prevention information due to the wide availability of ICT (including mobile phones) globally. A major strength of mHealth IPV prevention programming is the ability to tailor interventions to individuals needs without extensive human resource expenditure by providers (Anderson et al., 2019). Additionally, ICT presents an opportunity to deliver culturally sensitive multilingual interventions using consumer health informatics, however, there is a clear need to develop women centred ICT design when programming for IPV. (El Morr and Layal, 2020).

Addressing the Impact of COVID-19

During the COVID-19 pandemic in 2020-2021, a rapidly emerging literature suggests that levels of VAWDASV have been impacted by the COVID-19 public health restrictions, including lockdown, shielding and social distancing regulations (Snowdon et al., 2020). Whilst the full picture of how the pandemic has impacted on VAWDASV is still to fully emerge, it appears likely that both the scale and nature of VAWDASV may have worsened, with rising

helpline contacts for all forms of VAWDASV and increased reports to emergency services in some areas for domestic abuse (Hohl and Johnson, 2020).

Many prevention strategies and programming have been put on hold or been forced to adapt during the pandemic because of restrictions on movement, face to face interactions and public events. However, given the increasing number of reports of VAWDASV during the COVID-19 crisis, it is more important than ever to promote prevention through the transformation of norms, attitudes and stereotypes that accept and normalise violence. Also, while traditional avenues of prevention, such as face to face interactions are limited, new opportunities have emerged, multiple forms of media, online communications and many community mobilisation programmes involve delivering activities virtually (UN General Assembly, 2020). A number of interventions included in this report utilise online platforms (Real Consent and mHealth screening tools), these interventions may have particular relevance where face to face interactions may be limited.

Strengths and Limitations

A strength of undertaking a systematic review of reviews is that it allows the creation of a summary of reviews within a single document (Smith et al., 2011). This review identified a substantial number of reviews, encompassing a range of types of VAWDASV and intervention types and provides a comprehensive overview of key evidence in relation to what works to prevent VAWDASV. Additionally, using a two-stage search process enabled the identification of primary studies which had not been included in the systematic reviews and this resulted in a broader range of studies being included in the final report.

In terms of applicability to the Welsh Context, the focus was interventions which were implemented in high income countries. While much of the research was from the US (and differences in healthcare systems must be acknowledged) there is a growing body of research from other high-income countries including the UK.

However, the broad review question and relatively short time scale in which the review was conducted means that the search for evidence cannot be exhaustive and consequently certain topic areas may be missed. In this review, there is no intervention in relation to the prevention of coercive control, trafficking, VAWDASV among older age groups or so-called honour based abuse other than FGM. Further, all review methods risk generating inconclusive findings that provide a weak answer to the original question. Finally, the diverse methodological frameworks of the reviews and primary studies present challenges in terms of synthesising data, presentation of findings and drawing conclusions.

Further Research

Whilst the literature is rapidly progressing in this field, there are still significant gaps in the research. Additionally, concern was raised in respect of the quality of studies under consideration by a number of reviewers including a paucity of studies with impact evaluations over a long follow up period, and a lack of trials conducted in UK settings, as opposed to the US (Kovalenko et al., 2020, Fenton et al., 2016, O'Doherty et al., 2014).

Areas to be considered for further research include broader mechanisms for modifying environments and promoting gender equitable societal norms. In this review, many interventions focus on changes at the individual and relationship level within community settings, however, there is less evidence for societal level prevention, considered a critical gap in the field (DeGue et al., 2014). While individual level interventions are easy to assess, comprehensive multi-level, multi components programmes and institution wide reforms, key to long term prevention are much more challenging to evaluate and therefore remain under-researched (World Health Organisation).

Further research is also urgently needed for the prevention of specific forms of VAWDASV including coercive control, so-called honour based abuse, exploitation and trafficking, and how prevention programmes intersect with the needs of individuals and communities who are LGBT+, BAME, and older age groups.

Section

6

Conclusion

Section 6: Conclusion

The prevention of VAWDASV is seen as an increasingly critical component in the societal response to this public health issue. This systematic rapid evidence assessment reviews the current evidence in this field of research. The review found a broad range of evidence for effective programmes including programmes which have a long term effect on preventing the perpetration of VAWDASV, including several high-quality studies undertaken recently. The number of studies acknowledges the necessity of prioritising the prevention of VAWDASV and demonstrates the feasibility of research in this field as well as the interest from researchers and funding bodies.

International reviews suggest a need for comprehensive multi-sectoral long-term collaboration between governments and civil society at all levels of the ecological framework (Krug et al., 2002). The ecological model conceptualises violence as a product of multiple, interacting levels of influence however many prevention strategies focus on creating change at the individual level, with some addressing peer influences or small-scale social norms change. Critically, this highlights that VAWDASV prevention may require multiple strategies if it is to be prevented at a population scale.

Consequently, preventing VAWDASV should form part of a suite of programmes that aim to prevent the perpetration of VAWDASV across the ecological spectrum including transforming gender norms, peer group beliefs and attitudes, skills for healthy relationships, effective healthcare and service responses to VAWDASV, context-specific programmes for different settings such as the workplace and night time economy, and effective legislation. All elements of the model must interact to develop a system which encourages safe, healthy and prosocial behaviours and discourages and holds violent behaviour to account (DeGue et al. 2012 cited in DeGue et al., 2014).

Whilst the literature is rapidly progressing in this field, there are still significant gaps in the research. These include broader mechanisms for modifying environments and promoting gender equitable societal norms. Further research is also urgently needed for the prevention of specific forms of VAWDASV including so-called honour based abuse, exploitation and trafficking, and how prevention programmes intersect with the needs of individuals and communities who are LGBT+, BAME, and older age groups.

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Appendix 1

Evidence Summary

Appendix 1 Evidence Summary: What Works to Prevent VAWDASV?

Intervention type	Description	VAWDASV type	Target audience	Settings	Examples of good practice	Evidence summary
Changing gender norms	Interventions that seek to transform gender norms to prevent VAWDASV	• GBV • IPV • SV	• Men and boys • General population	• Colleges • Schools • Online • Sports clubs/ programmes • Universities	• **Real Consent** • **Coaching Boys into Men**	**Strong** evidence of behaviour change (decrease in perpetration of VAWDASV) through multiple, robust randomised controlled trials.
School based interventions	Interventions delivered in a school setting to prevent VAWDASV, typically including healthy relationships education and bystander skills	• GBV • IPV • SV	• School aged students	• Schools	• **Fourth R** • **Healthy Relationships Programme** • **Shifting Boundaries** • **Safe Dates** • **Stepping Stones**	**Strong** evidence of behaviour change (decrease in perpetration of VAWDASV) through multiple, robust randomised controlled trials with long follow up periods
Preventing adolescent violence	Programmes targeted at young people (adolescents) to prevent VAWDASV, typically including healthy relationships education and bystander skills	• GBV • IPV • SV	• Adolescents and young people	• School • College • Online • Community	• **Safe Dates** • **Fourth R** • **Shifting Boundaries**	**Strong** evidence of behaviour change (decrease in perpetration of VAWDASV) through multiple, robust randomised controlled trials with long follow up periods.

Intervention type	Description	VAWDASV type	Target audience	Settings	Examples of good practice	Evidence summary
Bystander programmes	Bystander programmes focus on equipping people with the confidence and skills to safely intervene when they witness behaviours that can result in VAWDASV	• SVA • GBV • IPV	• School, college and university students • Community/ general population	• Schools • College • University • Community settings	• **Green Dot** • **Bringing in the Bystander** • **The Intervention Initiative**	**Promising –> Strong** Strong evidence of positive impact on changing attitudes and beliefs, skills and confidence to intervene in multiple studies and settings. Evidence of positive behaviour change (decrease in perpetration of VAWDASV) found in one randomised controlled trial (Green Dot).
Web and ICT based interventions	Use of web-based or mobile technologies to optimize identification, referral and prevention programmes	• IPV	• Adults	• mHealth • telehealth • education • Healthcare		**Promising** - web-based approaches to IPV prevention have the capacity to reduce risk and studies demonstrate effective web-mediated access to telehealth services such as CBT, online support groups for victims, and changing behaviour expectations through educational programming. Some indicative evidence of reduced physical IPV at 12 month follow up.
Theatre interventions	Applied, participatory theatre projects delivered in schools and college and community settings	• GBV • IPV • SV • CSE	• Children and young people • Adults	• School • College • Community	• **Every 3 Days** • **Safe Dates**	**Promising** evidence through robust studies of positive intermediary outcomes including creating awareness of IPV, reducing gender stereotyping and developing skills for non-violent conflict resolution.

Intervention type	Description	VAWDASV type	Target audience	Settings	Examples of good practice	Evidence summary
Empowerment	Interventions designed to promote empowerment through self-defence and coaching for young women	• GBV • IPV • SV • CSE	• Girls and young women	• School • Community	• **My Life My Choice**	**Promising** evidence from a small number of studies indicating decrease in IPV victimisation and improvements in intermediary factors including awareness raising and skills to recognise inappropriate behaviour and keeping friends safe.
Marketing	Social norms marketing campaign	• SV	• Male University students	• University	• **Social Norms Sexual Violence Prevention Marketing Campaign**	**Promising** results suggest reporting of less sexually aggressive behaviour and increased frequency of engaging in bystander interventions
Night time economy	Bystander interventions, awareness raising campaigns and alcohol legislation	• GBV • SV	• Employees in nightlife settings	• Night time economy	• **Good Night Out Campaign**	**Promising** results suggest greater readiness and confidence to intervene in bystanders interventions.
Education and screening	Education and training for healthcare professionals	• IPV	Adults in contact with healthcare services	• Primary care • A&E • Range of healthcare settings • Health visitors	• **IRIS**	**Promising** evidence of professional behaviour change through multiple studies. More limited evidence of patient level outcomes, which may reflect lack of longitudinal studies.

Intervention type	Description	VAWDASV type	Target audience	Settings	Examples of good practice	Evidence summary
Alcohol Policy	Alcohol price, outlet density, bar management, sexist alcohol marketing content, and alcohol bans on college campus and in substance-free dorms	• SV	• General population • Students	• General population • University campuses • Nightlife settings	• **Minimum Unit Alcohol Pricing**	**Promising** evidence that there is a consistent link between policies which increase price (or prevent low prices) and relevant health outcomes including sexual violence prevention.
Legislation	Legislation designed to invest in VAWDASV prevention and improved funding and response	• VAWDASV	• General population	General population	• **Violence against Women Act (VAWA) introduced in the US in 1994**	**Promising** evidence from two studies where findings indicate that areas which had received increased funding for VAWDASV and improved legislation (in the US) saw reductions in numbers of sexual and aggravated assaults compared with areas that did not.
Workplace	Prevention and response to VAWDASV in the workplace	• IPV	• Adults	• Workplace	• **Recognise, Respond and Refer** • **Men and Women as Allies** • **Domestic Violence and the Workplace**	**Limited** evidence – one study found that there may be benefits in terms of increased knowledge and provision of information and resources, but strong evidence of effective interventions is limited at this time and further research is required
Preventing FGM	Recognition of FGM as gender-based violence, providing clear preventive roles for frontline professionals, clear protection and prosecution approaches, and participation of affected communities	• FGM	• Survivors of FGM • Healthcare providers	• Community • Criminal Justice System • Healthcare		**Limited** evidence of prevention programmes with a clear requirement for further research.

Uned **Atal** Trais
Violence **Prevention** Unit

Wales Violence Prevention Unit
WHO Collaborating Centre for Investment
in Health and Wellbeing,
Public Health Wales
Floor 5
2 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ