WHAT WORKS TO PREVENT VIOLENCE AGAINST WOMEN AND GIRLS ANNUAL SCIENTIFIC MEETING, 5-6 JULY 2017

PRETORIA, SOUTH AFRICA



WhatWorks TO PREVENT VIOLENCE
A Global Programme to Prevent Voilence Against Women and Girls

WhatWorks TO PREVENT VIOLENCE
Voilence Against Women and Girls in Conflict and Humanitarian Crises

WhatWorks TO PREVENT VIOLENCE
Economic and Social Costs of Violence Against Women and Girls

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INTRODUCTION

What Works to Prevent Violence Against Women and Girls (VAWG) is a DFID funded flagship programme that is comprised of three interrelated components led by three distinct consortia. An external independent evaluation that was added in 2016, led by IMC Worldwide. The Global Program commonly known as Component 1 is led by the South African Medical Research Council (SAMRC) in partnership with Social Development Direct (SDD) and the London School of Hygiene and Tropical Medicine (LSHTM). Component 2 focuses on what works to prevent VAWG in conflict and humanitarian crises settings and is led by the International Rescue Committee (IRC) in partnership with CARE UK and LSHTM, and Component 3 is a partnership between the University of Galway, Ipsos Mori and the International Centre for Research on Women (ICRW).

A core element to promote learning and sharing across the entire What Works programme exists through the Annual Scientific Meetings (ASM). The meeting is held over two days annually and the venue moves between regions to facilitate wider attendance. The overall aim of the ASM is to share through presentations of work in progress and emerging findings from epidemiological research, intervention evaluations and economic analyses. The first Scientific Meeting was convened in September 2015, in Stellenbosch, South Africa, and the second Scientific Meeting was convened in September 2016, in Dubai, United Arab Emirates.

The third Scientific Meeting, which will be the focus of this report, was convened in Pretoria South Africa on 5-6th July 2017. The meeting focused on sharing and learning from research findings across the consortia from the past year, sharing and learning from processes of developing theoretically grounded interventions, and deepening an understanding of and ideas for using research effectively to influence VAWG policy and programming.

The meeting brought together all three What Works Components, as well as the external evaluation team. Participants included researchers, implementers, technical staff from the three Components, DFID staff from the VAWG team, DFID Research and Evidence Division and some country offices, members of the International Advisory Board, representatives from the South African Medical Research Council and the Sexual Violence Research Initiative (SVRI) programme (see Appendix 2 for the full list of participants). The meeting, which consisted of 7 sessions was built around four broad thematic areas: Poverty and the Role of Economic Empowerment in VAWG Prevention, the intersection between Violence against Women and Girls and Violence against Children, Violence and Disabilities as well as VAWG in Conflict and Humanitarian Settings. Other foci of the meeting included; Emerging Findings in a Nutshell, Types and Prevalence of VAWG, VAWG in Conflict and Humanitarian Settings: Responses and Costs, and Synergies across Projects.

GOALS OF THE MEETING:

1. Strengthen the policy-relevance and coherence of the What Works research programme, including by beginning to develop a coherent narrative and set of key messages emerging from across the programme as a whole.
2. Discuss research methods and approaches to understanding VAWG in order to share learning and strengthen them.
3. Share new learning across What Works components and partners, and deepen understanding of the work that is being conducted across the three components of the What Works Programme.
4. Provide a forum for exchange of ideas from across What Works components and partners with a view to strengthening the science of "What Works", and strengthening the framing of research questions, future findings and recommendations within current policy and programming debates.
5. Deepen understanding of the work and emerging thinking across the components, in order to identify cross component synergies.

WEDNESDAY 5TH JULY: DAY ONE

WELCOME AND OVERVIEW SESSION

Prof Glenda Gary, President of the South Africa Medical Research Council, acknowledged DFID as visionary for supporting the What Works to Prevent Violence against Women and Girls Programme. She welcomed the programme partners from Asia, Africa and other parts of the world. Prof Gray acknowledged the important work they are doing to address VAWG in the Global South. She prefaced the meeting by highlighting the imperative to address VAWG, which impacts on women and girls health and wellbeing, through increased seeking of abortion, including illegal abortion, which can affect their Sexual and Reproductive Health (SRH). Violence and abuse increases



frequency of depression among women, and increases women's susceptibility of HIV acquisition. Prof Gray noted the variable measures for psychological violence, which can be more difficult to articulate than physical or sexual violence. She further noted the extent of child marriage, forced sexual intercourse, and female genital mutilation and circumcision (FGM-C) f young girls, and the need for interventions and measures to address such violence, law reform, and an enabling system for women and girls to report violence. She expressed the need to acknowledge sub-populations of women more vulnerable to violence due to their sexual orientation, disability, ethnicity, and/or religion. She noted the value of What Works for evaluating the efficacy of a diversity of interventions in the home, work place, communities, places of worship, conflict and post-conflict settings. Finally, she expressed her appreciation of the rigorous, interdisciplinary research, and South to South collaboration that characterizes the What Works programme.

The directors of the three programme components offered brief reflections on progress over the past year.

PROF RACHEL JEWKES, Component 1 Consortium Lead, reported on the progress made over the last year. Highlights included were:

- All the intervention developments had been completed, and implementation was complete or underway for all projects
- All the baseline data has been collected, and among the projects that have planned midline research, 6 projects



Figure 1: The Three Components of the What Works Programme

have completed midline, 3 are in progress, and 3 to start in November 2017
- 4 formative research reports have been published from Tajikistan, India, Nepal, Bangladesh, and 1 baseline paper from DRC is nearly complete
- Methods papers from 10 projects have been published, submitted or nearly complete
- To date there are 28 publications from the What Works
- research; a further 16 articles are in peer review or in press

Rachel noted the tremendous progress in terms of capacity development highlighting one example of the teams from Tajikistan, HTAC and VSO Nepal that came together for a workshop to learn about quantitative data analysis. She discussed research research uptake (RU) progress, including that 2 grantees presented at the Commission on the Status of Women this year, there are over 1000 twitter followers of What Works, and the active use of radio, newspaper articles, and blogs. Rachel highlighted how the government of Rwanda was trained on IPV research and the work being done with the South African government on VAWG prevention in higher education. She noted how the consortium developed a cross component theory of change for research uptake to support broader stakeholder engagement. She also identified that What Works received an A+ in the Annual Review (AR) from DFID and the independent mid-term review that was very positive.

TIM HESS, Consortium Lead of Component 2, reported that over the last year, they completed data collection in South Sudan, which included a survey, focus groups and interviews. They completed a 9-month cohort survey in Dadaab refugee camp in Northern Kenya, which included over 300 interviews with women. They completed qualitative data collection for the state building and peacebuilding study across Sierra Leone, Sudan and Nepal. Tim noted how they faced some challenges on the ground; in South Sudan, there was an escalation of conflict while operating data collection, which meant this had to be suspended quickly and re-started later in the year. In Dadaab, they faced challenges with disruptions in the camps arising from announcements by the Kenyan government that they wish to close the camps.

Tim further reported that the different research teams are now focusing on analysis, writing reports, and planning for dissemination and research uptake. They are planning up to 6 report launch events for the Kenya and South Sudan findings in Sudan, Washington, Juba, London, Nairobi and at the Dadaab camp. There are also plans for a programme of communications, media and policy engagement. Five panel presentations and 2 posters will be presented at the SVRI in Brazil. IRC is in the final stage of scoping a site for the impact evaluation around IRC's cash transfer programming on women's empowerment and protection in conflict settings, and intend to have data collection finished by the end of this year.

DR NATA DUVVURY, Component 3 Consortium Lead, noted that despite significant difficulties in South Sudan, they completed field collection in February 2017. They completed surveys with women, household surveys, business surveys with male and female employees, and a survey with managers across 100 businesses in Ghana, Pakistan and South Sudan. Nata noted that the intention of Component 3 is to assess the cost of IPV in the workplace, as well as consequences of violence at home in the workplace.

As this is a new area of research, she observed that they have been actively engaged in uptake of research, and creating a demand for this kind of research throughout the past year. Nata discussed the component's participation in a policy dialogue on costs of VAGW as part of the UN general assembly sessions in September 2016, and presentation at the first IMF conference on gender and macro economy around the economic costs of violence. They participated in an international, economic forum for the Americas organized by the Canadian government and business leaders from North and South America. She noted the intention of Component 3 to emphasize the need to consider the macro economic impacts of VAWG. They plan to have final reports completed by July 2018 and initiate various research uptake activities afterwards.

SESSION 1: POVERTY AND VAWG AND THE ROLE OF ECONOMIC EMPOWERMENT IN THE VAWG PREVENTION

The first technical session was chaired by Dr Claudia Garcia-Moreno (WHO, Independent Advisory Board Chair) and featured presentations from Nata Duvvury (University of Ireland, Galway), Abigail Hatcher (Witwatersrand University), Felix Asante (University of Ghana), Satyanaryana Ramanaik (KHPT), Ruchira Naved (ICDDRB), Henri Myrttinen (International Alert) and Nwabisa Jama-Shai (SAMRC).

DR NATA DUVVURY provided an overview of how IPV is a global phenomenon experienced by all women no matter their socio-economic status, and poverty is a key driver of IPV at the individual level. Yet, it is not only increased vulnerability

to IPV, which is an outcome of poverty, but IPV can increase women's vulnerability to poverty. Thus, the relationship between poverty and IPV should be conceptualized as a self-reinforcing loop. She identified specific pathways between poverty and IPV including lower SES, ill health, increased stress, and lower educational attainment, which influences women's increased dependency or lower power within the household, which in turn drives IPV. IPV can affect women's ability to work and have economic security through out of pocket expenditures often involved when women experience IPV, such as expenses for health care. IPV also affects productivity, which can lead to decreased economic security of the household, which drives women's increased dependency and lower power relations within the household. Nata introduced evidence that IPV has been associated with food insecurity including in countries in the Global North with stronger economies. A recent analysis by What Works of women's experiences of IPV in Cambodia, China, Papua New Guinea, and Sri Lanka found that poorer women (measured by food insecurity and ability to find money for an emergency) were more vulnerable to IPV.

Nata noted that assets such as property and employment can be protective but can also increase the likelihood of women experiencing violence. She noted that Component 3 wants to identify both individual and macro-economic impacts of IPV. In Vietnam, they found opportunity costs of IPV for individual women were as much as 34% of their household income, which reduces their economic security. IPV can result in unplanned or unwanted pregnancy, which has impacts on the care work women have to mobilize, and can increase their economic insecurity. She noted that the relationship between poverty, IPV and care work needs to be explored in much greater depth. Nata discussed how the evidence suggests that livelihood strengthening and IGAs may reduce IPV, but also identified some of the risks involved with cash transfers. For instance, women can be forced to hand over earnings to husbands or mothers in laws, be prevented from working, or feel pressured to invest in businesses controlled by their husbands, rather than establishing their own. Unpaid care work for children or other dependents may undermine women's participation in and use of economic interventions. In conclusion, she asserted that poverty is a key driver of IPV, but IPV also shapes women's poverty and effective interventions need to tackle gender inequalities and poverty to prevent VAWG.

DR ABIGAIL HATCHER noted that little is known about violence experience or perpetration in informal settlements where everyone is relatively poor, with insecure access to water, housing and sanitation. She introduced the analysis of two What Works studies in South Africa to better understand the relationship of poverty and VAW among men. The studies provided combined data from 2516 young men; only 43% had high school education, 49% experienced household hunger, and nearly 2/3 of men felt stressed about work or income. Almost 60% (59.5) of men reported past year physical or sexual violence against women, 40% of men never used violence in the last year, and 16% used violence once. Abigail noted how some research suggests that men who use violence once may be different from men who use violence as a pattern, and that their final analysis will consider this. The analysis found that while markers of poverty increase odds of past years of violence (stress about work, borrowing food or money, hunger or stealing because of hunger), providership also increases odds of violence (being employed in the last year, owning a home versus renting, having some income versus none at all). They used the GEM scale and Sexual Relationship Power Scale to assess how these indicators relate to masculinities, and found that economic precarity (hunger) may be linked to both once off and repeat use of VAW via household stress. They also found providership may be risky in situations of overall high poverty, with the implications being that poverty or providership, as well as gender inequitable beliefs are central to multiple VAW use. Abigail suggested the need to compare this data in informal settlements with other settings, and for DHS surveys to include men's perpetration of violence. She also emphasized the need to explore absolute poverty versus relative poverty and its relationship to IPV. She also noted the potential for micro finance interventions with men, building on what we know from working with women, and a platform to engage men for broader gender transformative work.

DR FELIX ASANTE introduced the Business Employee Survey, which focused on understanding the cost of IPV to businesses. The survey was carried out in Accra and Kumasi in Ghana, with 805 employees, across 100 businesses. The majority of respondents were male, had a bachelor degree, with a mean age of 32. Many respondents had been engaged in jobs for more than 5 years. They found that time spent at work is similar for men and women, however the mean monthly wages favour men, and men tend to be paid more for equal work done compared to women. Felix discussed how they found the difference in wages was due to income discrimination or that men had different job specifications and operated in sectors that attracted more monetary rewards. Their sample had more men in the industrial

sector, which tends to pay more compared to women, who dominated the service sectors. More women suffered all forms of IPV compared to men, and psychological violence was identified as common form of violence among women. No men identified sexual abuse, although Felix noted the difficulty for men to be open about abuse, especially sexual abuse, by their partners.

MR SATYANARAYANA RAMANAIK discussed how Karnataka Health Promotion Trust (KHPT) aims to reduce IPV and increase condom use in intimate partnerships among female sex workers by working with female sex workers, intimate partners, and community based organizations in Karnataka, India. He noted that the underlying causes of female sex work in India are poverty and the caste system, and that it is common for them to have at least one intimate partner in their lifetime. These intimate partners start as paid clients, and slowly develop intimate relationship (typically after 6-12 months), and as the man becomes a lover, he stops paying for sex but may bring food or look after the children. He noted how such men typically want to keep such relationships confidential, as most are married, and expect their partners to stop sex work, which is often seen as betrayal and immoral. Men may use violence as a way to discipline their partner for continuing sex work, even if they do not provide sufficient economic support. Female sex workers typically aspire to have social status similar to a wife, and may tolerate IPV as a sign of love and intimacy and/or given their economic dependence on their intimate partner. He also discussed the finding that female sex workers with higher income were more likely to experience IPV in the last 6 months, and how this emphasizes the need to focus on economic empowerment of female sex workers, while also building their self-esteem, negotiation and control over resources.

DR RUCHIRA NAVED, asserted the limited, methodologically sound studies on female garment workers experiences of violence in Bangladesh. Their analysis assessed male reports of perpetration of violence against female garment workers in Bangladesh through a management survey in 8 factories with 200 staff, as well as formative face to face interviews with female garment workers, and informant interviews with management staff at the factory. This research was conducted as part of the baseline research for the HerRespect intervention to reduce workplace violence among female garment workers. Ninety four percent of management staff are male while 80% of garment workers are female. On average, management staff earn more than two times as much as garment workers. Sixty three percent of management workers reported perpetration of emotional violence and 2% of physical violence over the last 4 weeks. Ruchira discussed the identified beliefs on behalf of management that violence is the most effective tool for achieving production targets. Drivers of workplace emotional and physical violence identified were related stress, burn out, patriarchal attitudes, life satisfaction, which decreases with older age. Ruchira asserted the need for programmes to target management for eliminating use of violence to reach production targets, addressing patriarchal and violence condoning attitudes, and helping management better cope with work related stress and burnout. More research is needed on the adverse effects of violence on productivity and benefits of non-violence management and understanding why life satisfaction is a positively related factor with violence. In the concluding discussion, Ruchira noted that as long as women's empowerment is seen as a zero-sum game, there will always be backlash from men, which is why it is so critical to work with men.

DR HENRI MYRTTINEN, introduced the International Alert project in Tajikistan and how it is working with violence at the family level. **NWABISA JAMA-SHAI** discussed how in Nepal the VSO Youth club is working with migrant communities and family units including teenagers, and following the Tajikistan



model of the intervention. In Tajikistan, they have done an extensive literature review, 4 FGDs per intervention village, 4 women and 2 men life history interviews, a survey with 271 participants, 20 interviews and focus groups with participants and facilitators. In Nepal, they conducted formative research with 2 migrant communities to inform intervention development with 16 young unmarried women, 8 older women, 6 teen girls, 4 community leaders, and 3 FGDs per community, and did a baseline survey with 357 participants, 48 interviews, and 12 focus groups with participants and facilitators. In Tajikistan, they found among the highest levels of VAWG in the What Works consortium, although Henri noted that this was a small sample and not representative. They identified high levels of male labour migration (Russia, less to Kazakhstan), structural food insecurity, low-income levels, high levels of depression for women and men, and high levels of substance abuse including alcohol, opioids, and marijuana. Henri discussed how they intend to assess how life dissatisfaction and depression links to IPV. Nwabisa discussed how in Nepal, they found lower levels of VAWG in lifetime vs other studies in the What Works Programme, and identified male labour migration (Gulf States, India), some food insecurity, moderate income levels, and young married women having progressive gender attitudes, which could make them more likely predisposed to IPV. High levels of depression was a risk factor for past IPV in older women. Substance abuse was found to be associated with older women's exposure to IPV.

DR SHIV KUMAR, Know Violence in Childhood from India (Independent Advisory Board Member),, was the discussant and made the connections that the relationship between poverty and IPV is complex, and the conclusions not very clear. He discussed the importance of being conscious in errors of reporting. Richer families may be less reluctant to talk about violence because of social stigma. The relationship of women's economic status to IPV is ambiguous. It can be a threat if a wife earns more than husband. Shiv also discussed the need to consider women's economic independence and empowerment beyond employment and look at property ownership. In some parts of the world, property ownership gives much more tangible options for women and reduces their likelihood of violence. Shiv emphasized the need to remember that IPV is about unequal power relationships, to exercise control over powerless, helpless people, and interpret results with caution (such as to avoid representation that rich men do not use IPV or that poverty causes IPV, and to carefully interpret findings from India that female sex workers are more likely to experience IPV). Shiv emphasized the need to emphasize financial impacts of IPV, but to also not forget that any form of violence is moral deprivation, denial of freedoms, violation of rights, freedoms, and about human dignity.

DR CLAUDIA GARCIA-MORENO summarized the panel discussion by asking; how are we measuring poverty? Some researchers use income? Some use income and assets? She emphasized the need to clarify what the proxy measures and outcomes of poverty are, as there is some overlap.

SESSION 2: VIOLENCE AGAINST WOMEN AND GIRLS AND VIOLENCE AGAINST CHILDREN

FIONA CLARK from DFID, Africa Regional Department introduced the second session. Presentations were delivered by Prof Rachel Jewkes (SAMRC, South Africa), Dr Andrew Gibbs (SAMRC), Dr Julienne Corboz (WW Technical Advisor, Afghanistan), Dr Clea Sarnquist (Stanford University), Dr Mike Baiocchi (Stanford University), Dr Laura Murray (Johns Hopkins University)

RACHEL JEWKES introduced the Evidence Reviews which are synthesis documents produced by the What Works Global Programme Component One to draw on information from a range of projects. She discussed how the What Works programme primarily focuses on IPV or non-partner sexual regarding violence against women and girls, and on physical, sexual and emotional abuse and neglect of children, and peer violence against children (VAC). Rachel identified shared risk factors and social norms driving VAC and VAWG, co-occurrence and intergenerational cycle of two forms of violence. She emphasized that adolescents' experiences of violence can diverge depending on their context, and that they can experience similar conceptualizations and measurements of violence against adult women. Rachel identified the diversity of social norms related to norms of violence including gender, hierarchy, power, and acceptability of violence, which diverge across settings. Norms on gender imply who should use violence, and what can justify violence. She discussed how in a society where gender norms accept or demand violence be used in certain circumstances, those same norms will lead to women and children being beaten.

Rachel discussed how the structural equation model from an analysis of the UN Multi-country study shows childhood trauma (physical abuse, sexual abuse, emotional abuse) has multiple impacts on experiences of IPV as an adult.









Childhood trauma exposure influences women's ideas on gender equity, which impacts risks of violence. Childhood trauma influences women's partnering, and is an important risk factor for men's perpetration of violence. In households where men perpetrate IPV, they are also more likely to beat children, and in households where women experience violence, they are more likely to beat their children. The What Works analysis in Pakistan found that food insecurity impacts perpetration of violence through abuse of women in the home. IPV in the home influences girls and boy's perpetration of peer violence. Rachel emphasized the need for theoretically based interventions on changing social norms related to violence and gender, and the need to monitor the impact of programmes on VAC as well as VAWG. Given that children's exposure to violence can lead to later perpetration, it is critical to intervene with children early to break the cycle of violence, and schools can be a powerful platform for this. She noted that Right to Play and Help the Afghan Children are What Works programmes working at school levels.

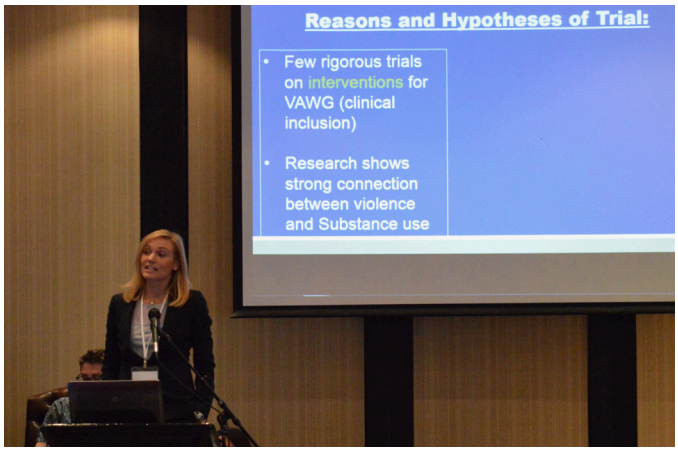
DR ANDREW GIBBS and **DR JULIENNE CORBOZ,** presented analysis from 3 baseline What Works studies they have supported (Help the Afghan Children and Women for Women International in Afghanistan, and Stepping Stones/Creating Futures in South Africa) around exposure to violence among children and other types of violence across the lifespan. They assessed baseline data across 3 different age groups (7-8 graders with HTAC, young adults in South Africa and women up to age 35 for the Women for Women trial). Julienne discussed how for the HTAC evaluation, a survey was conducted with 350 boys and 420 girls across 3 districts using face to face administered interviews given low literacy. Children were asked about witnessing their mother being beaten/father fighting, peer violence victimization and perpetration, if experienced beating at home and corporal punishment at school. The analysis indicated that girls who have been exposed to violence in the household are significantly more likely to be victimized by another child in the last month, more likely perpetrated violence against another child, more likely experienced corporal punishment at school, and more likely experienced physical violence at home. Boys observing their fathers fighting or mothers being beaten was significantly associated with boys being beaten at home, and observing their mother being beaten at home was associated with their use of violence against other children.

Andrew discussed how in South Africa, a baseline survey was conducted with 680 women in 34 clusters living in informal settlements in Durban. Surveys were conducted using self-administered questionnaires on cellphones, and participants were asked about experiences before age 18 and current past year experiences of IPV victimization. Thirty percent of women reported having witnessed violence before age 18. There was also a significant association between witnessing violence growing up and subsequent experiences of IPV and non-partner violence. Seventy-one percent of women reported any experience of physical abuse, 36% reported sexual abuse, and 72% reported emotional abuse and neglect. Andrew noted the similar patterns to the HTAC data, despite the different context and research questions that could be asked.

For the Women for Women International Intervention trial, an RCT was conducted with 1461 women. Women were asked about experiences of violence in childhood, and currently married women were asked about experiences of physical and emotional IPV. Twenty-five percent of married women experienced physical abuse before age of 18, and 30% reported emotional abuse and neglect. Women with childhood trauma were found to have elevated risk of subsequent IPV. Julienne summarized that while the prevalence of abuse in childhood varies, the impact remains constant across sites. Witnessing violence and experiencing a range of childhood violence is associated with other experiences of violence victimization and perpetration, and associations are immediate and long-term, through childhood, into early adulthood and adulthood.

DR CLEA SARNQUIST and **DR MIKE BAIOCCHI** introduced the No Means No Worldwide curriculum, which is a girls` classroom programme (grades 5-8), taught by teachers from the intervention communities across 5 settlements in Nairobi, Kenya. Girls learn empowerment, situational awareness, verbal and physical self-defense skills. There is also a boys` curriculum, which will be researched as part of the secondary analysis, where boys are taught healthy gender norms, positive masculinity, and bystander intervention. As part of the baseline evaluation, an RCT was conducted with 4000 girls and qualitative interviews were conducted with boys and girls. Girls were randomly selected using marbles (pulled blue or red), to protect their ability to respond more truthfully. Eleven percent of class 6 girls reported rape across both treatment and control groups. Mike raised the concern that some girls have had 5 or more experiences of rape, as it appears the intervention can impact girls having experienced rape 1 or 2 times, but less on experiencing multiple episodes of rape. Boyfriends were said to be the most likely perpetrator. Clea discussed how rates of self-efficacy seem to be highly related to impact of the programme, and also related to verbal and physical skills and self-esteem. The project is working on measurements to achieve desired safety outcomes, and situational awareness, which is the ability to identify physical features of a scene to identify safety.

DR LAURA MURRAY presented a randomized clinical trial in Zambia to test effectiveness of a cognitive behavioral therapy intervention to reduce and prevent VAWG among families living in Lusaka, Zambia. She noted that there are few rigorous trials on interventions for VAWG with a clinical inclusion. The study used a family unit and recruited an adult male and female in relation and 1 child (8-17 years), whereby the women had to indicate moderate to severe IPV, and men had to have a major substance use problem. The family units were measured at baseline, and 547 assessments were completed at 3-4 months past baseline. Both men and women were mostly unemployed, with mainly primary education. The highest prominence of IPV in the population was forced sex. Many women had suicidal thoughts and plans, and high rates of alcohol abuse were reported by men and women. There was a significant association found between poor mental health and IPV, for both adults and children. Men were more open about violence than women, although women became more open after their course of treatment. Men's drinking typically went up and down, but reduced by the end of intervention. Laura discussed how using a nuclear family unit in this setting has been very complicated, and relayed challenges of delivering the intervention, such as having to re-schedule with participants for being intoxicated. However, the intervention demonstrates the success of lay providers delivering evidence based treatments. She emphasized the importance of supporting men to deal with their own trauma and/or substance use in order to stop violence.



Discussant, **TINA MUSUYA,** from CEDOVIP (Independent Advisory Board Member) discussed the direct connection between VAW and VAC. There are shared risk factors that lead to experiences of both VAW and VAC, underpinned by the same social norms accepting occurrence of both. Patriarchy is a cross cutting risk underlying both VAW and VAC, which legitimizes who uses violence and condones acceptance of violence. Yet, Tina discussed that women and children are at distinct stages of life with different expectations for relationships and behaviors. We need to remember that power dynamics underlying IPV and parent-child relationships are different. For instance, parents usually have legitimacy over children and think they have to discipline and raise children properly using violence, yet IPV is typically more hidden and stigmatized. Parents often do not want their children to see them fighting, but the same parents may beat their own children. Interventions need to handle these dynamics.

SESSION 3A: EMERGING FINDINGS IN A NUTSHELL

As a product from the capacity development work that preceded the ASM on 3-4 July 2017, grantees were asked and supported to package their research findings by developing 5 minutes PowerPoint presentations that were delivered during the ASM and were as follows:

COMBAT, Ghana is a rural response intervention introduced by **ADOLPHINA ADDO-LARTEY,** which uses COMBAT (Community Based Action Team) volunteers to create awareness and sensitization on VAWG in communities. The baseline study found that men who experienced childhood neglect, witnessed abuse of their mothers, or experienced abuse in childhood are 3 times more likely to perpetrate IPV. Eighty five percent of men who perpetrated IPV also experienced neglect as a child. There is an urgent need to address parenting issues relating to child abuse and neglect through effective programs and law enforcement, including the Ghana children's protection act.

Engaging Faith Groups to Prevent VAWG, Democratic Republic of Congo (DRC) was introduced by **UWEZO LELE,** which focuses on engaging with faith leaders to prevent VAWG in remote communities where there is limited services or infrastructure. The baseline survey indicated that violence exists in communities and among partners, which is higher than violence committed by non-state actors. Since faith leaders have access to rural communities, they could become catalysts for working with communities. The baseline survey found that 68.8% of women experienced any IPV, 38.4% experienced sexual IPV, and 20.8% experience non-partner sexual violence in the last 12 months. Ninety-five percent of respondents identified with a religion (majority Christian or Muslim), and 83.4% described their faith as important or very important in their lives. People were more likely to agree with harmful attitudes if they were framed as 'scriptural.' Recommendations given were to prioritize addressing IPV and other forms of VAWG within conflict settings, ensure interventions address root causes at the community level, and to work with local faith groups to tackle gender norms, include challenging where faith leaders are upholding harmful gender norms.

Women for Women International, Afghanistan was introduced by **CARRON MANN,** which is a 12-month combined social and economic empowerment programme with women who are survivors of conflict, socially marginalized, and live in extreme poverty. The baseline survey with 1400 men and women found a physical violence prevalence rate of 23% from a sample of married women. Key risk factors for IPV were childhood trauma, being involved in women's groups, and women more likely to experience IPV if they had increasing arguments with their husbands, and if held less gender equitable attitudes. Some of the intervention results





were introduced including the significant change of 0 to 52% of women graduates having stopped violence before it was committed against them. Male graduates' positive attitudes towards women's role in family decision increased from 6% to 99%. There was a reported shift from 2 to 99% of women graduates educating another woman on her rights, and from 16 to 42% of men graduates reported taking action to stop violence against women.

Samvedana Plus, India intervention aims to reduce partner violence and increase condom use among female sex workers in India was introduced by **KAVITHA DL.** The 3-year pilot project and evaluation found that more than half of FSWs who experienced IPV are not disclosing, and that consistent condom use with intimate partners is low (43%), compared to with clients (92%). Existing gender and social norms were found to reinforce IPV. The findings indicate that IPV in sex work context is complex and challenging, and asserts the need to prevent health and well-being consequences of IPV among FSW, their families and communities, using a multi layered approach.

Stepping Stone and Creating Future, South Africa intervention combines Stepping Stones (gender transformative training) and livelihood strengthening among women and men aged 18-30 was introduced by **NOLWAZI NTINI.** The evaluation conducted mixed methods research including an RCT in 34 clusters in informal settlements in the Kwa-Zulu Natal region of South Africa. The baseline survey identified extremely high levels of violence against women with 65% of women having experienced IPV in the past 12 months. High levels of poverty, unemployment, and food insecurity were found to be drivers of IPV. Various risk factors linked to women's experiences of IPV included weak livelihoods, low educational attainment, inequitable gender attitudes, and experiences of controlling behaviors in relationships. Pathways and interactions identified in the study can help design appropriate interventions for this context of informal settlements. The evaluation findings promisingly indicate that Stepping Stones and Creating Futures has increased earnings, reduced depressive symptoms, reduced men's controlling behaviors, and reduced women's experiences of violence.

Living with Dignity, International Alert, Tazjikistan intervention was introduced by **SHAHRIBONU SHONASIMOVA,** with support from MRC, adapted the Stepping Stones intervention and incorporated livelihoods strengthening component to the context. The intervention in Tajikistan needed to not just focus on couples but on the family. The evaluation findings suggest that the methodology was very useful to participants, although there was some resistance to families joining at the beginning. The findings demonstrated the need to scale up evidence based approaches, combining economic empowerment and gender norms change with a focus at the family level.

SESSION 3B: INTERVENTION ROADSHOW PART 1

Participants then had the opportunity to learn more about two What Works interventions over 90 minutes, with 8 projects leading short sessions outlining their approach, often through role play, and ending with questions and discussion.

One Community, One Family, Nepal was presented by the VSO team. VSO Nepal showed a subtitled video on their intervention, including testimonials from male and female participants, the training, and contexts of data collection. They role-played a session from their intervention, which ended with a question about the possible end to the story. This led to a discussion about issues from nutrition to sexuality education, cultural norms and migration and suggestions about the way forward. The team successfully provided a snapshot of the context and the interventions and demonstrated how the intervention works. A follow up discussion answered participants' questions and further explained how the intervention is structured. Abina Adhikari provided an overview of the community engagement process.

Help the Afghan Children, Afghanistan Intervention on peace education project is being implemented in 4 Districts in Georgia, which aims to empower children with problem solving skills to be able to resolve conflict peacefully and avoid the use of violence. Two techniques used in the project were shared, which included stories and puzzles. During the sessions, children are asked to read the story and to answer in their groups a set of problem solving questions. Puzzles are also presented as a way of encouraging team work to resolve the problem presented in the puzzle exercise. Stories are based on the students' understanding and context of Afghanistan. They learn how to work together in contexts of limited resources, how to resolve conflict, develop an understanding of the drivers of violence and knowledge of how to respond. The project teaches them an idea of "thinking before responding" in an environment where people mostly react before thinking. It encourages them to listen, non-aggressive responses and seek to reduce use of violence. The project also targets teachers

who are empowered on positive discipline strategies. Workshops are also held in communities to teach parents peace education. Challenges were discussed including lack of participation and having attitudes counter to the project objectives, but this slowly improved over time. Learners who participated in the projects have spoken well about it, and made it attractive to their peers and parents. The way forward is to advocate for integration of peace education in the school curriculum, and to also include it in the teachers training programme.

Ma'an TV Network, Occupied Palestinian Territories intervention utilizes innovative media to help end violence against women and girls through community education and outreach. The programme has various components and has established a Gender Unit, to build capacity for all the Ma'an TV staff to remain considerate, sensitive and aware of social issues within communities. The Gender Unit promotes good governance, democracy, civic engagement, human rights and the prevention of Gender Based Violence. The Gender Unit provides overall support towards the production of the media content and materials produced by the Organization. Ma'an engages regularly with its Advisory Committee and Stakeholders, which assists with project implementation and delivery. Ma'an TV produces a wide range of shows including reality shows and produces awareness and advocacy campaigns. Ma'an TV hopes to change the age of entering into forced marriages for children and young adults in the near future. Ma'an has created a reality show, "The President" which empowers participants on the show to speak openly about gender issues. Ma'an TV assisted a young Palestinian girl Hanadi, who had been forced into an arranged marriage at the tender age of 14years. Ma'an TV intervened in the case and together with the assistance from the Police Services, Hanadi's story was widely publicized and awareness campaigns were rolled out at the community level. Due to the success of the activities, Hanadi was set free and permitted to divorce her husband. Ma'an TV aims to influence changes to the laws that currently exist in Palestine. Ma'an TV has produced a national campaign around Ramadan with 36 messages consisting of nine key messages.

Johns Hopkins University and SHARPZ, Zambia intervention was presented by Laura Murray who explained that the CETA intervention is an evidence-based Trans-diagnostic intervention with 2 least 2 RCTs on its efficacy already published. Trans-diagnostic means that although CETA is seen as one treatment, it has several components e.g. substance abuse, mental health problems (including depression), reducing traumatic experiences (including PTSD). She emphasized that the Trans-diagnostic approach is critical for the What Works interventions because if counsellors are only trained in one aspect of treatment, scalability is always a challenge. She also explained that single order interventions do not work except in homogenous populations where co-morbidity like violence aggression attitude is very common. Regarding the ordering of CETA use, she described how every counsellor knows all the elements but can implement them in any order with a client. The common component of flow for both men and women is usually the experience of trauma. CETA was originally meant for Low and Middle Income-Countries to address issues with trauma. CETA has 8 sessions total. One of the key components of CETA is to distinguish thoughts, feelings and behaviors. To demonstrate this, an activity was done to show how in everyday scenarios (e.g. being caught in traffic), what you think affects how you feel, which in turn affects how you act. The demonstration using the "being stuck in traffic scenario" further showed that change in feeling can lead to more productive behavior. The substance abuse reduction component has cognitive behavior elements, which is also evidence-based, and focuses on reduction of alcohol abuse. Using another activity, Dr. Murray demonstrated how role-play is used in sessions to understand reasons for substance





abuse and learning skills for reducing alcohol use. She explained that the ethics of this particular component is difficult because over 80% of women in the program had suicidal thoughts. She described situations in Zambia that make reporting of violence to authorities difficult such as, if a woman reports violence to the police, she is summoned to take this back to the husband. Dr. Murray showed a CETA adapted worksheet for safety and violence which is used in their project.

SESSION 3C: INTERVENTION ROADSHOW PART 2

Stepping Stones & Creating Futures, South Africa was co-facilitated by **LAURA WASHINGTON AND NOMFUNDO CHILI.** The objective of the session was for SSCF to showcase their intervention, which is based in informal settlements in Durban, South Africa. During the session, the room was split into two groups who were tasked with playing out a scenario where a couple was involved in an altercation with a "by-stander" group. The by-stander did not intervene. The overall group discussed how it felt to be a "victim" and how to be a perpetrator and how to be a "bystander". The entire group reflected on what it was like to be the "audience" to the session. In the next round the same two groups role played the scenario as above, but this time the "by-stander" was asked to intervene. In the last 10 minutes, the audience was asked to reflect on the value of "role plays" in violence prevention efforts. The team successfully provided a snapshot of the intervention, which stimulated a discussion on how other participants working in violence prevention think about the multiple players in VAWG.

COMBAT, Ghana intervention was facilitated by **DORCAS COKER-APPIAH,** and explained what COMBAT is, how they are selected, and what they do. COMBATs are volunteers (trained community members) taken through a training on VAW issues and counselling. They live and work in their own communities but may also work in surrounding towns/communities. If they extend their work scope and visit neighboring communities, they must follow up in those communities visited. COMBAT work involves constant engagement with the community. They undertake role play on sensitization and awareness of VAW issues. They use words such as laws of Ghana, rights of men and women, and your responsibility. Dorcas demonstrated how COMBATs would handle a typical social debate on VAW. ASM participants acted as community members and Dorcas was the COMBAT member. Issues such as, cultural expectations around roles of women, marital privileges and intimacy were addressed. Using dialogue amid hostile environments, Dorcas showed how COMBAT emphasizes the need to build families. She explained that when people insist on negative aspects of relationships, there will always be challenges; hence the importance of having positive attitudes which is a better solution. She further explained that addressing the risk factors for violence is crucial in resolving VAW issues and emphasized the need to avoid putting "labels" on the definition of violence.

Women for Women International, Afghanistan intervention integrates economic with social empowerment of women (skills, referrals and advocacy), who are mostly illiterate. The programme provides support to women in the form of cash transfers ($10), skills, social empowerment, health education, resources and business management skills. The project enrolls women in a 12-month module, where they also bond and establish peer to peer support systems. They also connect to other informal networks existing in the community, and participate actively in decision-making and governance processes. Visual methods are used during the participatory sessions. In addition, there is a 3-month complimentary programme with men including community leaders and faith leaders. Some of the outcomes of the



complimentary programme are: changing gender attitudes in communities, improving women's status in households, knowledge of women's rights, and other things. There is also a broadcasting of women's rights through local radio. Teaching methods include telling stories, lectures, group methods, use of graduates' experiences, videos of men's engagements, and vocational training, such as poultry farming. They work in communities that are secure, and also target seasons of less conflict. They select women who are 18 to 45 years of age, have not participated in the programme before, and one women from each household. The $10 is mainly spent on tuition fees for women's children, medication, and food.

Samvedana Plus, India intervention was introduced by **DL KAVITHA AND SATYANARAYANA RAMANAIK,** which is an intervention and evaluation to understand and address violence and HIV risk amongst the intimate partnerships of female sex workers (FSWs). The intervention works at the individual level with FSWs and intimate partners (IPs), and the community level through using effective strategies to shift social norms, challenge gender roles and prevent violence against women. The evaluation employs a cluster-randomised control trial design, including quantitative baseline, midline and endline assessments amongst FSWs, and baseline and endline assessments with their IPs; qualitative, longitudinal case studies with FSWs and their IPs; in-depth interviews with facilitators of the programme, and implementation monitoring. The study is investigating the relationship between social norms and HIV risk in the context of sex workers' intimate partnerships and will assess the efficacy of the intervention in modifying these norms. An activity based session was held with the workshop participants to act out, discuss and understand the relationship dynamics between FSWs, their male partners and IPV, and illustrate the type of community based activities that KHPT conducts with the participants in the field. The second part of the activity allowed the participants to gain a better understanding of maintaining a healthy relationship balance and the factors that help build a strong relationship.

SESSION 3D: EMERGING FINDINGS IN A NUTSHELL

ONE COMMUNITY, ONE FAMILY, NEPAL

The Sammanit Jeevan intervention was introduced by **GEETA PRADHAN, RATNA SHRESTHA AND ABHINA ADHIKARI** which is being offered in Baglung, Nepal, and is a family centered model intervention, with sessions with young married women, husbands, and in-laws. Baseline and formative findings on key drivers of IPV with 2 migrant communities found that young married women are stressed about being unemployed, quarreling with husbands, and thinking their mother in law is unkind. Men's childhood trauma was found to be a significant risk factor for their perpetration of IPV. One in four women were found to experience IPV in the past year and 1 in 7 men perpetrated IPV in past year. Although young women were found to hold more progressive gender attitudes, this did not protect them against violence. The findings also indicate some change in men's roles in the family, and attitudinal change among family members, which suggest the importance of working with all family members.

JOHNS HOPKINS UNIVERSITY AND SHARPZ, ZAMBIA

The intervention in Zambia was introduced by **FLOR MELENDEZ,** which is a Common Elements Treatment Approach (CETA) programme that works with families (a woman, her partner, and one of children in the home), over 8 to 12 weeks where they meet a counsellor once a week for a 1-2 hour session. Outcomes of the evaluation are domestic violence, alcohol abuse, mental health. Counsellors are from communities and trained to offer support and develop skills that can be used beyond the length of project. From the baseline data, 50% of women reported being slapped, 59% of women reported being pushed or shoved in the last 12 months. Seventy-three percent of men had self-reported drinking alcohol at a hazardous level and 93% of women reported their partners drinking alcohol at hazardous level related to IPV. Mental health was also strongly associated with IPV. CETA could be a low cost, easily accessible treatment program for families affected by violence and alcohol.

MA'AN TV NETWORK, OCCUPIED PALESTINE TERRITORY

This intervention, which uses innovative media including radio, TV, online and social media and texting to reach many people in different areas across Palestine was introduced by **ABED AL-AYDI.** The goal of the programme is to end VAWG through community education and outreach. Formative and baseline research found the occupation of Palestine is related to violence in the community. Most men and women faced violence in the occupation. Women's experiences of domestic violence was 37% in 2011, compared to 51% in 2016. Other types of violence women reported was occupation violence, economic, emotional, physical and sexual. The findings emphasize the need to create innovative programs, national campaigns, and a gender unit to audit all project materials to be gender sensitive.

CHANGE PROJECT, SONKE, SOUTH AFRICA

This Cluster randomized control trial which is being implemented in informal settlements around Johannesburg, South Africa, was introduced by **MWZAKHE KHUMALO.** The aim of the trial is determine whether the intervention can alter men's use of violence. Sixty percent of men who participated in research reported use of violence in the last year, which is significantly higher than the national statistics. The more men expressed gender inequitable views, the more likely they reported use of VAWG. The more men who were frustrated by weak economic status of the family, the more likely they were to perpetrate violence against women as a means of asserting their authority in the household. Men with more gender equitable views were more likely to affect positive economic situations in the home. The findings assert the importance of using community mobilization techniques to address gender inequitable views among men.

HERESPECT, BANGLADESH

The programme in Bangladesh was introduced by **TASNOVA RAHMAN,** which partners with the private sector and uses the workplace as an avenue of change, reflecting on social norms with participatory activities, building life skills like communication skills, and engaging male workers and supervisors. The baseline study found that 35.1% of female garment workers experienced economic violence, 49.5% experienced emotional violence, 34.4% experienced physical violence, and 42.8% experienced sexual violence, which are all significantly higher than the national average. The preliminary findings suggest that workplaces can be a powerful platform for preventing VAWG and for scale up, which is critical, as economic empowerment does not ensure women are free from violence.

REFLECTIONS IN PLENARY: WHAT HAVE WE LEARNED TODAY?

In the plenary discussion, the diversity of reporting of IPV according to context (i.e Zambia vs Nepal) was highlighted. Participants reflected on the learnings around the drivers of IPV and the importance of engaging the younger generation more carefully and consistently. Potential synergies were identified, such as poverty reduction and IPV, alcohol and IPV. The need to engage women's rights activists to use language of evidence in their advocacy, and balance between research and programmatic work was discussed. Overall, the first day emphasized the need for multi-faceted IPV work, and to consider carefully how programme elements can also be risk factors for violence (i.e. economically empowering women).

THURSDAY 6TH JULY: DAY TWO

SESSION 4: TYPES AND PREVALENCE OF VAWG IN CONFLICT AND HUMANITARIAN SETTINGS

KALLIOPI MINGEROU from (UN Women, IAB member) chaired the session and speakers included Mary Ellsberg (GWI, IAB member), Manuel Contreras (GWI), Stacey Striver and Nata Duvvury (National University of Ireland), and Nader Said (AWRAD)

DR MARY ELLSBERG shared materials based on two expert meetings in Washington DC with WHO to develop methodology for research in South Sudan, and with IRC and Bureau for Population, Refugees and Migration to develop a methodological toolkit. Their review of current and ongoing research on GBV prevalence in South Sudan found 130 articles, including 57 cross sectional surveys, prevalence and characteristics studies of GBV. Twenty-one studies were with refugees, 15 with IDPs, and majority (71) were with conflict affected groups, including evaluations of prevention and response programs and about 1/3 were RCTs. Key methodological challenges include lack of comparability and standardization in measurement and definitions of conflict related sexual violence, IPV, and child sexual abuse. They collected 15 prevalence instruments in the study and every study measured violence slightly differently. It is difficult to measure temporality, few conflict studies are longitudinal, which makes it difficult to understand when GBV took place, whether it increased or decreased during multiple conflicts. Finally, there is limited understanding how to address conflict related violence against men. The What Works evaluation in South Sudan thus asked about prevalence of violence against men, whether it is different from violence against women and how. For ethical reasons, they conducted research in areas where IRC had full services for GBV survivors. Mary related the difficulties in getting privacy and sampling in informal settings and ensuring follow up services are available. She also discussed how they recruited men and women from 3 different ethnicities where some of them didn't feel safe, and they had to consider how to manage emotional and physical safety of fieldworkers. Security issues can change in such contexts, and last year they were in middle of fieldwork and there was fighting in Juba, and insecurity in the camps, which stalled research for 3 months. Mary noted that their use of mixed methods, including participatory, formative interviews have helped contextualize their quantitative findings. For instance,

the qualitative research revealed the importance of bride price as a driver of conflict, for cattle raids and abduction of girls. She emphasized the importance to engage local communities, and that they will work with IRC to ensure the data gets used and accessed by communities in ways that are sensitive and appropriate.

DR MANUEL CONTRERAS presented initial results from the mixed-methods study in South Sudan, which examined prevalence and characteristics of different types of VAWG during different phases of conflict, and used participatory formative research and IDIs with stakeholders, a population based household survey with women and men aged 15-64 and qualitative research with survivors and community members. Research was conducted in 4 diverse settings in South Sudan. Manuel focused on findings from the women's data set; the median age 22-26, very low education, majority do home/domestic work, primary source of income is their husbands or relatives, and 90% had currently or formerly married partner. Almost 90% of women think it is natural men should be the head of the family, there was high justification of VAWG, 40-55% of women were in polygamous marriages, more than 80% had dowry and marriage under 19 in two settings. Prevalence of physical and/or sexual IPV ever: was 60% Juba, 73% Rumbek, and 54% POCs. Around 25% of women in all settings experienced non-partner sexual violence. In Juba, the most common perpetrator (48%) people known to the women. In Rumbek, most common (31%) perpetrator are complete strangers/unknown. In POCs, the most common perpetrator (29%) are police officers or armed actors. Many women have experienced attacks on villages and in Rumbek and POCs, experience of sexual assault was clearly linked to the conflict situation. In Juba City, harmful attitudes and behaviours remain firmly entrenched for most women. In Rumbek, women are exposed to harmful practices, especially around marriage, and restricted from education, and are exposed to inter-communal conflict. In the POC camps, harmful practices continue, and have been exacerbated due to displacement. Manuel summarized by noting that women in South Sudan are affected by current conflicts but experience different realities depending where they live and their ethnicity. The crisis has directly and indirectly exacerbated all types of violence including IPV, and pervasive inequitable norms shape women's lives in South Sudan.

STACEY STRIVER highlighted emerging quantitative findings with women across 3 research sites from What Works Component 3. Surveys were conducted with 6998 women across 3 countries (2002 in Ghana, 3000 in Pakistan, 1996 in South Sudan) to understand impacts and costs of violence including in relation to health, capabilities, and social cohesion. Different sites were chosen to assess differences based on stable, fragile or conflict affected contexts. Across all types of violence, the survey found 15% of women experienced sexual violence, 29% of women experienced physical violence, and 45% experienced psychological violence. 44.1% of women in Ghana experienced any form of violence in the last 12 months, 30.2% in Pakistan, and 80.2% in South Sudan. Home was the most likely place a woman would encounter violence by either a partner or family member in Ghana and Pakistan. In South Sudan, violence in the public space was slightly more common than violence in the home. There was a lower prevalence rate for workplace violence and violence in educational institutes, but this smaller rate in the overall sample hides the fact that amongst women who go to school and work, violence in those spaces is quite high. 67% of women in South Sudan experienced IPV in the past 12 months, 45% in Ghana and 21% in Pakistan.

Psychological violence within IPV was the most common types of violence experienced in all 3 sites. Economic violence was very common in Ghana and South Sudan, but not as commonly reported in Pakistan. Pakistan had much higher levels of physical violence reported. Sexual violence was the least commonly form of IPV reported across all 3 settings. 82% of women who had attended an educational institute in the last 12 months had experienced violence there, 51% in Ghana and 18% in Pakistan. Stacey discussed that the early takeaways are patterns of violence are similar across all sites; in conflict affected contexts, while patterns did not change, all forms of violence were elevated. Although fewer women were in education and work, there appeared to high risks for those that are across conflict, fragile and stable contexts. Pakistan continuously demonstrated lower prevalence of IPV, but this requires more probing as there may be more reasons for under reporting in Pakistan.

NADER SAID emphasized the importance of engaging with theoretical frameworks of colonialism and neo-colonialism, and third world feminism, and that patriarchy and colonialism should not be separated. Nader discussed that as part of the What Works evaluation, they conducted FGDS, IDIs and expert interviews as part of the formative research, and a baseline survey with 1067 female and males in West Bank and Gaza as well as family discussions and follow up interviews. They used a hegemonic apartheid system of colonialism and patriarchy for analysis. The findings indicate the negative influences from land confiscation,

overcrowding, inability of rural women to access land, and how economic policies lead to high unemployment rates. The Israeli prevention of men's labour movement places pressure on women's access to local markets. Movement restrictions denies mobility of women, access to education, health and work is curtailed, there are higher rates of school dropout and early marriage. Palestinian men are emasculated by their inability to provide, imprisonment, inability to defend/protect family, and humiliations by soldiers/female soldiers on check points. 55% of women reported any form of direct occupation related violence including humiliations, arrest, beaten/wounded, land confiscation, house demolition, witness of killing of family members. If a husband has been exposed to occupation violence (beaten, hit or wounded), it is 13.5% more likely women will be exposed to such violence by their partner. Such examples indicate the relation between occupational violence and IPV.

MENDY MARSH from UNCIEF was a discussant and reflected on the continuum of violence for women, that the home is not safe, but in conflict settings, public settings can also be unsafe for women. She highlighted the more conclusive evidence on prevalence of VAWG in conflict settings, and the need to now decide how to respond to these challenging situations. Inequitable gender norms, patriarchy and structural discrimination are the backdrop which conflict is overlaid and makes situations more dangerous for women and girls. She noted that the What Works studies presented are including men's experiences of violence as well, which is a new area for the humanitarian field. There is a need to consider what it means to live in a constant state of violence and danger in such settings for our programming. Duty bearers and police are also one of the groups perpetrating VAWG, which means there are multiple actors we need to work with. There is a need to bring research back to the community for women to use, and have their voices guide how we intervene, and not sidelined as is traditionally done in humanitarian settings. fact that the home is most unsafe for women implicates on children's exposure or vulnerability to violence. How can our research uptake and advocacy try to shift the story line of state actors being the primary perpetrators of sexual violence in conflict settings, and which groups should be targeted with this message?

SESSION 5: VAWG IN CONFLICT AND HUMANITARIAN SETTINGS

SARAH FISHER WHITE (DFID UK) chaired the session with presentations from Sheru Muuo (Africa Population and Health Research Center), Gina Alvarado (ICRW), Nata Duvvury (National University of Ireland), Lisa le Roux (University of Stellenbosch) and Maggie Sandliands (Tearfund, UK), Maureen Murphy (GWU)

SHERU MUUO shared preliminary findings from Dadaab case management research. GBV is common in Dadab camp including non-partner violence, early and forced marriage and FGM. Comprehensive case management services were introduced to support survivors. Service provision is handled by national staff skilled case managers and refugee community workers who are trained in GBV response work. The aim of the research was to understand how this model can influence access, quality, health and safety outcomes among refugee GBV survivors. They conducted a cross sectional survey and in-depth interviews with 71 refugee community workers (RCWs), and interviews with 15 national staff in 2015. In 2016, they conducted interviews with 209 survivors at assessment stage, 136 interviews at stage 2, and with 88 survivors at stage 3 to assess progress of service provision using this model. In 2017, they conducted 34 interviews with survivors, 5 with refugee community workers and 3 with national staff. 30% of RCWs had experienced non-









partner violence in the past year and 7% had experienced physical IPV in the past year.

IDIs with RCWs acknowledged the pervasiveness of GBV in the camps, single/unmarried women and girls were viewed as most likely to experience GBV, and major contributions to GBV identified were poverty, idleness, culture/religion and ethnic/clan clashes. Men were the most common perpetrators, walking at night, fetching water/firewood, using toilets outside home or living alone were reported as GBV risks. Being from a minority clan or a single mother or marriage to a man from different clan or non-Somali were identified risk factors for rape. 58% of RCWs reported being threatened with violence by another refugee because of their work as GBV RCWs, 42% of female and 23% of males were hit or hurt in the past year because of their work. 97% felt the services were high quality and would want to receive them themselves and 75% felt satisfied with their work, despite reported threats, stigma from the community, inadequate pay and support.

National staff acknowledged the supportive role that RCWs play in expansion of service delivery. Survivors reported services were helpful and 43% were return visits to the GBV center and 1/3 participants heard about GBV services through community groups. 66% of participants from three assessments appreciated services, felt comfortable sharing experiences, and especially liked home follow up visits and interactions with RCWs. A key motivator was material support such as getting mattresses, nets, small cookers, basins, soap. Shame was given as a key barrier to not seek GBV services. Some women feared being treated differently by RCWs if from different ethnic groups, feared their husbands would find out, or retaliation from attackers. Data collection challenges were identified including the difficulty recruiting qualified interviewers fluent in English and Somali, survivors expecting benefit directly from the research, difficulty of reaching respondents, disruptions caused by verification and repatriation exercises, food distribution or religious activities.

NATA DUVVURY presented preliminary data from assessing the costs of VAWG to businesses in Pakistan and South Sudan. They undertook a survey of 100 businesses (fairly large ones to protect confidentiality) in Pakistan and South Sudan using a self-filled anonymous questionnaire surveyed with 532 employees in Pakistan and 680 employees in South Sudan. Gender proportion of respondents was roughly equal. The study explored prevalence of IPV and non-partner sexual violence, costs in terms of pocket costs for accessing services, missed days of work, lack of focus on work. The study also assessed the costs among men for perpetration and experience of IPV and non- partner sexual violence. The study is also assessing bystander costs in terms of absenteeism and presenteeism for colleagues. 14% and 24% of all employees reported a female colleague had told them she had experienced violence, and almost all of them provided some form of assistance, from talking to helping find a service or doctor, which averaged to 2.9 hours. This shows the significant potential of helping colleagues as a cost to businesses and that costs are not limited to survivor of violence or perpetrator.

GINA ALVARADO discussed the study in Pakistan which involved 24 IDIS and 8 FGDS, began in January/February 2017 and is largely complete. Local teams collected information and were involved in process of coding and helped interpret the findings. A wide range of experiences were identified as violence by women and IPV was the most common type of violence discussed. High levels of domestic violence by inlaws were found, and other perpetrators were from extended family, and a high level of street and workplace harassment was found. It was challenging to classify types of violence found, such

as suspicion of a woman's fidelity. In contexts where a woman's honour is so important, suspicion can taint her and create anxiety and can be understood by women as psychological violence. A large extent of forced marriage was reported. Qualitative data helps explains why women under report IPV.

LISA LE ROUX introduced the Tear Fund/Heal Africa intervention in North, Eastern DRC which aims to address VAWG through equipping local faith communities to change social norms related to gender equality and IPV. **MAGGIE SANDILANDS** introduced findings from a quantitative baseline household survey conducted with 769 respondents, administered by sex matched enumerators using tablets, and noted the poor, remote, low SES, lack of infrastructure, resources and low education levels of the context of the intervention and research. It is a conflict affected context, although not an acute, humanitarian crisis, yet the population has experienced previous displacement, conflict and ongoing attacks by militia. 68.8% of women experienced any IPV in the last 12 months, which was much higher than non-partner sexual violence (20.8%), and the IPV is re-occurring. Lisa noted how this prevalence is being echoed in the qualitative panel research with the faith leaders, who are being interviewed at 7 month intervals. Maggie noted the reach and influence of faith groups demonstrated from the baseline survey; 95% of respondents identified with a religion and 83.4% described faith as very important in their lives, and faith leaders were identified as the only social referent whose opinion people felt significantly motivated to comply with. There are few other comparable structures within these communities. A regression analysis found that IPV is associated with witnessing violence as a child, alcohol consumption, and found a significant association between active engagement with a faith group (engaging with services, having a leadership position, decision making role within faith group) and reduced risk of experiencing physical or sexual IPV for women in the last 12 months, and having more gender equitable attitudes, which was consistent when adjusted for other factors. Men more likely to believe God created men and women equal when actively engaged with faith groups. Faith texts could also be used to condone violence; harmful beliefs were stronger when phrased as a scriptural (i.e religious) principle. Lisa discussed how with the progression of the intervention, faith leaders use of interpretation of scripture is becoming more supportive of non-violence and gender equality, although there are still difficult areas, like forced marital sex. They are finding that faith leaders are actively implementing trainings, using existing spaces but creating news spaces as leaders, and that community members are actively attending and interpreting discussions. Even with little training and no payment, activities are ongoing after the third year of the intervention, which may be because of the rural context, and reasons for this will be explored further.

MAUREEN MURPHY introduced that peace building (PB) refers to supporting inclusive peace process and agreements, addressing causes and effects of conflict, and building mechanisms to resolve conflict. State building (SB) is developing a state's capacity, institutions and legitimacy. Maureen introduced research which assessed how VAWG has been integrated and addressed within post-conflict state building policy and programming, and how VAWG is related to efforts to achieve peace and stability in conflict-affected countries. They started with a literature review and found many theoretical connections between peace building and state building (PBSB) and gender equality, VAW, but from a public health perspective, there is little empirical evidence to support these claims. PBSB work often has a gendered component but is not explicitly linked to VAWG. VAWG is primarily conceptualized as militarized rape in PBSB literature. They built a conceptual framework around peace processes and outcome agreement and tried to gender this, incorporating VAWG. The project built a theoretical model based on information including amnesties for VAWG during conflict, women's rights and VAWG included in administrations and decision-making forums, VAWG included as a specific issue within PBSB processes. They also assessed VAWG expertise in staffing, policies, budgets and strategies adopted to address VAWG. They conducted qualitative research in Nepal, Sierra Leone and South Sudan. VAWG was found to be a factor driving conflict in South Sudan and could manifest in cattle raiding, forced marriages, and dowries. VAWG is not considered to be a priority issue by many in the government of South Sudan, and the current efforts to address VAWG are mainly driven by the international community. The Ministry of Gender is not empowered and has limited budget. A disconnect between practitioners of PBSB and VAWG practitioners was noted. For instance, no awareness in GBV sector of national action plan on violence against women, whereas PBSB communities are very aware. In summary, Maureen emphasized the need for a more unified approach.

LORI HEISE was a discussant and highlighted the siloed communities this panel identified. She noted that we

need to be using this data and try to work between those boundaries. For instance, militarized rape is not the defining problem for all sectors, and most settings we are working in are long-term development settings, and we need to consider the ways in which programming and funding is delivered in such settings. South Sudan provides a useful case study given there are a few What Works research projects in this country. Lori emphasized the need to be strategic about the story we are telling and who we want to take the story to.

EMERGING FINDINGS IN A NUTSHELL, PART 3

Right to Play, Pakistan was introduced by **YASMEEN SOMANI,** which is a school based therapy project to prevent violence against school boys and girls. An RCT was conducted in schools with boys and girls (separate sex schools), and used peer perpetration and victimization scale and child depression as a primary outcome. The survey found that 94% of boys are experiencing peer violence and 85% of girls experience peer violence. 85% of boys perpetrated violence and 66% of girls perpetrated violence. Food security, school performance, a father regularly fighting with other men, abuse of mother, and gender attitudes were mediators in pathways for violence perpetration. Reasons for days lost from schools was a mediator only for boys. They expect the Right to Play programme to have an empowering, resilience supporting impact among school boys and girls. Life based learning, and life skills development is expected to increase self-esteem, leading to less violence, an ability to say no to violent attitudes, resilience, and an improvement in school performance and mental health.

IMPower, Kenya was introduced by **GABRIEL OGUDA.** She works with girls to provide empowerment training and build self-esteem, and runs courses with boys to challenge ideas of masculinity that condone VAWG. The programme is expected to reach 20,000 boys and girls in 5 urban informal settlements of Nairobi. 21% of girls from age 10-14 are in relationships, 16% have experienced 1PV and 11% were raped in the last12 months. More than 30% of girls did not tell anyone about GBV. The findings indicate the need to make schools safe spaces for girls and boys, establish or strengthen the guidance and counseling departments, and ensure joint partnership with parents, community support systems and government bodies.

Help the Afghan Children (HTAC), Afghanistan which offers peace education in schools, works with religious leaders, empowers women and works with activists, was introduced by **ABDUL WAHID SIDDIQ.** The baseline survey in 4 districts with 350 boys and 420 girls found that 44.2% of boys experienced corporal punishment and 35.2% of girls experienced corporal punishment in school. The data suggest a significant relationship between peer violence and corporal punishment in schools. Reducing peer violence in Afghanistan may require a school based approach that supports peace education and conflict resolution for both students and teachers.

Change Starts at Home, Equal Access, Nepal project was introduced by **BINITA SHRESTHA,** which developed a context relevant intervention to target social norms by combining radio and community mobilization through formation of listening radio groups among couples. The 9 month curriculum follows a B (beliefs, norms) I (intention for change), and G (growth) approach. Firstly, couples reflect on social norms, then they are equipped with skills to change behaviours and shift norms, and in the third phase, they support diffusion of new norms and behaviours. The baseline study across 3 districts found that almost 1/3 of female respondents have experienced IPV in their lifetime. Only 5% of couples dropped out from the curriculum, and on average, participants attended 90% of weekly sessions. Monitoring suggests high levels of change among participants. The community action toolkit including full length feature film, and radio dramas appear to be effective as ice breakers to organize community dialogues on IPV.

SESSION 6: VAWG AND DISABILITIES

Alice Kerr-Wilson chaired the session with presentations from Ingrid Van Der Heijden (SAMRC), Deda Ogum Alangea (University of Ghana), Cari Clarke (Emory University), Rozina Karmaliani (Aga Khan University) and Julienne Corboz (WW TA Afghanistan)

INGRID VAN DER HEIJDEN prefaced the limited systematic research on disabilities and violence in LMIC, and the need for evidence of inclusive prevention research. She indicated that the medical model considers disability as an individual health/problem that needs to be cured, whereas the social model considers disability as an interaction of individuals' physical and mental health function with their social context and environment. Because of impairments (i.e. physical, mental health conditions) social stigma, physical barriers and lack of resources, they are restricted from participating fully in society. Ingrid discussed a wealth of interconnections between



disability and violence. For instance, 80% of women and girls living with disabilities are in LMIC, and are more likely poor, uneducated and underemployed. Women with mental health disabilities are 4 times as likely to experience GBV. Children with disabilities are 4 time at more at risk for violence than children without disabilities. Girls with disabilities more likely suffer malnutrition, neglect, are denied education, forced into early marriage, and experience more sexual abuse than boys with disabilities. Women with disabilities have increased dependency on their partners, and more likely stay in abusive situations for longer, with increased severity and duration. Those with learning/cognitive disabilities are particularly vulnerable to forced marriage.

Women with disabilities are less likely able to negotiate sexual practices, and often excluded from accessing information to sexual health education. They more likely suffer forced sterilisation, abortion and virgin rape to cure HIV, and are often excluded from IPV prevention and services. Women with disabilities experience adverse SRH outcomes at a higher rate than women without disabilities. Higher levels of discrimination and gender bias increases psychological distress/mental health conditions among women with disabilities. Ingrid discussed how disability inclusive prevention research using quantitative methods can disaggregate prevalence and diversity/severity, identify consequences and how this links to GBV/IPV, and identify links for heightened GBV risk. Qualitative research can identify risk factors and settings for perpetration of GBV against women with disabilities, underlying inequalities and social norms, factors associated with under-reporting, coping strategies and help seeking, and highlight enablers and barriers to existing interventions. Ingrid asserted the need for disability inclusive guidelines for violence prevention research and programmes, and how the evidence emerging from the What Works projects can support these.

DR CARI CLARKE presented the research question around whether disabled women are at greater risk of IPV and violence from other family members in Nepal. She also asked 'do disabled women have less support from natal and in-law family members for IPV? Do disabled women seek help for IPV at lower rates than women without a disability?' For the Change Starts at Home programme, which is operating in 36 villages in Nepal, they conducted a baseline study with 1800 women and found 5% of the sample had a severe disability and 35% had some disability. They found an associated relationship with severe disability and being more likely to experience emotional, physical, economic and sexual IPV. They also found lower family support for women with disabilities. They found that women with some disability are showing slightly higher help seeking rates than women with no disability, however women in the severe disability category seek much less help. Disabled women have fewer familial resources to intervene, leaving them to seek recourse within formal sectors. Those unable to rely on families were more likely to report violence to formal sources, but this is based on the small numbers of women who reported having used formal sources of assistance.

DR DEDA OGUM ALANGEA discussed the linkages between VAWG and disabilities among adult women in 4 districts in Ghana. Deda presented findings from a study, which assessed the community level impact of the Gender Centre's Rural Response System to combat VAWG. More than half of women with a disability had primary school









or no formal education at all, which was much lower education levels than those without disabilities. The age at first marriage for women with disabilities was a bit higher than average, but they had more children and were more likely married. There was no difference in work in past 3 months, but 69% of women with any disability experienced both sexual and physical IPV compared to 43% of women with no disability. 43% of respondents had some form of disability. Past year physical or sexual IPV was not associated with specific disability types. Several factors were found to be associated with IPV. For instance, people who experienced sexual abuse in childhood were more likely to experience IPV in the past year, and these odds were much higher for people without disability.

DR ROZINA KARMALIANI presented background information around disability prevalence in Pakistan, and reported that an estimated 28.9% of the total people with disabilities are at school going age. **JULIENNE CORBOZ** noted the limited disability prevalence data in Afghanistan, and that mental and learning disabilities are highly stigmatised in Afghanistan, much more so than other disabilities such as physical disabilities resulting from war. Rozina noted this is the first study to assess disabled children's exposure to violence in schools in Pakistan and Afghanistan and associations with factors including school performance, gender attitudes, violence at home and at school. The baseline survey from the evaluation of the Right to Play programme in Pakistan, and the baseline survey evaluating HTAC's peace education in Afghanistan both used the Washington Group Disability questionnaire, and child depression inventory. School performance for grades were assessed in Pakistan, whereas numeracy and literacy rates were assessed in Afghanistan.

Julienne indicated that the disability questionnaire assesses the difficulty of performing certain activities. The research found a 6% prevalence of disability among boys and girls of age 11 to 14 in Pakistan, whereby memory and concentration disability was the highest form of disability. A father fighting with other men and school performance were two significant factors found on a logistic regression model when adjusted for age and gender. In Afghanistan, 18% of students had disabilities. The proportion of students with memory and concentration problems was 45 % (similar to prevalence found in Pakistan), but more students had speech and visual difficulties. No relationship was found with exposure to violence and disability. Disabled students were found to more

likely be illiterate and innumerate than non-disabled students, more likely be depressed, exposed to corporal punishment, peer victimisation and more likely to be food insecure. Rozina and Julienne summarized that children with disabilities are vulnerable to peer victimization, at high risk for depression, vulnerable to corporal punishment in schools, and school performance is better among non-disabled children.

DR KRISTIN DUNKLE was the discussant and highlighted the need to unify measurement, including using a pediatric version of the Washington Disability Scale, as the field is currently limited to using an adult version of the scale. Measures of PTSD and depression have manifestations that overlap with some symptoms and impairments picked up in the Washington Scale. Kristin discussed how the data pointed to the importance of looking at diversity within disability, and severity of impairment as an important factor in the level of violence women experience. The social model of disabilities views disability as a broader human rights issue, and influences how we conceptualize interventions to facilitate full inclusion and participation of PLWD and disability activists.

SESSION 7: PANEL DISCUSSION ON SYNERGIES ACROSS PROJECTS

Dr Lyndsay McLean chaired the session with presentations from Prof Naeemah Abrahams (SAMRC), Dr Mary Ellsberg (GWI, IAB), Dr Shiv Kumar (Know Violence in Childhood, IAB), Mendy Marsh (UNICEF, IAB), Shanaaz Matthews (Children's Institute), Claudia Garcia-Moreno (WHO, IAB)

DR LYNDSAY MCLEAN introduced how over the past two days, we have started to identify common findings and key differences across contexts we are working in regarding risk factors of violence and how they interact with specific risks of men's perpetration of violence. We heard about a variety of interventions, which were adapted to their contexts, and research being conducted to evaluate their impact. Lyndsay asked the panelists, after looking across emerging findings from the What Works projects, and building on wider experience in the field, what are the 3 most important insights for our understanding of the drivers of violence or what works to prevent it? She also asked panelists to suggest the way forward for the What Works programme.

PROF NAEEMAH ABRAHAMAS responded to this question by noting that firstly, a broad knowledge based has now emerged. From the drivers of violence research, What Works developed the interventions. We know child abuse, social norms, are all drivers of IPV, but we are now making connections between those risk factors and interventions. Other forms of violence are starting to be addressed like violence by teachers, in families, but we need to consider how different experiences of violence influence our abilities to do interventions. The second insight is that measuring drivers of violence like poverty, food insecurity, providership, need to be standardized so we can make comparisons across the projects. This remains a challenge. Thirdly, What Works is about primary prevention but we need to not ignore the impact that secondary prevention has. When asked about the way forward, Naeemah recommended considering innovations about IPV preventions, especially using social media to address gender norms issues. Research uptake and use of research needs to be done in ways that access, support and convince policy makers to take interventions to scale, which is dependent on a country' political situation, whether there are women's movements, and the work with community settings.

DR SHANAAZ MATTHEWS identified insights around the intersection of VAWG and poverty, which highlights the complexities of measuring and carefully considering data. Shanaaz discussed the need to consider how children are more at risk to violence for being in households with poverty, and childhood trauma can be driven by poverty. Secondly, structural equation models can indicate pathways for victimization and perpetration and common risk factors underlying both VAW and VAC. They can also indicate co-occurrence; when a mother experiences violence, whether the children witness or not, this impacts children. Shifting that intergenerational cycle is critical, and interventions need to be multi-layered to address these complexities. Thirdly, the work in Zambia demonstrates how to respond to mental health outcomes and how to reduce long-term impact and developing cost effective measures in LMIC for therapeutic programmes. For the way forward, she asked to consider the context of what is evidence? Are RCTs always necessary? She also emphasized the need to engage with policymakers early on and take them through that process from the beginning, so they understand importance of work you are doing. Regarding scale up, she advised that we need to consider the costs to sustain implementation.

DR CLAUDIA GARCIA-MORENO discussed how one of the first insights is that at the level of global monitoring, we tend to look at national or sub-national prevalence, but the work presented indicates that within countries there are huge variations, in specific settings such as IDP camps, informal settlements, and among specific groups, such as garment workers and sex workers. We thus need to look beyond the

broad aggregates at specific vulnerable settings and groups. The richness of the data presented allows us to nuance our messaging. We still tend to address GBV in silos, and we need to consider the package of interventions needed to address multiple drivers. Secondly, Claudia raised the issue of regarding prevention as a continuum and not a dichotomy of primary and secondary prevention. Services can play a role in prevention such as identifying children at risk or witnessing violence, and we should consider this for how we design services in ways that contribute to prevention. Thirdly, partnerships and collaborations bringing together programmers and intervention design and researchers is not easy and has been challenging, but has evolved so much since the beginning of What Works, and we are seeing the fruits of those collaborations. This will be critical for our research uptake. For the way forward at national and local levels, a challenge with research uptake will be to draw out messages that can be distilled and cut across different research projects. There is also the challenge of consistency of measurement and conceptualizations (i.e. psychological violence) across studies. Claudia also suggested that programming consider how to increase cohesion across VAW and VAC prevention.

DR MARY ELLSBERG remarked on the tremendous progress on so many research fronts in a short period of time. Only a few years ago, we started talking about prevention, it's intersections with disability, conflict, VAC, livelihoods, and now there is a huge, rich body of evidence. Alliances between research and programming are critical to ensure we have the right story, but also who owns story, and how should they be using it. Civil society and the women's movement need to own data at a local level, and this only will happen if we create those alliances and trust. For the way forward, she suggested using synthesis and reflection across projects to push the field forward in terms of better programming and better measurement. Effective research uptake needs to consider how to move key issues forward with our evidence such as around conflict, immigration, and poverty. To do this, we need strong alliances with activists who are pushing for social change.

MENDY MARSH discussed the value of combining research and implementation to ensure practiced wisdom is being used through intervention and research. We can take advantage of the network we have established through What Works, and our different advocacy pressure points. She emphasized the need for interventions to address structural drivers of IPV and community based social norms. VAC and VAW fields have often been divided, and this collaboration is extremely informative for partners like UNICEF who want to bring these two fields together to have an impact needed across the lifespan for both children and women. The way forward is to be ready to articulate what scaling up a programme would look like, and how can we have all intervention pieces in place. We need to be more strategic with the language we use in the current political climate or we will miss a huge opportunity, as there will be significant expectations for the outcomes of What Works that we need to take advantage of.

DR SHIV KUMAR discussed the deep social and economic roots of violence, and the need to influence the order of cultures, hegemonic masculinity, inequality, injustice and lack of freedoms simultaneously. A number of promising strategies and interventions are clustered into 1) interventions that seek to enhance individual capacities of parents, caregivers, children 2) interventions to embed violence prevention in institutions and services and 3) interventions to eliminate root causes of violence including ending conflict, situations of war, humanitarian situations, and an element of this is to change adverse norms. Shiv discussed the need to improve evidence, and push for more specialized research, knowledge and evaluations. Ending VAW is a necessary condition for ending VAC and it is wonderful to see them being brought together under What Works. The way forward is to use What Works unique emphasis on the economic component. We need a more nuanced understanding of the interconnections between income, poverty, deprivations, inequality and violence. We can establish the impact of certain interventions but the unanswered question is how do you scale it up, how much will it cost to prevent violence, and how this relates to minimum and maximum standards.

KEY INSIGHTS FROM THE ROOM

PROF RACHEL JEWKES noted that the way forward is to be in a situation where we are not just evaluating interventions in one setting, but are assessing what happens when we have baskets of interventions in one setting working on mental health, schools, women's empowerment etc. to get the bigger picture.

SHEENA CRAWFORD noted that for the evaluation team, they are beginning to see synergies between the 3 components and areas for potential further synergies, and should use those in the future for the global prevention of VAWG, which is a significant development from the mid-term review.

DR NATA DUVVURY said that we should celebrate the multi-disciplinarity that the What Works consortium represents, and that we should commit ourselves to take this research and our findings to multiple disciplinary discourses. That is where we will have the maximal impact to draw new stakeholders into VAWG prevention.

KALLIOPI MINGEROU noted that we should link to UN systems, and use this as an opportunity to inform VAW prevention more broadly, and the need for a more comprehensive approach. She noted the need to address violence as a continuum rather than the dichotomy between conflict and post conflict.

DR LORI HEISE noted that What Works has ended up doing a lot more intervention development, and adaptation than originally anticipated. We should try to capture some of that and what it means in terms of lessons for adaptation. For instance, there is a Stepping Stones type interventions in a few settings, but this varies significantly. We need to get a sense of what we are transferring to different settings, and an inventory of how they vary between different programmes would be important for us to learn. This will help us move towards understanding principles that need to be achieved in each setting.

DR KRISTIN DUNKLE noted how after having the endline trial results, there will be much more we can learn, and asserted value of having more time with the grant and with the data. This could allow us to better understand to what components of interventions are essential, for what populations are they most effective, and with another 12-18 months with the data, we can answer those questions. This meeting raised so many questions about different impacts around age, location, disability status, and context etc. that could affect interventions.

DR LYNDSAY MCLEAN wrapped up by highlighting the emerging research agendas and analysis identified from this meeting. There is a wealth of practice based learning to come out of this consortium, as well as partnerships, capacity development processes we have used. We need to consider research into action, and how we make changes on the basis of what we found, which is a process that will continue for some years.

CLOSING: The meeting was officially closed by Sarah Fisher-White, Tim Conway and Emily Esplen from DFID, London.

APPENDIX 1:
Agenda of the 3rd What Works? Annual Scientific Meeting

APPENDIX 2:
Full List of Participants of the 3rd What Works? Annual Scientific Meeting

APPENDIX 1: AGENDA 3RD WHAT WORKS? SCIENTIFIC MEETING

ANNUAL SCIENTIFIC MEETING
AGENDA 2017

KIEVITS KROON COUNTRY ESTATE, PRETORIA
SOUTH AFRICA, 5 – 6 JULY 2017

PREAMBLE: This is the third of four scientific meetings of *What Works?* The meeting will focus on:

1. Sharing and learning from research findings from the past year.
2. Sharing and learning from processes of developing theoretically grounded interventions.
3. Deepening understanding of and ideas for using research effectively to influence policy and practice.

GOALS OF THE MEETING:

1. Strengthen the policy-relevance and coherence of the What Works research programme, including by beginning to develop a coherent narrative and set of messages emerging from across the programme as a whole.
2. Discuss research methods and approaches to understanding VAWG in order to share learning and strengthen them.
3. Share new learning across What Works components and partners, and deepen understanding of the work that is being conducted across the 3 components of the What Works Programme.
4. Provide a forum for exchange of ideas from across What Works components and partners with a view to strengthening the science of "What Works", and strengthening the framing of research questions, future findings and recommendations within current policy and programming debates.
5. Deepen understanding of the work and emerging thinking across the components, in order to identify synergies across the components.

WEDNESDAY, 5 JULY 2017

08:30 – 09:00	REGISTRATION
09:00 – 09:30	**FORMAL MEETING OPENING AND WELCOME:** **VENUE:** De Kasteel 1 & 2 ***Glenda Gray, President of the South Africa Medical Research Council*** (10 mins) ***Progress in the last year from the Three Components*** (20 mins) ***Rachel Jewkes,*** Component 1 Consortium Lead ***Tim Hess,*** Component 2 Consortium Lead ***Nata Duvvury,*** Component 3 Consortium Lead
09:30 – 11:00	**SESSION 1:** POVERTY AND VAWG AND THE ROLE OF ECONOMIC EMPOWERMENT IN VAWG PREVENTION **CHAIR:** ***Claudia Garcia Moreno,*** World Health Organization, Switzerland, Plenary Session **VENUE:** De Kasteel 1 & 2 • Poverty and VAWG: Theory and the effectiveness of economic empowerment intervention: Nata Duvvury, National University of Ireland, Galway, Ireland (10 mins) • VAWG and costs to businesses: Felix Asante, University of Ghana, Ghana (10 mins) • Violence and sex work: Satyanarayana Ramanaik, KHPT, India (10 mins) • Violence in the workplace and the role of managers: Ruchira Naved, ICDDRB, Bangladesh (10 mins) • Poverty and VAWG in Tajikistan and Nepal: Henri Myrttinen, International Alert, Tajikistan and Nwabisa Jama-Shai, SAMRC (10 mins) • Violence in informal settlements in South Africa: Nicola Christofides and Abigail Hatcher, University of Witwatersrand, South Africa (10 mins) ***Discussant:*** *Making the Connections: Shiv Kumar, Know Violence in Childhood, India* (10 mins) **GENERAL DISCUSSION:** Questions and Synergies (20 mins)

11:00 – 11:30	TEA BREAK
11:30 – 13:00	**SESSION 2:** VIOLENCE AGAINST WOMEN AND GIRLS AND VIOLENCE AGAINST CHILDREN **CHAIR:** ***Fiona Clark,*** DFID, Africa Regional Department, Plenary Session **VENUE:** De Kasteel 1 & 2 • Connections between violence against children and violence against women: Rachel Jewkes, SAMRC, South Africa (15 mins) • Associations between childhood violence and adult violence exposure: Andy Gibbs, SAMRC, and Julienne Corboz, What Works Technical Advisor, Afghanistan (15 mins) • Early insights into preventing GBV in adolescents from the informal settlements of Nairobi, Kenya: Clea C. Sarnquist and Mike Baiocchi, Stanford University, USA (15 mins) • Violence against women and violence against children within Zambian families: Laura Murray, Johns Hopkins University, USA (15 mins) ***Discussant:*** *Making the Connections: Tina Musuya, CEDOVIP, Uganda* (10 mins) **GENERAL DISCUSSION:** Questions and Synergies (20 mins)
13:00 – 14:00	LUNCH BREAK
14:00 – 14:30	**SESSION 3 A:** EMERGING FINDINGS IN A NUTSHELL, PART 1 **CHAIR:** ***Kristin Dunkle,*** SAMRC Plenary Session **VENUE:** De Kasteel 1 & 2 *An opportunity for projects to share their most exciting emerging key messages via 5-minute presentations developed during the Capacity Development Workshop that preceded the ASM.* 1. COMBAT, Ghana 2. Engaging Faith Groups to prevent VAWG, DRC 3. International Alert, Tajikistan 4. Women for Women International, Afghanistan 5. Samvedana Plus, India 6. Stepping Stones & Creating Futures, South Africa
14:30 – 15:15	**SESSION 3 B:** INTERVENTION ROADSHOW, PART 1 *An opportunity for ASM participants to experience a sample session from one of four What Works projects and speak with project staff about their work.* **Parallel Sessions, 45 mins** • One Community, One Family, Nepal (Venue: De Kasteel 3) • Ma'an TV Network, Occupied Palestinian Territory (Venue: De Kasteel 1 & 2) • Help the Afghan Children, Afghanistan (Venue: Rust & Vrede) • SHARPZ, Zambia (Venue: Buitenverwachting)
15:15 – 15:45	TEA BREAK
15:45 – 16:30	**SESSION 3 C:** INTERVENTION ROADSHOW, PART 2 *An opportunity for ASM participants to experience a sample session from one of four What Works projects and speak with project staff about their work.* **Parallel Sessions, 45 mins** • Stepping Stones & Creating Futures, South Africa (Venue: De Kasteel 3) • Samvedana Plus, India (Venue: De Kasteel 1 & 2) • Women for Women International, Afghanistan (Venue: Rust & Vrede) • COMBAT, Ghana (Venue: Buitenverwachting)

16:30 – 16:55	**SESSION 3 D:** EMERGING FINDINGS IN A NUTSHELL, PART 2 **CHAIR:** ***Kristin Dunkle,*** SAMRC, Plenary Session **VENUE:** De Kasteel 1 & 2 *An opportunity for projects to share their most exciting emerging key messages via 5-minute presentations developed during the Capacity Development Workshop that preceded the ASM.* 1. One Community, One Family, Nepal 2. SHARPZ, Zambia 3. Ma'an TV Network, Occupied Palestinian Territory 4. CHANGE Project, Sonke, South Africa 5. HERrespect, Bangladesh
16:55 – 17:10	**REFLECTIONS IN PLENARY:** What have we learned today? What key messages are emerging? **FACILITATOR:** ***Kristin Dunkle,*** SAMRC **VENUE:** De Kasteel 1 & 2

THURSDAY, 6 JULY 2017

09:00 – 10:30	**SESSION 4:** TYPES AND PREVALENCE OF VAWG IN CONFLICT AND HUMANITARIAN SETTINGS **CHAIR:** ***Kalliopi Mingerou,*** UNWomen, USA, Plenary Session **VENUE:** De Kasteel 1 & 2 • Evidence gaps, theoretical issues, and current debates: Mary Ellsberg, GWI (15 mins) • Prevalence, forms and drivers of violence in South Sudan: Manuel Contreras GWI (15 mins) • Types and prevalence in Component 3 research settings: Stacey Scriver and Nata Duvvury, National University of Ireland, Galway (15 mins) • Types of VAWG in the Occupied Palestinian Territory: Sifting through the social and the colonial: Nader Said, AWRAD, Palestine (15 mins) ***Discussant:*** *Making the Connections: Mendy Marsh, UNICEF, USA* (10 mins) **GENERAL DISCUSSION:** Questions and Synergies (20 mins)
10:30 – 11:00	TEA BREAK
11:00 – 12:30	**SESSION 5:** VAWG IN CONFLICT AND HUMANITARIAN SETTINGS: RESPONSES AND COSTS **CHAIR:** ***Sarah Fisher White,*** DFID UK, Plenary Session **VENUE:** De Kasteel 1 & 2 • Findings from the Dadaab VAWG case management research: Sheru Muuo, Africa Population and Health Research Centre, Kenya (15 mins) • Costs in conflict and humanitarian settings: Gina Alvarado, ICRW, USA and Nata Duvvury, National University of Ireland, Galway, Ireland (15 mins) • VAWG in DRC and the potential for faith-based interventions: Lisa le Roux, University of Stellenbosch, South Africa and Maggie Sandilands, Tearfund, UK (15 mins) • Intersection of VAWG with state building and peacebuilding processes in Sierra Leone, South Sudan and Nepal: Maureen Murphy, GWU, USA (10 mins) ***Discussant:*** *Making the Connections: Lori Heise, LSHTM, UK (10 mins)* **GENERAL DISCUSSION:** Questions and Synergies (25 mins)

12:30 – 12:55	**EMERGING FINDINGS IN A NUTSHELL, PART 3** **CHAIR:** ***Kristin Dunkle,*** SAMRC, Plenary Session **VENUE:** De Kasteel 1 & 2 *An opportunity for projects to share their most exciting emerging key messages via 5-minute presentations developed during the Capacity Development Workshop that preceded the ASM.* 1. Right to Play, Pakistan 2. IMPower, Kenya 3. Help the Afghan Children, Afghanistan 4. Indashyikirwa, Rwanda 5. Change Starts at Home, Equal Access, Nepal
12:55 – 14:00	LUNCH BREAK
14:00 – 15:20	**SESSION 6:** VAWG AND DISABILITIES **CHAIR:** ***Alice Kerr-Wilson,*** Social Development Direct, UK, Plenary Session **VENUE:** De Kasteel 1 & 2 • Connections between VAWG and disabilities: Overview and theory: Ingrid Van Der Heijden, SAMRC, South Africa (15 mins) • VAW and disabilities among adults: Deda Ogum Alangea, University of Ghana, Ghana and Cari Clarke, Emory University, USA (15 mins) • Disability and violence among children: Rozina Karmaliani, Aga Khan University, Pakistan and Julienne Corboz, What Works Technical Advisor, Afghanistan (15 mins) ***Discussant:*** *Making the Connections: Kristin Dunkle, SAMRC (10 mins)* **GENERAL DISCUSSION:** Questions and Synergies (25 mins)
15:20 – 15:40	TEA BREAK
15:40 – 16:40	**SESSION 7:** PANEL DISCUSSION ON SYNERGIES ACROSS PROJECTS Chair: Lyndsay McLean, Plenary SessionVenue: De Kasteel 1 & 2 **PANELLISTS:** • ***Naeemah Abrahams,*** Director, Gender and Health Research Unit, South Africa Research Medical Council • ***Mary Ellsberg,*** Director, Global Women's Institute, George Washington University, USA • ***Shiv Kumar,*** Global Co-Chair, Know Violence in Childhood • ***Mendy Marsh,*** Specialist, Gender Based Violence in Emergencies, UNICEF, USA • ***Shanaaz Mathews,*** Director, Children's Institute, University of Cape Town, South Africa • ***Claudia Garcia-Moreno,*** Team Leader, Violence Against Women and Girls, World Health Organization, Switzerland
16:40 – 17:00	**CLOSING REMARKS** Emily Esplen, Tim Conway and Sarah Fisher White, DFID (20mins)

APPENDIX 2: LIST OF PARTICIPANTS WHAT WORKS? SCIENTIFIC MEETING

ANNUAL SCIENTIFIC MEETINGS ATTENDANCE LIST

5 - 6 JULY 2017, KIVIETS KROON COUNTRY HOTEL, PRETORIA

NO	NAME	SURNAME	ORGANIZATION
1	Abd Al Aziz	Al Ayed	Ma'an TV, OPT
2	Abdul Wahid	Siddiq	Help the Afghan Children, Afghanstan
3	Abhina	Adhikari	VSO, Nepal
4	Abigail	Hatcher	Wits University
5	Adolphina	Addo-Lartey	University of Ghana
6	Alexandra	Bayfield	DFID
7	Alice	Kerr-Wilson	Social Development Direct
8	Ama	Fenny	Component 3
9	Andrew	Gibbs	SAMRC , HEARD
10	Angelica	Pino	Sonke Gender Justice, SA
11	Benjamin Omondi	Mboya	UJAMAA, Kenya
12	Binita	Shrestha	Equal Access, Nepal
13	Cari	Clarke	Emory University
14	Carron	Mann	Women for Women International
15	Celine	Mazars	UNFPA
16	Claudia	Garcia-Moreno	WHO
17	Clea C.	Sarnquist	Stanford University
18	Cuthbert	Asiimwe	SAMRC
19	Deda Ogum	Alangea	University of Ghana
20	Dilorom	Abdulhaeva	International Alert, Tajikistan
21	DL	Kavitha	KHPT
22	Dorcas	COKER-APPIAH	Gender Centre, Ghana
23	Dumisani	Rebombo	Sonke Gender Justice, SA
24	Ellen	Khomo	SAMRC
25	Emily	Esplen	DFID
26	Erin	Stern	What Works
27	Esnat	Chirwa	SAMRC
28	Fazal Karim	Rahimi	Women for Women -Afghanistan
29	Felix	Asante	Component 3
30	Fiona	Clark	DFID
31	Flor	Melendez	JHU

NO	NAME	SURNAME	ORGANIZATION
32	Gabriel	Oguda	AIHD
33	Geeta	Pradhan	VSO, Nepal
34	Gemma	Ferguson	Equal Access, Nepal
35	Gina	Alvarado	Component 3
36	Giulia	Ferrari	London School of Hygiene & Tropical Medicine
37	Glenda	Grey	SAMRC
38	Grace	Namata	DFID
39	Helen	Appleton	Technical Advisor
40	Henri	Myrttinen	International Alert, Tajikistan
41	Ingrid	Van Der Heijden	SAMRC
42	Jessica	Wan	Business for Social Responsibility, Bangladesh
43	Judith	McFarlane	University of Texas
44	Julienne	Corboz	Technical Advisor
45	Kalliopi	Mingeirou	UNWOMEN
46	Karuna	Onta	DFID
47	Kate	Bishop	Social Development Direct
48	Kristin	Dunkle	SAMRC
49	Laura	Washington	Project Empower
50	Laura	Murray	JHU
51	Leane	Hariparsaad	SAMRC
52	Lisa	Le Roux	University of Stellenbosch
53	Liz	Dartnall	SAMRC
54	Lori	Heise	London School of Hygiene & Tropical Medicine
55	Lyndsay	Mclean	Social Development Direct
56	Maggie	Sandilands	Tearfund, DRC
57	Manuel	Contrers-Urbina	George Washington University
58	Marat	Yu	Business for Social Responsibility, Bangladesh
59	Maria	Krisch	DFID
60	Markus	Goldstein	World Bank
61	Mary	Ellsberg	The Global Women's Institute
62	Maureen	Murphy	Global Women's Institute
63	Md. Mahfuz Al	Mamun	ICDDRB
64	Megan	Lloyd-Laney	IMC
65	Mendy	Marsh	UNICEF
66	Mercilene	Machisa	SAMRC

NO	NAME	SURNAME	ORGANIZATION
67	Mike	Strauss	HEARD
68	Mike	Baiocchi	Stanford University
69	Modiegi	Mooko	SAMRC
70	Monalisa	Hela	SAMRC
71	Mseni	Ndlovu	SAMRC
72	Muhammad Atta	Soomro	Right to Play
73	Mzwakhe	Khumalo	Sonke Gender Justice, SA
74	Nader	Said	AWARD
75	Naeemah	Abrahams	SAMRC
76	Nata	Duvvury	Component 3
77	Nicola	Christofides	Wits University
78	Nolwazi	Ntini	HEARD
79	Nomfundo	Chili	Project Empower
80	Nwabisa	Shai	SAMRC
81	Osman	Hemat	Help the Afghan Children, Afghanistan
82	Pinky	Mahlangu	SAMRC
83	Rachel	Jewkes	SAMRC
84	Rana	Hussain (Obeid)	Ma'an TV, OPT
85	Ratna	Shrestha	VSO, Nepal
86	Rebecca	Ladbury	Communications Specialist
87	Rozina	Karmaliani	Aga Khan University
88	Ruchira	Tabassum Naved	ICDDRB
89	Samantha	Willan	SAMRC
90	Sangeeta	Shrestha	DFID
91	Sarah	Fisher White	DFID
92	Satyanarayana	Ramanaik	KHPT
93	Sergio	TorresRueda	London School of Hygiene & Tropical Medicine
94	Shahribonu	Shonasimova	International Alert, Tajikistan
95	Shanaaz	Mathews	University of Cape Town
96	Sheena	Crawford	DFID External Reviewers, IMC
97	Shehnaz	Munshi	Wits University
98	Sheru	Muuo	Africa Population and Health Research Centre
99	Shiva	Kumar	KNOW
100	Stacey	Scriver	Component 3
101	Tamsin	Bradley	Component 4, IMC

NO	NAME	SURNAME	ORGANIZATION
102	Tasnova	Rahman	Change Associates
103	Tim	Hess	RESCUE
104	Tim	Conway	DFID
105	Tina	Musuya	CEDOVIP
106	Tirhani	Manganyi	SAMRC
107	Uwezo Baghuma	Lele	Heal Africa
108	Yandisa	Sikweyiya	SAMRC
109	Yasmeen	Somani	Aga Khan University
110	Zulfiqar	Shaikh	Right to Play

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