WhatWorks
TO PREVENT VIOLENCE
A Global Programme To Prevent Violence Against Women and Girls

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New learnings on drivers of men's perpetration, and women's experiences, of physical and/or sexual intimate partner violence and the implications for prevention interventions

EVIDENCE REVIEW | JANUARY 2020

Andrew Gibbs, Kristin Dunkle, Leane Ramsoomar, Samantha Willan, Nwabisa Shai, Sangeeta Chatterji, Ruchira Naved, Rachel Jewkes

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ABOUT WHAT WORKS

The **What Works to Prevent Violence against Women and Girls** programme was a flagship programme from the UK Department for International Development, which invested an unprecedented £25 million over six years from 2013 to 19 on the prevention of violence against women and girls. It supported primary prevention efforts across Africa and Asia seeking to understand and address the underlying causes of violence, and to stop it from occurring. Through three complementary components, the programme focused on generating evidence from rigorous primary research and evaluations of existing interventions to understand what works to prevent violence against women and girls generally, and in fragile and conflict areas. Additionally, the programme estimated social and economic costs of violence against women and girls, developing the economic case for investing in prevention.

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A critical task of the past 25 years of research on violence against women and girls (VAWG) has been to develop an understanding of the drivers of men's perpetration of intimate partner violence (IPV) – physical and/or sexual violence against their female partners – and the risk factors that shape women's experience of IPV. Such information is critical to developing the effective IPV prevention interventions required for governments to meet their obligations under the Sustainable Development Goals (SDGs) and achieve women's human rights, health and wellbeing.

Over the past six years the *What Works to Prevent Violence Against Women and Girls Global Programme* (*What Works*), has supported 15 evaluations of violence prevention interventions across Africa and South and Central Asia, as well as research on prevalence and drivers of VAWG in conflict and humanitarian settings. In this brief, we reflect on the evidence produced through What Works, as well as the wider body of literature that has emerged in the past six to ten years. We also provide a comprehensive review of new knowledge of the drivers of, and risk factors for, men's violence against their wives or girlfriends.

The key drivers of IPV are structural: gender inequalities, patriarchal privilege, the normalisation and acceptability of the use of violence in relationships, and poverty. Armed conflict is a further structural factor. These in turn drive, and are driven by, individual and relationship-level risk factors including childhood neglect and abuse and exposure to violence (including abuse of the child's mother), poor mental health and harmful substance use, and poor communication and conflict in relationships. These risk factors are exacerbated for women with disabilities. To complement the existing knowledge and ongoing research, future research on drivers of IPV should focus on:

- **In-depth qualitative research** to develop a stronger understanding of how drivers intersect and operate to create vulnerability to IPV in different social and cultural contexts, with particular consideration of avenues and entry points for interventions to prevent violence.
- **Research with complex statistical modelling strategies**[1] to deepen our understanding of how drivers operate over time and across populations and population sub-groups.
- **Research with vulnerable groups** to understand how aspects of their social, economic and cultural context operates to create vulnerability to IPV: notably, women and girls with disabilities; women and girls and boys and men living in conflict and post-conflict settings, in both displaced and non-displaced settings; and adolescent girls and young women.
- **Understanding how drivers intersect and operate** to heighten risk in settings with much higher rates of IPV than national averages, such as urban informal settlements.
- **Understanding more about the acceptance of the use of VAWG** in different populations and the circumstances in which this is contested, and how it intersects with contextual factors such as age, disability, sexual and/or gender identity.
- **Understanding more about the connections between VAWG and violence against and witnessed by children**, and how interventions that aim to break the cycle of violence with children impact on their experience of VAWG as they transition to adulthood.

1 Complex statistical modelling strategies include structural equation models, latent class analysis and various longitudinal models, which move beyond 'basic' regression models to further our understanding of IPV.

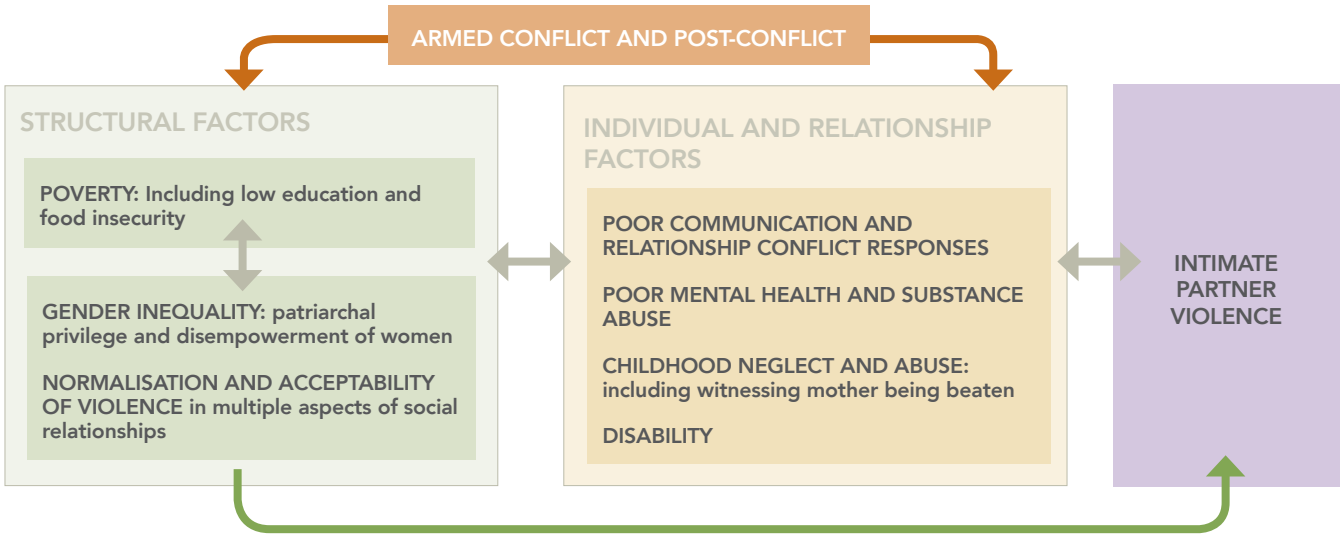


FIGURE 1: Drivers of IPV

Since the early 1990s, researchers, activists and practitioners have made significant strides in delineating the drivers and risk factors for IPV – i.e. the factors that have been empirically shown to be associated with an increased risk of men's perpetration, and women's experience, of IPV. Figure 1 shows a framework outlining the drivers of, and risk factors for, IPV and the pathways between them.

Underpinning men's perpetration of IPV are structural factors, specifically gender inequality in the form of patriarchal privilege and the disempowerment of women, and the normalisation and acceptability of violence in social relationships, alongside poverty. A further structural factor is armed conflict, which has impacts during both conflict and post-conflict periods. These factors individually and synergistically drive IPV perpetration and increase women's risk of experiencing IPV, as well as increasing the risk of poor mental health, substance misuse, poor communication and relationship conflict, and childhood abuse and neglect, which in turn fuel IPV. Disability further exacerbates other risk factors. While pathways suggest an inevitable relationship between these drivers and IPV, experiencing any one (or all) of the drivers, does not necessarily lead to IPV, rather it increases the likelihood that it might happen.

The framework in Figure 1 builds on extensive foundational work around risk factors. Heise [1] used the ecological model to describe how risk factors operate at multiple levels (individual, relationship, community, and societal) to increase women's experience and men's perpetration of IPV [2]. *What Works* adapted this framework by adding additional risk factors evident in conflict and humanitarian settings, such as forced displacement and rape as a weapon of war [3]. A rather different approach to understanding the causes of IPV was outlined by Jewkes [4], who emphasised the need to consider the causal processes through which poverty, and ideologies of 'male superiority' and the 'culture of violence', drive IPV.

At the start of *What Works,* Fulu and Heise [5] reviewed the evidence on drivers of IPV to provide an evidence-driven foundation for IPV prevention efforts. They concluded that knowledge about the drivers of IPV was still limited, especially our understanding of the drivers of men's perpetration of IPV. Over the last six years, *What Works* has generated a considerable body of research on risk factors and drivers of violence through analyses of its primary research data, as well as secondary analysis of large datasets. This evidence brief discusses new learnings on drivers of, risk factors for, and pathways to IPV emerging from this body of knowledge at the end of the *What Works* programme, and offer recommendations for next steps in this field.

In 2019, the World Health Organization (WHO) developed and launched the RESPECT framework [6], which provides policymakers and implementers with action-oriented steps to design, implement and monitor IPV prevention efforts. It draws on the ecological model to describe IPV risk factors that are important for IPV prevention interventions. In this brief, we tackle most of the factors presented in the RESPECT framework [6], but exclude a few not directly relevant here, such as the provision of services for abused women and making environments safe, which while important for IPV prevention, lie outside the scope of this discussion of drivers.

Gender inequalities: Patriarchal privilege, the disempowerment of women, and the normalisation and acceptance of violence

Underpinning men's perpetration of IPV against women are two foundational concepts: the gender hierarchy within a society, and the extent to which violence is normalised and accepted in interpersonal relationships [4]. Globally, patriarchal privilege is dominant, and men's dominance and control over women is normalised. Prevailing gender attitudes, norms, roles and identifies emerge out of this [7]. In addition, laws and policies, and the enforcement of these, similarly reflect, stem from, and reinforce, the gender hierarchy. Men's use of violence is a source of power for men (as well as an expression of this power), and where violence is accepted in social relationships, it is viewed as a legitimate strategy in men's assertion of dominance over women and children.

There has been considerable work over the last six years to better understand men's perpetration of violence, and in particular, to address two key questions: "Why do men as a group use violence against women?" and, "Why do particular men use violence, while others do not?"

In answer to the first question, research has emphasised how men use violence against women to communicate and reinforce their power over women by punishing real or imagined transgressions. The threat of violence itself acts as a means of social control [8]. Connell's [9 10] theory of hegemonic masculinity helps understand how gender inequalities are entrenched by a hierarchy of masculinities and femininities. Within this established hierarchy, the potential of men's violence against women reinforces men's power over women as seen in men who perform hyper-masculinity [11] – practices indicative of a very anti-social, violent and controlling masculinity. Alongside the harm they cause to the women who experience this violence, the actions of these men reinforce to all women the latent threat of men's violence, thus bolstering the status quo [12 13].

To start to answer the second question, studies have sought to understand why some men use violence. One approach has been to use latent class analysis (LCA) to identify different groups of men based on their use of violence. An early analysis by *What Works* drew on population-based data from South Africa [14] and identified three groups of men: the **'most violent men'**, 25% of the sample, reported very high levels of lifetime IPV perpetration (57%), a third (30%) were in

the **'medium violence'** group, where men reported less lifetime IPV perpetration, though this was still high (41%), and a **'lower violence'** group (46% men), who reported the least (but still high) lifetime IPV perpetration at 10%. Compared to the low-violence men, the high-violence group also reported significantly more non-partner sexual violence perpetration [14].

The study [14] assessed the factors associated with men placed in the most violent group. The assessment revealed the roles of much deeper poverty, extensive exposure to abuse and neglect in childhood, being bullied in childhood, and, especially for most violent men, having a cruel father [14]. The impact of child abuse and neglect on the psychopathological development of the men has been shown to result in greater instrumentality in relationships, a limited capacity for remorse and empathy, and a tendency to externalise blame [15], all of which were measured associations in this study [14].

Social norms

There is general agreement that ideas about gender and power are socially learnt and usually taken-for-granted patterns of thought and behaviour [16]. There has been considerable research which shows that not only are we taught how to respond in different situations, but also that the opinions and actions of others matter in relation to behaviour in general, and specifically violence perpetration [16 17]. Social norms theory argues that the views and actions of others strongly influence how we act. It distinguishes behavioural patterns (what we, as an individual, do), collective attitudes (what we, as a group, think and feel about something) and individual beliefs about the behaviour and attitudes of others (what I believe others would do and think) [16 18 19]. It argues that our beliefs about the behaviour and attitudes of others, and collective attitudes, have the greatest impact on what we think and do.

Over the last five to six years, a key area for debate has been the importance of social norms versus other drivers of violence. In Nepal, a *What Works* study assessed the role of social norms in women's experiences of IPV, and found that women were more likely to experience IPV in communities where social norms were more supportive of IPV, and individual women perceived social norms to be more supportive of IPV [17]. In contrast, some studies among men emphasised that the most violent men do not live their lives in a way that shows great concern and attention to the views of the mainstream (social norms) [20]. However, men who are very violent are often strongly influenced by their own equally violent peers, including in extremely violent contexts, such as in gangs [20 21]. Emerging evidence suggests that although social norms are important, they vary contextually; mainstream norms may not be the most important influencers on individual men, and are not necessarily the same (even for neighbouring communities) with a range of other factors that operate in a community and intersect with social norms. The impact of social norms is also filtered through individual life experience (especially of poverty and childhood and later traumas), personality, individual attitudes towards gender and violence, and so forth. Thus, social norms have a role as expressions of the 'gender regime' within a setting, but are one of many other drivers of IPV, rather than occupying a privileged position as the core drivers [22].

Poverty

Poverty is a key factor influencing men's violence perpetration as well as women's options when exposed to VAW [23]. Previously, debate about the role of poverty as a driver of IPV recognised that women of all social classes experience IPV, and noted that higher levels of reporting among poorer households was driven by a greater willingness to report IPV because of fewer social concerns about sharing this information [24 25]. In addition, reviews of the literature often show no clear association between some markers of poverty and IPV (e.g., assets [26] and work [27]). However, *What Works* research and other studies have started to clearly demonstrate that poverty, particularly as indicated by food insecurity, is both a direct and indirect driver of IPV [28-30].

Two *What Works* studies conducted in the highly patriarchal contexts of South Africa and Afghanistan [29 31] showed indirect associations between poverty and IPV. In these studies, growing up in poverty was associated with poorer educational attainment, and in turn associated with less gender equitable attitudes, and likely linked to less empowerment and exposure to diverse ideas from schooling. Having less education also further entrenches poverty in later life. *What Works* has shown across multiple settings [31-33] that growing up in poverty increases the likelihood of experiencing childhood physical, sexual or emotional abuse or neglect, partly because of the challenges of raising children in poverty (such as having to work and not being able to afford childcare) and the resultant stress.

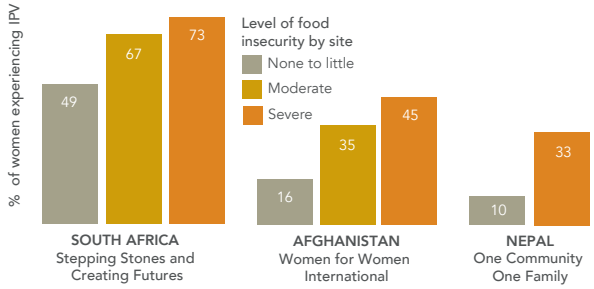


FIGURE 2: Associations between food insecurity and women's experiences of IPV in three studies in *What Works*

There is also strong evidence that poverty, particularly food insecurity, is a direct driver of IPV, with clear pathways through which this occurs. Across *What Works* studies, women's food insecurity was strongly associated with their recent experience of IPV across multiple settings (Figure 2).

There are three pathways through which food insecurity leads to increased IPV. First, in acutely food-insecure households there is more stress about the distribution of food (and resources more generally), which can lead to conflict. Second, poor households experience more stress and shocks, and have less capacity to deal with further daily stressors, which increases conflict. Third, lack of food has physiological impacts on individuals, which leads to reduced ability to regulate emotions and reduced cognitive functioning, further contributing to conflict [34 35].

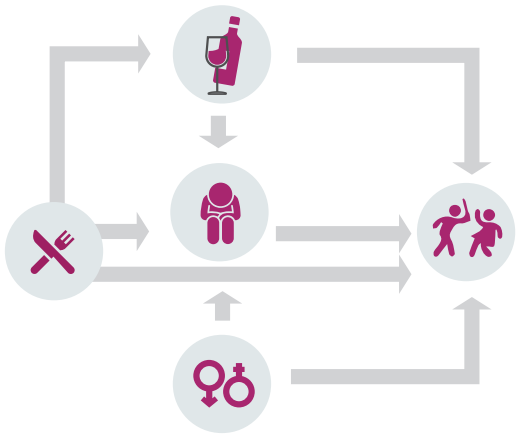


FIGURE 3: Diagram of pathways between food insecurity and men's perpetration of IPV among men in South Africa (Partial structural equation model taken from Hatcher et al [30])

A *What Works* study in South Africa examined the pathways from food insecurity to men's perpetration of IPV (see Figure 3). The study showed that not only was there a direct pathway from increased food insecurity to IPV perpetration, but also indirect pathways whereby higher levels of food insecurity were associated with more depression, and more alcohol use, both of which increased IPV perpetration [30]. The study also highlighted the important role of gender inequitable attitudes in IPV perpetration.

Childhood experiences of violence and neglect

In contexts of poverty, where patriarchal privilege structures relationships and violence is normalised and acceptable, childhood experiences of physical, sexual and emotional abuse and neglect are much more likely, and children are also more likely to witness IPV. Such experiences in childhood are strongly associated with subsequent IPV experience among women and perpetration among men [36-38]. There are two pathways through which childhood trauma may drive IPV: the social learning of violence, and the impact of trauma on children's brain development and later personality, including consequent and co-occurring poor mental health and harmful substance use.

A key pathway through which the experience and witnessing of violence in childhood leads to subsequent IPV is social learning around violence. Social learning theory suggests that there are four mechanisms through which behaviour becomes ingrained: observation of others, internalisation of attitudes supportive of that behaviour, imitation of role models, and reinforcement of behaviour through rewards and sanctioning [39]. Boys, in particular, learn when and where violence can be used, and what it can achieve.

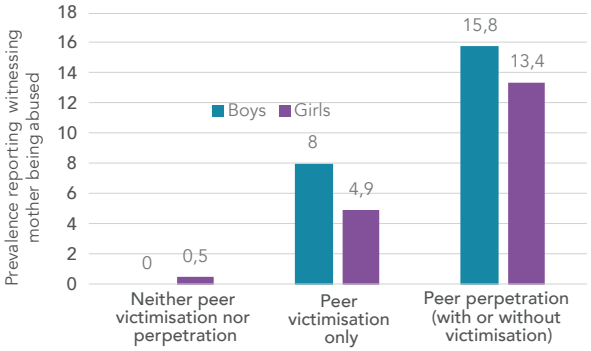


FIGURE 4: Association between witnessing mother being beaten and victimisation and perpetration of peer violence

What Works research has demonstrated the overlapping nature of violence in households. In Pakistan, boys and girls who had witnessed their mother being beaten were more likely to experience and perpetrate peer violence [40] (Fig 4). In Afghanistan, married women who experienced IPV from their husbands were much more likely to experience violence from other family members [41].*What Works* research also reinforced the evidence that witnessing one's mother being abused as a child increased women's experiences and men's perpetration of IPV later in life in Ghana [42 43].

Outside of *What Works*, research has emphasised a second pathway operating through the impact of childhood trauma on brain development, and later personality, whereby the brain circuits and responses to stress are changed [15]. Children – both boys and girls – who experience violence in childhood may develop deep mistrust and insecurity, lack empathy and guilt, and/or have low self-esteem, which negatively impacts on all relationships [15]. Men may be drawn to violent and anti-social peer groups. The pathways through which child abuse and neglect lead to a deep mistrust of women and lack of empathy and guilt have been described in the lives of men who kill their intimate partners [44]. For girls, this can lead to increased risk of experience of IPV in later life. In addition, these changes in the brain structure also increase the likelihood of poor mental health, and harmful substance use [45].



Substance use and mental health

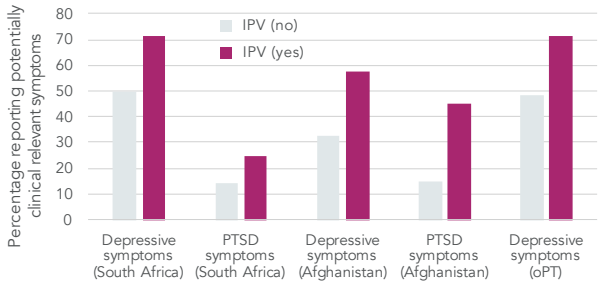


FIGURE 5: Association between IPV experience and poor mental health among women

Harmful substance use and poor mental health often co-occur in individuals [46] and are strongly associated with women's experience of IPV [47 48]. In *What Works*, this emerged across different study settings; women who experienced recent IPV were more likely to report poorer mental health (Fig 5) as well as higher levels of substance use.

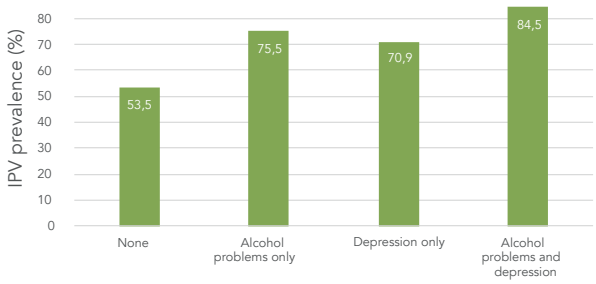


FIGURE 6: Association between alcohol problems, depression and IPV experience in South Africa

Harmful substance use and poor mental health are also, themselves, drivers of IPV [47-49], and can be an outcome of poverty, gender inequalities and childhood physical, sexual and emotional abuse and neglect [50]. *What Works* evidence shows the overlaps between substance misuse and poor mental health and IPV experience in South Africa (Figure 6). The evidence showed a clear dose response: women who reported either harmful alcohol use or depression had higher past year IPV experience than those with neither and those who reported both harmful alcohol use and depression had the highest past-year IPV experience. These relationships are clearly bi-directional and additional research is needed to understand this in greater detail.

Harmful alcohol use may lead to more frequent quarrelling about drinking, finances and household responsibilities, as well as diminished alcohol-related cognitive functioning, which may lead to arguments. This is especially true when couples drink together, which can result in more arguments and arguments escalating into violence. Qualitative research in the *What Works* IPV-prevention trial, Stepping Stones and Creating Futures, found that one way in which women sought to reduce IPV risk was not arguing with their male partner if he was drunk, or she herself was drunk. Although this did not transform gender relationships, it was an important harm-reduction strategy that recognised how alcohol, quarrelling and IPV are interlinked [51]. Similarly, quantitative research from *What Works* confirmed that the pathway from alcohol use to IPV was often via quarrelling [28-30 52].

There is less research on drug-use and IPV, outside of populations characterised by heavy drug-use. In a South African *What Works* study, young women who used drugs were more likely to experience IPV, even after adjusting for alcohol use [29]. Similarly, in a four-country study in Asia-Pacific, women who reported that their partner used drugs also reported more IPV, again after adjusting for partner alcohol use [52].

Poor mental health in men and women is also recognised as a driver of IPV. Longitudinal studies have shown that women who experience depression are more likely to subsequently experience IPV [47]. There is less evidence on whether other common mental health disorders, such as anxiety, and post-traumatic stress disorder [PTSD] increase the risk of women's experience of IPV. These tend to co-occur with depression; the analyses showing the relationships between PTSD, anxiety and IPV experience have not been longitudinal and as such it remains unclear whether they are drivers of IPV [53]. For men, there is strong evidence from longitudinal studies that PTSD is associated with IPV perpetration, mainly from studies of US war veterans [54]. Other forms of poor mental health, including depression [28 49] and anxiety [55], have shown mixed evidence of an association with men's IPV perpetration.

Although research has tended to separate out harmful substance use and poor mental health as different concepts, and has also focused on specific manifestations of each (e.g., alcohol use versus drug use, depression versus anxiety), they overlap significantly. For women, IPV is a driver of poor mental health and substance use, and poor mental health and substance misuse increase women's risk of experiencing IPV. For men, substance misuse and poor mental health are drivers of IPV. The *What Works*-funded intervention Violence Alcohol and Treatment (VATU) in Zambia used the Common Elements Treatment Approach (CETA) to address symptoms of common mental disorders (depression and anxiety), substance use and IPV, in couples in which the man had a problem of harmful alcohol use and used IPV. The randomised control trial (RCT) evaluation showed significant impacts on reducing IPV, symptoms of common mental disorders and alcohol use [56].

Disability

According to the WHO, approximately 15% of people in low- and middle-income countries (LMICs) have a disability [57] and that disability is increasingly recognised as an important risk factor for IPV [58 59]. However, it is not yet systematically integrated into IPV-prevention research. The majority of *What Works* research projects included the Washington Group Short Set (WGSS) of questions [60] to assess disability. A pooled analysis of *What Works* baseline data demonstrated that women with a disability were twice as likely to report recent experience of IPV [61].

The pathways through which disability increases IPV risk are likely multifaceted and bidirectional, but are not yet adequately theorised. There is likely to be a direct pathway because a disability can introduce additional stress in households, through care and support needs and additional costs. Further, the stigma of disability socially devalues the affected woman and thus reduces her power in the home and community. Women with disabilities may not be able to fulfil 'traditional' roles as women, which may expose them to retaliatory violence. In addition, disabled women may be more economically and socially dependent on immediate family and caregivers, and therefore face additional barriers to help-seeking and/or attempts to exit abusive relationships. Programmes and institutions that serve women who experience IPV often fail to fully accommodate the access needs of women with disabilities.

There remain many outstanding questions around the association between disability and IPV experience. Different types of disability may have varying relationships to IPV. Many disabilities are not adequately captured in the WGSS, particularly chronic illnesses with intermittent manifestations. In addition, as the majority of research to date is cross-sectional, the extent to which disability drives IPV risk and vice versa is unknown. Further research is required to understand the pathways through which women living with disabilities have a higher likelihood of experiencing IPV and identify possible points for beneficial intervention.

Armed conflict

Armed conflict has the potential to increase the likelihood of IPV – during the conflict and in its aftermath. Non-partner rape is most closely associated with armed conflict in discussions of conflict-related VAWG, and, while it is often very prevalent, IPV is still the most common experience of VAWG for women who live through conflict and in post-conflict settings [62 63]. *What Works* studies in South Sudan and the DRC have highlighted the very high prevalence of VAWG experience in conflict-affected populations: population-based research from South Sudan has shown that the lifetime prevalence of non-partner sexual violence experienced by women ranged from 28 to 33%, while IPV had been experienced by 54 to 73% of ever-partnered women and girls [3]. Similarly, in the DRC, 68% of women reported having experienced IPV in the past year, and a fifth (20.8%) reported non-partner sexual violence in the same period [3]. A *What Works* analysis of women's experiences of conflict in the occupied Palestinian Territories (oPT) showed that if women themselves, or their husband, had experienced conflict, women were more likely to report past-year IPV (Figure 7).

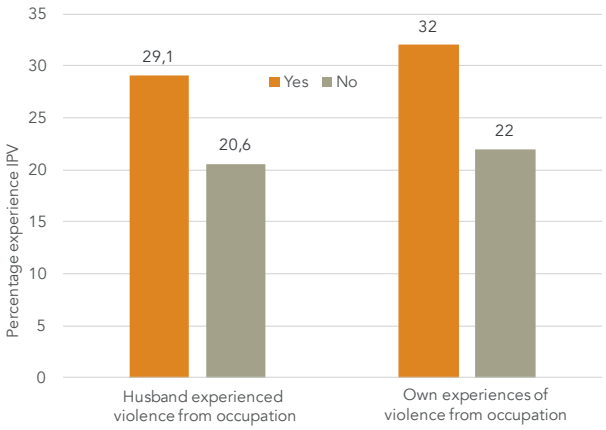


FIGURE 7: Association between war trauma and IPV experience in the occupied Palestinian Territories

In South Sudan, a *What Works* analysis that looked at lifetime risk factors for IPV found in multivariable models that the likelihood of IPV was much higher for women who had a forced marriage because of abduction, pregnancy or non-partner rape (likely linked to the ongoing armed conflict); women who had ever been displaced because of conflict, women who had ever experienced an attack on their village, and/or women who had experience of other physical, traumatic conflict-related events [64].

The understanding of why armed conflict leads to increased IPV during conflict and in its aftermath, is only just starting to be theorised. Armed conflict and forced displacement have indirect impacts on IPV which include the destruction of livelihoods and subsequent higher poverty, the forcible ending of schooling [65], and the destruction of social support systems, which further entrench these factors [3]. There is also generalised collapse of the rule of law, including informal structures, which results in decreased social control [3].

Armed conflict and forced displacement also increase the direct drivers of IPV. Experiences of war-related traumas and the chronic stress of living under threat of attack (shelling and raids, etc.), all contribute to poorer mental health, particularly PTSD, for women and men [66]. The impact on mental health can last long after the conflict has ended [67].

Armed conflict also impacts on men's masculinities in two potential ways. During periods of violence there may be greater prominence of 'strong man' masculinities, which is fueled by a need for protection, but also enables the normalisation and acceptability of violence by men. In contrast, war may also lead to the undermining of men's masculinities as their livelihoods and positions of authority are destroyed, with men seeking to reassert their power and authority through control of women, including the use of violence 'if necessary' [3].

A number of these potential pathways have been described in *What Works* research. In South Sudan. *What Works* research emphasised how girls were often married earlier because of the conflict [3 64], either to reduce the economic burden on households, or to provide them with some security [68]; early and forced marriage is also associated with higher IPV [69]. In Afghanistan, *What Works* research showed that women who had experienced war trauma had less education [31], which impacts on long-term poverty reduction and may be linked to an unwillingness to let girls outside of homes during periods of conflict. In addition, research elsewhere emphasises the impact of war trauma, especially PTSD, and the lingering impact of lost education and economic opportunities on exacerbating poor mental health and harmful substance use [54 70], which result in increased risk of IPV.

Future directions for research on drivers

Research over the last 6-10 years has deepened our understanding of the core drivers of men's perpetration of IPV against women and girls. We recommend the following directions for future research on drivers:

- **In-depth qualitative research** to develop stronger understandings of how drivers intersect and operate to create vulnerability to IPV in different social and cultural contexts, with particular consideration of avenues and entry points for interventions to prevent violence.
- **Research using complex statistical modelling strategies** to deepen our understanding of how drivers operate over time and across populations and population sub-groups.
- **Research with vulnerable groups** to understand how aspects of their social, economic and cultural context operate to create vulnerability to IPV: notably women and girls with disabilities; women and girls and boys and men living in conflict and post-conflict settings, in both displaced and non-displaced settings; adolescent girls and young women; and people with diverse sexual and/or gender identities.
- **Understanding how drivers intersect and operate** to heighten risk in settings with much higher rates of IPV than the national average, such as urban informal settlements.
- **Understanding more about the acceptance of the use of VAWG** in different populations and the circumstances in which this is contested, and how it intersects with contextual factors such as age and disability.
- **Understanding more about the connections between VAWG and violence against, and witnessed by, children**, and how interventions that aim to break the cycle of violence with children impact on their experience of VAWG as they transition to adulthood.

Conclusion

The field of violence against women and girls has developed substantially in the past few years, with stronger understanding of the drivers of IPV and the pathways through which these drivers lead to IPV, which has also led to more effective IPV-prevention interventions based on rigorous theories of change. This work needs to continue, to enable more sophisticated intervention models to eliminate violence against women and girls.

The growing understanding of drivers and risk factors for IPV summarised in this brief suggests that large-scale structural change is critical if we are to end VAWG, and that interventions to prevent IPV need to be aligned to and supportive of these changes. Interventions to address structural inequalities, specifically gender inequalities and poverty, and support for institutional change to protect and assist survivors of VAWG, will have impact on VAWG at a population level, even if it is difficult to assess in the short term.

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