

Empowerment Self-Defense Frequently Asked Questions

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What is Empowerment Self-Defense?

- **Empowerment self-defense (ESD) is a comprehensive, evidence-based, trauma-informed approach to resisting and preventing violence. ESD:**
 - focuses on the full range of gender-based violence, from everyday harassment to life-threatening situations.
 - is grounded in empirical evidence about assaults and the kinds of responses that are most likely to stop them.
 - recognizes that most assaults are perpetrated by acquaintances and intimates, and provides strategies appropriate for these situations.
 - teaches effective physical tactics that require minutes or hours rather than years to master and can be adapted for any body.
 - includes boundary-setting, de-escalation, and verbal self-defense strategies as well as physical techniques. These skills empower students to stop assaults in their early stages, before they escalate to physical danger.
 - offers a “toolbox” of strategies for avoiding and interrupting violence and empowers students to choose the options that are appropriate for their own situation.
 - expands students’ freedom and agency, empowering them to make their own choices about where they go, what they do, and who they do it with.
 - addresses the social conditions that facilitate sexual assault and the psychological barriers to self-defense that make resistance difficult for women and other marginalized groups.
- There are many kinds of self-defense training. **ESD is the only form of self-defense training with research evidence supporting its effectiveness.**

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Does ESD training prevent violence?

- This is really two questions. **First, can women's² resistance stop violence? Yes.** There is a large and nearly unanimous body of research that demonstrates that most women resist when they are being assaulted, and that their resistance is frequently successful.
- **Second, does self-defense training decrease women's risk of assault? Yes.** Five major studies over the past several years, including a large, randomized control trial, found that women who complete an ESD class were at least 50% less likely to be raped over the following year than similar women who did not learn self-defense. Self-defense students were also much less likely to report an attempted rape. In other words, women who learn self-defense are both more likely to avoid rape if they are attacked, and much less likely to be attacked in the first place. Studies also report significant decreases in sexual harassment, sexual coercion, and physical violence.

Is ESD training victim blaming?

- **No.** ESD classes explicitly attribute responsibility for assault to perpetrators, not victims. Just because someone is capable of defending themselves does not mean that they are responsible for doing so.
- Some people have worried that women who learn self-defense may blame themselves if they are later unable to prevent an attack. However, research has found that women with ESD training who experience a subsequent assault blame themselves no more – or even less – than women without self-defense training. Moreover, women who are raped but physically resist are actually *less* likely than other women to blame themselves for their assault.

Does physically resisting assault increase the risk of injury?

- **No.** There is an *association* between resistance and injury, in that women who resist a sexual assault are also more likely to be injured. But research examining the sequence of events has found that in general, injury precedes resistance. In short, women resist because they are being injured, rather than being injured because they resist. **On average, resistance does not increase the risk of injury.**

² Most research on ESD has evaluated classes specifically for women, and so this document focuses mostly on ESD classes for women. However, ESD classes are increasingly welcoming of nonbinary and trans people, boys, and men.

Is self-defense training cost-effective?

- **Yes.** Sexual assault is very expensive in terms of post-assault medical services, legal services, and human suffering. Self-defense training, in contrast, is quite inexpensive. A recent Nairobi-based study found that comprehensive ESD training cost US\$1.75 for every assault prevented, compared with an average of US\$86 for post-assault hospital services. Given the higher cost of medical services, it is likely that the savings would be even greater in the United States.

Shouldn't we be focusing all our resources on preventing perpetration or training bystanders?

- **No.** We don't yet have good evidence that perpetrator-focused strategies actually work. Most strategies that have been rigorously evaluated have been found to be *ineffective* at preventing violence. Similarly, bystander intervention training has not yet been shown to reduce perpetration or victimization. It also can replicate harmful gender stereotypes.
- Ultimately, large-scale social changes will be needed to end sexual assault and other kinds of gender-based violence. In the meantime, ESD training can provide an immediate and effective antidote for sexual violence. We do not have to choose only one approach; we need multiple strategies to address this complex social problem.

What else do I need to know about ESD training?

- ESD training **empowers women in ways that go far beyond preventing assault**. ESD training decreases women's fear and anxiety and increases their confidence, their sense of self-efficacy, and their self-esteem. Learning self-defense helps women feel stronger and more confident in their bodies. Women report more comfortable and empowered interactions with strangers, acquaintances, and intimates, both in situations that seem dangerous and those that do not. ESD training **can be healing to survivors** of sexual violence. ESD classes also **contribute to social change** by transforming gendered ideologies and practices.

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Testing a Model of How a Sexual Assault Resistance Education Program for Women Reduces Sexual Assaults

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Abstract

The Enhanced Assess, Acknowledge, Act (EAAA) program has been shown to reduce sexual assaults experienced by university students who identify as women. Prevention researchers emphasize testing theory-based mechanisms once positive outcomes related to effectiveness are established. We assessed the process by which EAAA's positive outcomes are achieved in a sample of 857 first year university students. EAAA's goals are to increase risk detection in social interactions, decrease obstacles to risk detection or resistance with known men, and increase women's use of effective self-defense. We used chained multiple mediator modeling to assess the combined effects of the primary mediators (risk detection, direct resistance, and self-defense self-efficacy) while simultaneously assessing the interrelationships among the secondary mediators (perception of personal risk, belief in the myth of female precipitation, and general rape myth acceptance). The hypothesized multiple mediation model with three primary mediators met the criterion for full mediation of the intervention effects. Together, the mediators accounted for 95% and 76% of the reductions in completed and attempted rape, respectively, demonstrating full mediation. The hypothesized secondary mediators were important in achieving improvements in personal and situational risk detection. The findings strongly support the benefit of cognitive ecological theory and the Assess, Acknowledge, Act conceptualization underlying EAAA. This evidence can be used by administrators and staff responsible for prevention policy and practice on campuses to defend the implementation of theoretically grounded, evidence-based prevention programs. *Online slides for instructors who want to use this article for teaching are available on PWQ's website at <http://journals.sagepub.com/doi/suppl/10.1177/0361684320962561>*

Keywords

sexual assault, sexual violence, prevention, resistance, women

For at least 40 years, people and communities affiliated with feminist, health, and educational organizations and institutions have been working to prevent sexual assault (e.g., Morrison et al., 2004; Women Against Rape, 1980), and since the early 2000s, there has been increased interest in evidence-based program development and evaluation to rigorously assess interventions' successes and failures. Much of this work has been accomplished on university campuses. A number of qualitative and quantitative review articles and meta-analyses have summarized the state of the field and made recommendations for promising directions for academics and practitioners (Basile et al., 2016; DeGue et al., 2012; DeGue et al., 2014; Ellsberg et al., 2015; Gidycz et al., 2002; Lonsway et al., 2009; Schewe, 2002). As well, prominent researchers have called for resources to be focused on evidence-based, theory-driven, effective programs within a comprehensive approach to sexual violence prevention (e.g., Banyard, 2013; Banyard & Potter, 2017; Orchowski et al., 2010; Orchowski et al., 2018). This approach includes, and extends beyond, student programming to changing entire

campuses and communities. Included in current recommendations by a consortium of independent sexual violence prevention researchers and the Centers for Disease Control are bystander-based interventions for students of all genders, resistance education for female students, and continued development of programming for male students related to a

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bystander and social norms education (Basile et al., 2016; Orchowski et al., 2018).

These opinions are strongly supported by the prevention science literature (e.g., Nation et al., 2003), where it has long been recommended that all prevention work be comprehensive in having multiple interventions targeted for different audiences within a system and use prevention best practices (e.g., include opportunities for active interaction and application of skills). Researchers in academia and public health have also recommended improvements to evaluation research in order to answer more precise questions about what works and why (Banyard et al., 2014; DeGue et al., 2014; Orchowski et al., 2018). Published standards for reporting randomized and nonrandomized evaluation trials (Des Jarlais et al., 2004; Schulz et al., 2010) and calls for better reporting of interventions so that they can be understood and implemented with findings replicated and improved upon by others (e.g., Hoffmann et al., 2014; Pinnock et al., 2017) have also emerged. Specifically, within the sexual violence prevention field, researchers have argued for more rigorous studies that would allow the testing of theory-based mechanisms once positive outcomes related to their effectiveness are established (e.g., Norris et al., 2018).

Salazar et al.'s (2019) recent analysis of the mechanisms for change in the *RealConsent* program for university men is a good example of such an analysis. While high attrition in the follow-up period and the short duration of the positive outcomes make the authors' conclusions tentative, it is an important first attempt to understand how a theory-based sexual assault program works. To our knowledge, no studies of sexual assault resistance education programs for university women have assessed the process by which positive outcomes are achieved (Senn et al., 2018), despite increasing calls for such analyses (Hollander, 2018; Norris et al., 2018). This is our goal.

The current article focuses on the first author's Enhanced Assess, Acknowledge, Act (EAAA) sexual assault resistance education program, which is also known as the *Flip the Script*TM program. EAAA is the only program that in a randomized controlled trial (RCT) has been shown to substantially reduce the sexual assaults that women university students experienced over the subsequent year (i.e., 50% reduction in attempted and completed rape as well as reductions in other forms of sexual assault; Senn et al., 2015). In fact, positive outcomes occur for at least 2 years (Senn et al., 2017). A few empowerment self-defense or risk reduction programs for women have also demonstrated positive sexual assault outcomes. Specifically, assessment of a 30-hour empowerment self-defense program using a quasi-experimental design indicated significant reductions in sexual victimization for college women for at least 1 year after participating in the program (Hollander, 2014). A shorter, 7.5-hour risk reduction program, evaluated using an experimental design, also led to significant reductions in sexual victimization for subsets of

college women who participated in the program for a few months (e.g., Gidycz et al., 2006; for a review of theory and evidence for the type of program more generally, see Orchowski & Gidycz, 2018). Thus, the benefits of understanding how these types of programs work extend beyond a single program.

We were ideally situated to provide answers to this question for many reasons. EAAA was evaluated in a multi-site RCT with a large sample of 893 women students. There were prospective data for women who did and did not take the program, which included information about their backgrounds and baseline scores on key variables. Further, we followed them with assessments across more than a year with high retention. Data collection included measurement of potential mediators (mechanisms) 1-week post-intervention and sexual assaults in the 12 months following that assessment, which allowed for prospective temporal conclusions regarding the mediators' influence on post-program sexual assault outcomes. As such, we were able to go beyond the goal of finding out whether a program works to decrease sexual victimization to how and why the program works. This article describes a chained multiple mediation analysis, which allowed us to assess the joint processes that produced treatment outcomes. Through this analysis, we tested the model of theoretically postulated mechanisms that drove the development of the sexual assault resistance education program. This is important for scientific and practical reasons and has not previously been reported.

Theoretical and Empirical Foundation of EAAA

The EAAA program's name acknowledges that it is based in large part on the recommendations of Rozee and Koss (2001), who synthesized decades of theory and rape research to suggest a theoretically driven, evidence-based approach for sexual violence prevention programming for young women.¹ They named this conceptualization "Assess, Acknowledge, Act (AAA)." AAA was conceived on a bedrock of theory and feminist research, particularly the cognitive ecological theory proposed by Norris and Nurius (e.g., Norris et al., 1996; Nurius & Norris, 1996) and the evidence of effective sexual assault resistance strategies provided by Ullman (1997, 1998) as well as a long tradition of feminist grassroots activism, advocacy, theory, and self-defense practice (e.g., Bateman, 1978; Rozee et al., 1991; Wen-Do Women's Self Defence, n.d.; Women Against Rape, 1980). These underpinnings are described in more detail elsewhere (Rozee et al., 1991; Rozee & Koss, 2001; Senn et al., 2015; Senn et al., 2017). Rozee and Koss's proposed approach challenged past practices that were not theory- or evidence-based, tended to focus primarily on stranger sexual assault, and were largely ineffective (see Morrison et al., 2004, for review of research evaluations of programs conducted prior to this period). They argued that, given the continuing alarming rates of sexual violence experienced by young women, the complete lack of success in

reducing perpetration, and the substantial evidence base available, providing women with knowledge and skills to prepare them to detect risk, overcome emotional obstacles to acknowledging the danger, and to resist sexual coercion or sexual assault by men they know was imperative.

In response to this call, the first author designed a resistance program curriculum to bring the conceptualized program into reality. The term “resistance” is used in its broadest sense to represent any attitudes women hold or actions they take to refuse to accept or comply with social norms or expectations that (a) support woman-blaming explanations for sexual violence, (b) undergird societal tolerance of rape culture, and/or (c) undermine women’s sexual autonomy. Resistance includes defensive actions women take to protect their boundaries, their body, and sexual integrity in interactions with others. For survivors, resistance also includes the refusal to accept sexual violence perpetrators’ views of them and what occurred. EAAA reduces the sexual victimization women experience while holding perpetrators entirely responsible for their actions (Senn et al., 2015; Senn et al., 2017) and interrupts messages often perpetuated in a rape culture (Radtke et al., 2020). The program has a gendered framing, focusing on sexual assaults perpetrated by men who are known to young women (i.e., it uses a broad definition of acquaintances that includes family members, intimate partners, classmates, neighbors, and other men they know). EAAA is designed and implemented to recognize the diversity of experiences of participants who self-identify as women in terms of prior sexual victimization history (i.e., that there will always be survivors in the room), demographics (e.g., race, class, religion), abilities (e.g., physical ability, ability to be loud), sexual identity (i.e., explicitly acknowledges heterosexual, bisexual, lesbian, and asexual identities), and relationship and sexual experience.

The goals of the program are to (a) increase the likelihood that empirically supported risk cues in social contexts (e.g., isolation, alcohol) and revealed in men’s behavior (e.g., persistence, sexual entitlement) will be detected by women as early as possible in social interactions, (b) decrease women’s emotional or cognitive obstacles to risk detection or resistance in situations involving known men, and (c) increase the likelihood that women will use defensive actions (e.g., leaving when possible, forceful verbal and physical self defense) that are most likely to lead to better outcomes (i.e., reduced severity of the sexual assault, interruption of rape; Tark & Kleck, 2014; Ullman, 1997) when threats are detected.

To accomplish these goals, the curriculum has four 3-hour units. Unit 1, Assess, is designed to help women identify situations and behaviors that signal a higher risk for sexual violence. Unit 2, Acknowledge, was created to assist women to overcome emotional barriers to acknowledging the threat from men they know and provides practice in identifying and resisting verbal coercion. Unit 3, Act, provides empowerment verbal and physical self-defense training (based on Wen-Do Women’s Self Defence) focused on effective strategies for

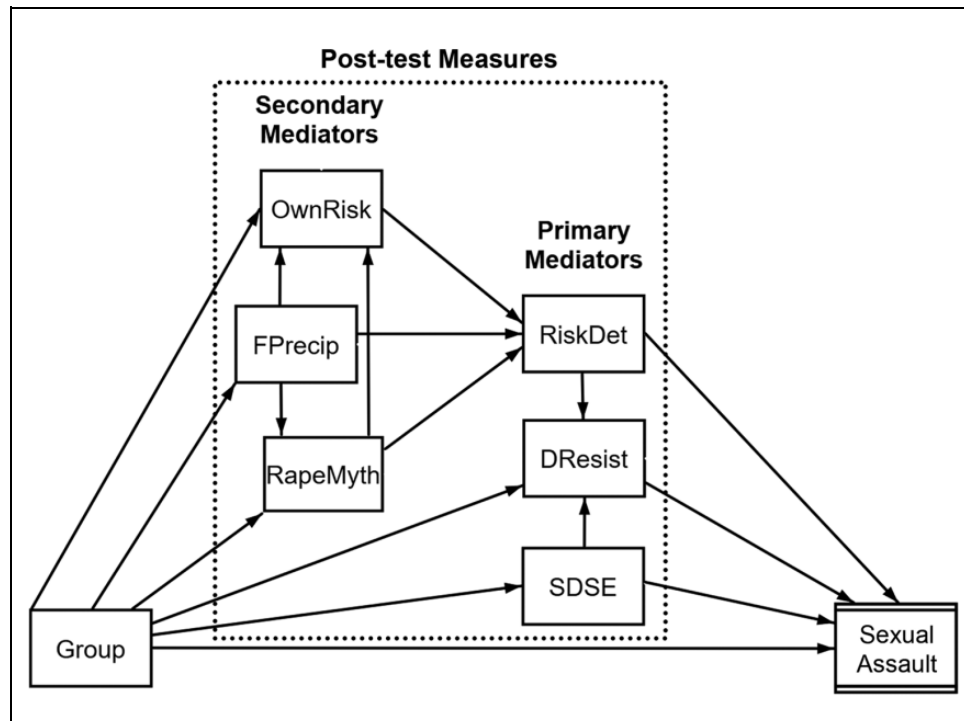
resisting common acquaintance tactics. Unit 4, Relationships and Sexuality, adapted from the Our Whole Lives curriculum (Goldfarb & Casparian, 2000; Kimball & Frediani, 2000), offers high quality sexual information and a context for exploring and talking about their own sexual desires and relationship values. In other words, EAAA gives women evidence-based information, skills, and practice within a positive sexuality framework to empower them to more quickly identify a sexually coercive situation involving a male acquaintance as dangerous and get out or use forceful resistance if necessary. More detail on the program content is provided elsewhere (Radtke et al., 2020; Senn et al., 2013).

The key findings for the registered, multisite (three universities), RCT (SARE Trial) evaluating EAAA have been published elsewhere (Senn et al., 2015; Senn et al., 2017) but are briefly summarized here. The reductions in sexual violence for young women who were assigned to the EAAA program (Senn et al., 2015) were accompanied by positive program effects on a number of other important outcomes (Senn et al., 2017) measured 1 week after participation and, for most, at 6 and 12 months (and up to 24 months). We measured these additional outcomes because they were hypothesized mediators; that is, they encompassed most of the theoretical mechanisms targeted by the AAA approach to increase women’s safety without limiting their freedom. In this study, we go beyond our previous analysis of the program’s positive effects on these outcomes to test whether, together, they are mediators of the reductions in the sexual assault across time. In other words, do improved scores on these outcomes at post-test (1-week after participation) combine to account for the reductions in sexual assault experienced from that point until the 12-month follow-up?

In the following section, we explain the hypothesized multiple mediation model (Figure 1) and, specifically, the theory behind our expectations that the possible mediators would combine to lead to reductions in sexual assault. Given that the model was built based on the best evidence available, there are no competing theoretical models to be tested; rather, we are assessing whether the model works as a whole and whether the relationships for any hypothesized elements are not supported. Any variable that is hypothesized to explain a portion of the EAAA program’s effect on sexual assault victimization through a direct link to the outcome, we refer to as a “primary mediator.” These are the primary elements of the AAA model. Any variable that is hypothesized to have an indirect link to the outcome through its influence on a primary mediator, we refer to as a “secondary mediator.”

Mediators of Reductions in Sexual Assault

Risk detection is a key element of the primary appraisal process outlined in Nurius and Norris’s (1996) cognitive ecological model and hence also the theoretical underpinning of the first unit (Assess). The program is designed to undermine socialization processes about “stranger risk” that direct

Figure 1. Hypothesized Multiple Mediation Model.

Note. Primary mediators are variables that are hypothesized to explain a portion of the Enhanced Assess, Acknowledge, Act program's (Group) effect on sexual assault victimization and have a direct link to the outcome (Sexual Assault). Secondary mediators are variables that are hypothesized not to have a direct link to the outcome themselves but rather are expected to influence the primary mediators. OwnRisk = perceived risk of acquaintance rape; FPrecip = belief in female precipitation of rape; RapeMyth = rape myth acceptance; RiskDet = risk detection; DResist = direct resistance; SDSE = self-defense self-efficacy.

women to use a wide range of precautionary strategies involving restrictions on their freedom without protecting them from sexual violence (e.g., not walking alone at night; Gordon & Riger, 1989; Stanko, 1990). The curriculum provides information and practice in identifying empirically supported risk factors for acquaintance sexual assault and encourages women to trust their own instincts and judgments when they identify risk cues in social situations. Based on past research (e.g., Marx et al., 2001) and theory, better risk detection (i.e., more accurate, earlier) at post-test, which was a positive outcome of participation in EAAA (Senn et al., 2017), should be directly linked to reductions in sexual victimization in the subsequent 12 months and hence a primary mediator.

The EAAA program also addresses obstacles women encounter at secondary appraisal stages (i.e., after risk has been detected and when they are making "determinations of coping resources, options, and outcomes"; Nurius & Norris, 1996, p. 130) in interactions with coercive men. Content and activities in the second unit of the EAAA program focus on strengthening women's belief in their own sexual and relationship rights and undermine the belief that relationships must be preserved at all costs. Young women are provided with a context in which they can practice asserting their needs and confronting common verbal and physical acquaintance perpetrator tactics. In the third unit, facilitators present

evidence that direct forceful verbal and physical resistance strategies and leaving lead to better outcomes in sexual assault situations. In any given situation, participants are then able to select their own toolbox of effective strategies from among the many techniques taught. Nurius and Norris (1996) summarize the goal of intervention to improve the situation for women as follows:

Thus, the extent to which a woman is prepared to see assertive behavior as a reasonable resistance stance *and* is assisted to gain assertiveness skills and habits may have an indirect effect mediated through a woman's cognitive structures operating at the time of the coercion. (p. 122, emphasis added)

Thus, both increases in self-defense self-efficacy, that is, confidence that she could assert and defend herself across a range of situations, and the ability and willingness to use more direct resistance strategies in a hypothetical situation should be related to one another and be primary mediators of the EAAA program's effects on sexual assault. Notably, in our previously published analysis, we found both variables to be positively impacted by program participation (Senn et al., 2017).

Based on the research evidence (e.g., Vitek et al., 2018), risk detection was a primary mediator expected to be influenced by secondary mediators (i.e., other specific attitudes

and beliefs directly affected by the EAAA program). Three hypothesized secondary mediators that were included in the RCT were (a) women's perceptions of their own general risk of sexual assault, (b) acceptance of rape myths, and (c) the belief that women play a causal role in sexual assault. All were affected in the desired direction by program participation at the post-test, and these effects were maintained for at least 2 years (Senn et al., 2017). These attitudes and behaviors were not expected to have direct effects on sexual victimization (i.e., changes in attitudes and beliefs alone have never been sufficient to reduce the incidence of sexual assault; Morrison et al., 2004). Instead, they were included in the trial precisely because any improvements in these attitudes and beliefs were hypothesized to facilitate risk detection. Thus, we hypothesized that in combination these three factors would be related to each other and would lead to better outcomes in sexual assault through their relationships with risk detection. Each is described in more detail below.

An optimism bias, which is the belief that while others are at risk of experiencing a particular negative outcome, we are not ourselves at risk, can in some circumstances be protective (e.g., against depression; Conversano et al., 2010). However, "unrealistic optimism" (Nurius & Norris, 1996) is an obstacle to detecting acquaintance sexual assault risk (Norris et al., 1996). Unsurprisingly, an optimism bias is present in women's estimates of their sexual assault risk (Gidycz et al., 2006). The problematic piece of this perception is not the judgment of risk for other women who are similar to us—this tends to be relatively accurate (i.e., there is a possibility the bad event could occur)—but rather judgment for one's self (i.e., it is unlikely to occur to me). The RCT analyses showed that the EAAA program increased women's perceptions of their own general risk of sexual assault (Senn et al., 2017).² We hypothesized that this should be related to women's risk detection in specific situations by making "danger cues" relevant and worthy of attention as they arose in those situations.

Similarly and relatedly, commonly held myths about the characteristics of rape, rape perpetrators, and rape victims (e.g., that rape is most likely to be perpetrated by strangers) may be psychologically self-protective (e.g., "only women who do X, wear Y, or go to Z are raped and I would never do those things") but may also have negative consequences, such as impairing perceptions of one's own risk of sexual assault (e.g., Bohner et al., 2009; Yeater et al., 2010). Victim-blaming beliefs are thought to be particularly pernicious in this regard. We therefore hypothesized that the program's positive effects in reducing rape myths in general and the specific incorrect belief that women cause rape by their own actions (Senn et al., 2017) would be related to improved risk perception. Further, we expected that reducing the belief that women cause rape by their own actions, a belief that when applied to the self can give one false sense of security (e.g., If I don't go there or do that, then it can't happen to me), would be related to increases in women's perceptions of their

own personal risk because reducing these beliefs makes salient that any woman is potentially at risk.

The theory and evidence upon which EAAA was built emerges from many different, primarily correlational studies often focused on a single domain (e.g., risk perception or self-defense strategies) that were related to positive outcomes (Norris et al., 2018; Tark & Kleck, 2014; Vitek et al., 2018). Although changes in individual domains can occur and can be important in their own right (e.g., more high-quality information about a phenomenon or more skill is usually better than less), our focus is on how the combined domains of the whole model are implicated in achieving the reductions in attempted and completed rape³ affected through participation in the EAAA program.

We focused on the 1-year data from the SARE Trial RCT, because a drop in effect sizes after 1 year and a decrease in the sample size across 2 years reduced our ability to test these relationships beyond this period.⁴ We assessed mediation prospectively using participants' scores on the hypothesized primary and secondary mediators that were measured 1-week post-program and their experience of sexual assault in the subsequent 12 months after the post-test. Given our large sample size, we were able to test the mediation effects for completed and attempted rape separately. It should be noted that rape is broadly and behaviorally defined to include oral, vaginal, and anal penetration by a man without the woman's consent through a range of perpetrator tactics including threats, force, and taking advantage of or inducing women's incapacitation from drugs or alcohol (Koss et al., 2007).

Method

Participants

Eight hundred and ninety-three first-year undergraduate students who identified as women were recruited at three universities and enrolled in the SARE RCT. The full trial protocol has been published (Senn et al., 2013), as have the 1- and 2-year primary and secondary outcomes (Senn et al., 2015; Senn et al., 2017). The prospective analysis in the present study required valid responses on potential mediators measured post-intervention at a 1-week post-test and sexual assault outcomes measured beyond that point. A total of 871 (97.5%) women completed the 1-week post-program survey. Among these, 857 (98.4%) completed one or both of the 6- and 12-month follow-up surveys (i.e., not lost to follow-up) and were included in this study. The 36 participants who were excluded were not characteristically different from the 857 who were retained in the present study (all *ps* *ns*). The average age of the included women was approximately 19 years, almost all were heterosexual or bisexual, one-quarter were women of color, one-half lived in a university residence, one-third had previous self-defense training, and approximately one-quarter had experienced the previous victimization (see Table 1).

Table 1. Between-Group Comparisons of Participant Characteristics at the Time of Randomization.

Participant Characteristic	EAAA (<i>n</i> = 434)	Control (<i>n</i> = 423)	<i>p</i>
Age in years, <i>M</i> (<i>SD</i>)	18.5 (1.2)	18.5 (1.2)	.90
White race, <i>n</i> (%)	316 (72.8)	313 (74.0)	.69
Heterosexual identity, <i>n</i> (%)	399 (91.9)	390 (92.2)	.89
Living in a university residence, <i>n</i> (%)	235 (54.1)	230 (54.4)	.95
Sexually active, <i>n</i> (%)	268 (61.7)	259 (61.2)	.87
Currently involved in a romantic relationship, <i>n</i> (%)	197 (45.4)	189 (44.7)	.83
Currently involved in a sexual relationship, <i>n</i> (%)	191 (44.0)	196 (46.3)	.49
Previous sexual assault education, <i>n</i> (%)	16 (3.7)	18 (4.3)	.67
Previous self-defense training, <i>n</i> (%)	147 (33.9)	140 (33.1)	.81
Sexual victimization since the age of 14 years, <i>n</i> (%)			
Completed rape	95 (21.9)	98 (23.2)	.65
Attempted rape	107 (24.6)	120 (28.4)	.22
Perceived risk of acquaintance rape, <i>M</i> (<i>SD</i>)	1.83 (1.03)	1.80 (0.99)	.71
Belief in female precipitation of rape, <i>M</i> (<i>SD</i>)	15.0 (7.5)	15.3 (7.2)	.56
Rape myth acceptance, <i>M</i> (<i>SD</i>)	31.8 (12.0)	31.8 (11.6)	.92
Self-defense self-efficacy, <i>M</i> (<i>SD</i>)	43.9 (7.8)	44.9 (8.3)	.09

Note. EAAA = Enhanced Assess, Acknowledge, Act.

Intervention

EAAA. This small group (≤ 20 participants) intervention was led by pairs of highly trained, slightly older peer (< 30 years) women facilitators. Women attended an average of 3.62 (*SD* = 0.82) of four sessions, with most (91%) attending three or four sessions. Curriculum fidelity was high (average 94%) as measured by the assessment of randomly selected audio recordings.

Control. To match the standard of care common to all university campuses at the time, brochures on sexual assault were available for participants to take and read, with a friendly and knowledgeable person available to answer any questions that arose about sexual assault or available resources from the group of participants. Brochures chosen were specific to the campuses but had common elements, including the provision of general sexual assault information, date rape drug facts, legal and medical information for survivors, and local resources.

Procedure

The detailed RCT protocol and procedures are published elsewhere (Senn et al., 2013), but we provide a brief overview here. Participants were recruited through a variety of means, including posters, emails, tabling, and advertising in research participant pools. Interested students made contact by phone or

email, were screened by a research assistant and given a detailed explanation of the purpose of the study, the longitudinal survey process and timing, and the randomization procedure. They then chose the timing of the baseline and EAAA intervention sessions that matched their schedule without yet knowing to which condition they would be randomly assigned. All participants attended a baseline session to complete surveys in a computer lab, were randomized (using Randomize.net), and then directed to their intervention room. A meal was provided, the randomization outcome was revealed, and the session facilitated. Depending on their chosen schedule, those students randomized to the EAAA program completed the other units during the same weekend as the baseline session, with two program units delivered each day, or across the next 3 weeks, with one program unit delivered immediately and the other three in subsequent weeks. Control participants attended their brief group brochure session and then did not return until the post-test survey session. Both control and program participants completed in-person, post-test surveys. For the program participants, these occurred 1 week after the final program session. Control participants completed these surveys at the same time as the program participants with whom they attended the baseline and randomization session. Thereafter, all participants completed follow-up online surveys at 6 months, 12 months, 18 months, and for those enrolled in the first year of the trial 24 months, after the baseline session. The CONSORT flowchart is published elsewhere (Senn et al., 2015; Senn et al., 2017).

In the original published article on the efficacy of the program in improving sexual assault outcomes (Senn et al., 2015), an intention-to-treat analysis was used. This required that any sexual assaults occurring between the baseline and the post-test be included in the assessment of efficacy even though participants in the program condition had not yet received the full dose of the intervention. This affected program participants who chose the weekday format more since there was more time between their baseline and post-test survey sessions (average of 28 days) compared to those choosing the weekend format (average of 8 days). For the current prospective analysis, sexual assaults needed to have occurred after completion of the post-test sessions where potential mediators were measured. Therefore, while other aspects of intention-to-treat were still used, we scored sexual assaults occurring after the post-test as the first occurrence of this outcome. As randomization was effective in ensuring equality between groups on all potential mediators measured at baseline (Senn et al., 2015) and two mediators were assessed using single-use measures only at post-test, the current analysis used only mediator data obtained at the post-test survey.

Measures

Sexual assault was measured using the Sexual Experiences Survey–Short Form Victimization (SES-SFV; Koss et al.,

2007). The SES-SFV provides participants with seven items consisting of a stem that describes a sexually coercive or assaultive act or attempted act (e.g., “A man put his penis into my vagina or [someone] inserted fingers or objects without my consent by . . .”), followed by five descriptions of perpetrator tactics or strategies (e.g., “using force, for example, holding me down with their body weight, pinning my arms, or having a weapon”). The tactics range from verbal pressure to physical force. Given the gender-specific focus of the program, we removed the gender-neutral reference to “someone” to ensure reports were victimization by men only. Participants responded to each stem and tactic based on the frequency of occurrence (a) since the age of 14, (b) since the baseline (1-week post-program), and (c) since the last survey for 6- to 24-month follow-ups. When participants reported an attempted or completed rape, they were prompted to use a pop-up calendar to pick the (approximate if necessary) month and the day the incident happened. As such, the outcome/dependent variable in the mediation model is analyzed as time-to-event. Victimization by attempted or completed rape between the 1-week post-program survey and 12-months of follow-up is the focus of the current analysis and randomization to the EAAA program or control group is the causal variable.

Mediators. Figure 1 illustrates the hypothesized chained multiple mediation model. Primary mediators are those variables hypothesized to have a direct link to the outcome. Secondary mediators are hypothesized to influence primary mediators without direct relationships to the outcome. Responses to these measures at a 1-week post-test are the focus of the current analysis. All measures demonstrated good internal consistency in the current sample (Senn et al., 2017).

Primary Mediators. These included situational risk detection, direct resistance, and self-defense self-efficacy. Situational risk detection was assessed using Testa et al.’s (2006) measure that provides a hypothetical acquaintance dating scenario with escalating coercion revealed at two time points (collapsed data used here) and asks the question, “How likely is it that the situation just described will result in . . .” followed by 10 positive (e.g., “an evening that ends pleasantly”) and negative (e.g., “You being upset by Michael’s behavior”) outcomes. Participants rated the likelihood of each on a 7-point scale. The 6 item Direct Resistance subscale (Testa et al., 2006, built on items from Norris et al., 1999, and Davis et al., 2004) was used to measure willingness to use effective self-defense strategies (e.g., “Forcefully push him away”) in a hypothetical situation. It was administered following the coercive dating scenario described above on the same 7-point likelihood Response Scale with the data collapsed across the two time points. Self-defense self-efficacy was measured by responses on a 7-point Confidence Scale to 11 items adapted by (Senn et al., 2017) of Marx et al.’s (2001) adaptation of Ozer and Bandura’s (1990) scale (e.g., “If a situation develops in which you feel you could be in

danger of sexual assault, how confident are you that you could successfully think up ways to get out of that situation and then execute your plan?”).

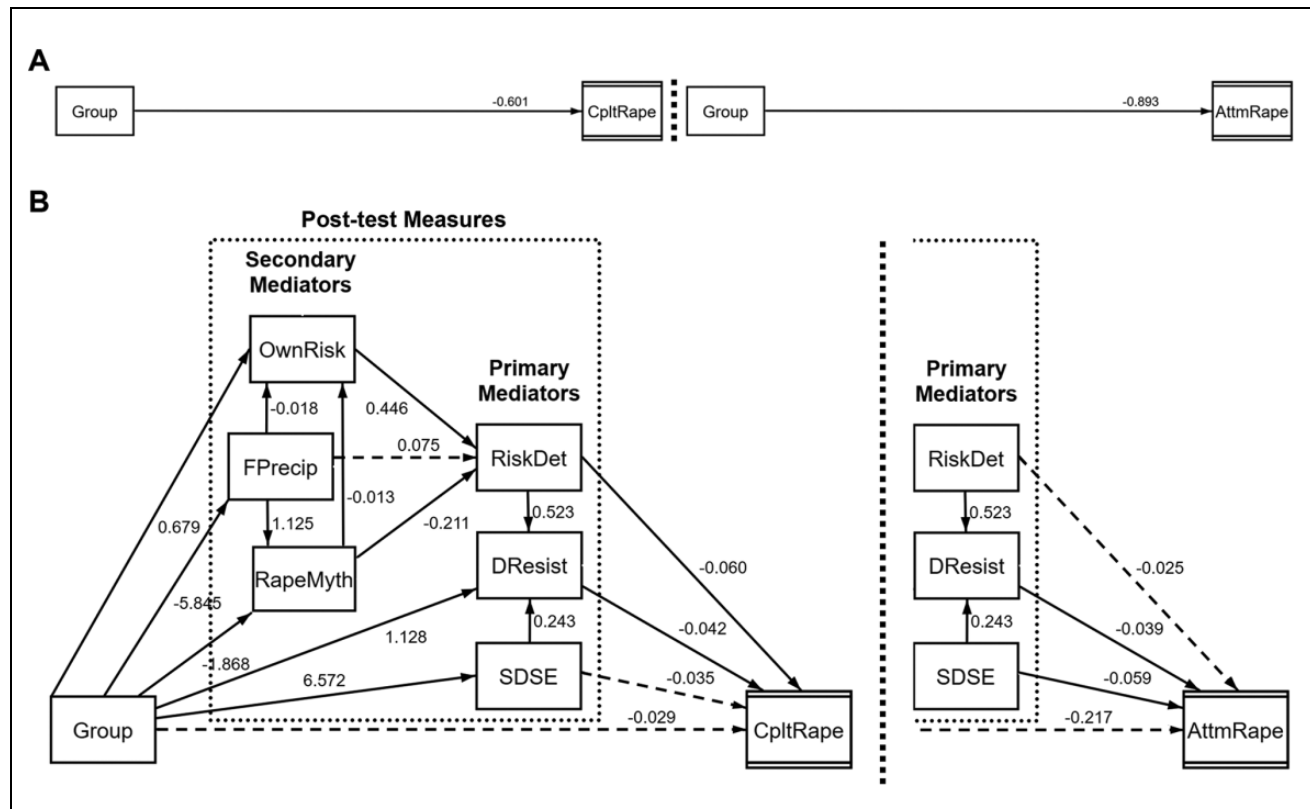
Secondary Mediators. These include (a) a single-item measure of perception of one’s own general risk of acquaintance rape, Perceived Risk of Acquaintance Rape (“What are your chances of being raped by someone you know?”), rated on a 5-point scale from “very likely” to “very unlikely” (adapted from Gray et al., 1990); (b) a specific measure of victim blaming, the 6-item Female Precipitation subscale of the Perceived Causes of Rape Scale (Cowan & Campbell, 1995; e.g., “Rape is caused by women allowing the situation to get out of control”); and (c) a general measure of rape myth beliefs, the Illinois Rape Myth Acceptance Scale–Short Form (Payne et al., 1999; e.g., “Men from nice middle-class homes almost never rape”).

Statistical Analyses

Path analyses were used to fit the chained multiple mediator models. Weibull proportional hazards regression models were used because the outcomes were time-to-first completed rape and time-to-first attempted rape and as such yielded hazard ratios which can be interpreted as relative risks (i.e., risk ratios). The proportional hazards assumption was assessed by plotting $\log(-\log[\text{survival}])$ versus the log of survival time and by testing the time dependent covariate in the regression models.

The total effect of the EAAA program was estimated by calculating unadjusted hazard ratios (HR) from Weibull proportional hazards regression models that included the intervention variable as the only predictor in the models. The direct effect was estimated by calculating adjusted hazard ratios from regression models that consisted of the intervention variable and the mediators. The percentage of the mediated intervention effect was calculated from the respective intervention regression coefficients in the total effect and direct effect models as follows: $[100 \times (b_{\text{total effect}} - b_{\text{direct effect}}) / b_{\text{total effect}}]$ (MacKinnon et al., 2007). The interpretation of the model findings was aided by converting the resulting pathway unstandardized regression coefficients (b) to hazard ratios for the primary mediators and semipartial Pearson correlation coefficients for the secondary mediators.

We tested the primary mediators jointly using a likelihood ratio test to establish whether they are the process through which the effects of the program are realized. Full mediation, defined as a non-significant direct effect, would suggest that the mediators explain the impact of EAAA, whereas partial mediation (a significant direct effect) would suggest that the mediators are important to the EAAA outcomes but not sufficient to explain the outcome. Given that both the EAAA program and control were conducted in group sessions, all regression models accounted for clustering of outcomes within group sessions by using the generalized Huber/

Figure 2. Total Effect Models and Final Chained Multiple Mediator Models for Completed Rape and Attempted Rape.

Note. (Panel A) The total effect, relating intervention group to completed rape without mediators, in terms of a hazard ratio was .55 ($b = -.601$, relative risk reduction = 45%, $p = .037$). After accounting for clustering the p value was .055. The total effect, relating intervention group to attempted rape without mediators, in terms of a hazard ratio was .41 ($b = -.893$, relative risk reduction = 59%, $p = .011$). (Panel B) The direct effect, relating intervention group to completed rape with mediators, in terms of a hazard ratio was .97 ($b = -.029$, relative risk reduction = 3%, $p = .933$); the percentage of the mediated intervention effect was 95.2% ($p < .001$). The direct effect, relating intervention group to attempted rape with mediators, in terms of a hazard ratio was .80 ($b = -.217$, relative risk reduction = 20%, $p = .595$); the percentage of the mediated intervention effect was 75.7% ($p < .001$). Solid lines represent significant paths and dashed lines represent nonsignificant but hypothesized paths. CpltRape = completed rape; AttmRape = attempted rape; OwnRisk = perceived risk of acquaintance rape; FPrecip = belief in female precipitation of rape; RapeMyth = rape myth acceptance; RiskDet = risk detection; DResist = direct resistance; SDSE = self-defense self-efficacy.

White/sandwich estimator of the variances. The extent of clustering was characterized by design effects. All analyses were conducted using Stata Version 16 (StataCorp LLC, College Station, TX, USA) and SAS Version 9.4 (SAS Institute Inc., Cary, NC, USA), and results with p values less than .05 were considered statistically significant.

Results

As shown in Table 1, the randomization of a relatively large number of women into the trial yielded two similar groups with regard to demographics, sexual experience, and potential mediators (those assessed pre-randomization), and therefore no adjustment for baseline covariates was necessary in the analyses. Among the 857 women included in the present study, 52 (6.1%) experienced a completed rape and

43 (5.0%) experienced an attempted rape between the time of completing the post-test survey and 12 months of follow-up, and only 2.1% (9 of 434) in the EAAA program and 2.6% (11 of 423) in control were lost to follow-up. As both the outcome event rates and lost to follow-up rates observed in the present study were low, it is permissible to calculate the percentage of the mediated intervention effect from the respective intervention regression coefficients without concern of bias (Burgos Ochoa et al., 2020). With regard to model proportionality assumptions, the plots of $\log(-\log[\text{survival}])$ versus the log of survival time yielded relatively parallel lines and the test of the time dependent covariate in the regression models yielded non-significant p values (.36 and .14 for completed and attempted rape, respectively). As the EAAA program and control sessions were conducted in 93 groups (clusters),

Table 2. Regression Coefficients for the Primary and Secondary Mediators in the Final Path Diagram With Respective Hazard Ratios and Correlation Coefficients for Completed and Attempted Rape.

	Completed Rape			Attempted Rape		
Global Primary ^a	Likelihood Ratio Test		<i>p</i>	Likelihood Ratio Test		<i>p</i>
RiskDet → Outcome DResist → Outcome SDSE → Outcome	<i>LR</i> _{3df} = 31.92		<.001	<i>LR</i> _{3df} = 20.50		<.001
Primary mediators ^b	<i>b</i> _{Adjusted}	HR _{Adjusted}	<i>p</i>	<i>b</i> _{Adjusted}	HR _{Adjusted}	<i>p</i>
RiskDet → Outcome	−0.060	0.94	.016	−0.025	0.97	.281
DResist → Outcome	−0.042	0.96	.032	−0.039	0.96	.033
SDSE → Outcome	−0.035	0.96	.121	−0.059	0.94	.006
Group → Outcome	−0.029	0.97	.933	−0.217	0.80	.595
Completed and Attempted Rape						
Secondary mediators ^b	<i>b</i> _{Adjusted}	<i>r</i> _{Semipartial}	<i>p</i>			
Group → OwnRisk	0.679	.24	<.001			
FPrecip → OwnRisk	−0.018	−.07	.026			
RapeMyth → OwnRisk	−0.013	−.08	.017			
Group → FPrecip	−5.845	−.39	<.001			
Group → RapeMyth	−1.868	−.07	.009			
FPrecip → RapeMyth	1.125	.64	<.001			
OwnRisk → RiskDet	0.446	.07	.027			
FPrecip → RiskDet	0.075	.05	.114			
RapeMyth → RiskDet	−0.211	−.23	<.001			
Group → DResist	1.128	.06	.023			
RiskAsmt → DResist	0.523	.50	<.001			
SDSE → DResist	0.243	.20	<.001			
Group → SDSE	6.572	.46	<.001			

Note. RiskDet = risk detection; DResist = direct resistance; SDSE = self-defense self-efficacy; OwnRisk = perceived risk of acquaintance rape; FPrecip = belief in female precipitation of rape; RapeMyth = rape myth acceptance; HR = hazard ratio.

^aLikelihood ratio test assessing the joint (global) significance of the three primary mediators. ^bEach row indicates each mediator's contribution to the model beyond their interrelations with other mediators; estimated from the final chained multiple mediator models that adjusted for all primary and secondary mediators and clustering.

with an average of 9.2 participants in each group, the within-group clustering resulted in design effects of 1.19 for completed rape and 1.11 for attempted rape.

For this sample of 857 women, the total effect of the EAAA program was a 45.0% reduction in the risk of completed rape ($HR = 0.55$, $p = .037$; ignoring clustering, $p = .055$; accounting for clustering; Figure 2, Panel A). For attempted rape, the total effect of the EAAA program was a 59.0% reduction ($p = .011$). Results from the final chained multiple mediation analyses are displayed in the path diagram (Figure 2, Panel B) and numerically summarized in Table 2. The three primary mediators in the hypothesized model, when tested jointly, were responsible for a significant reduction in the sexual assault outcomes (likelihood ratio test, $p < .001$). Some of the relationships (hazard ratios) between the primary mediators and the outcomes were nonsignificant because of the interrelationships among the mediators. All are critical to the overall mediation model as evidenced by the significant likelihood ratio test. The hypothesized

secondary mediators related to each other as predicted, rape myth acceptance and belief in female precipitation partially mediated the intervention's effect on the perceptions of one's own general risk, and perception of personal risk and rape myth acceptance mediated the intervention's effect on risk detection. One hypothesized path was not supported; belief in female precipitation did not have a significant path directly to risk detection.

The model fully mediated the intervention effects for both completed rape and attempted rape by yielding direct effects of 3% ($p = .93$) and 20% ($p = .59$) reductions in risk, respectively. Specifically, the model mediated 95.2% ($p < .001$) of the intervention effect for completed rape and mediated 75.7% ($p < .001$) for attempted rape.

In our theoretical model, we assumed that secondary mediators work solely through a primary mediator, so we also examined a model with paths from these secondary mediators to the outcome to test this presumption. The percentage of mediation did not increase. In addition, we evaluated whether

an all-paths model would improve mediation of the outcome over our theoretical model. Again, the percentage of mediation did not increase.

Discussion

In sexual violence prevention practice, we generally have presumed that effective programs work to achieve their outcomes in the ways that we theorized; however, we cannot move our theory and practice forward unless we test these models or mechanisms directly. Until recently, sexual violence prevention programs have not been sufficiently effective to warrant this type of exploration nor have the evaluation studies been sophisticated enough in design, sample sizes, quality of measured outcomes, and so on, to allow it. The current findings contribute to the sexual violence prevention field by advancing our understanding of how a sexual assault resistance program for university women works to reduce the sexual victimization that women experience.

Although mediation analyses often focus on one mediator at a time (Baron & Kenny, 1986; Preacher & Hayes, 2004), we used a chained multiple mediation analysis, which accounts for the relationships among the mediators. This analysis confirmed that the theoretical model we tested fully mediates the program's effects on sexual assault. In other words, the direct program effect is no longer statistically significant when the mediators are included in the model. More important, and surprising perhaps, the theoretical model tested accounts for 95% of the reduction in completed rape and 76% of the reduction in attempted rape. This is an unusually large mediation effect and provides strong support for EAAA's theoretical and evidentiary underpinnings (Nurius & Norris, 1996; Rozee & Koss, 2001). The theory works extremely well to explain the positive outcomes of sexual assault resistance education for women students in the early stages of their university studies.

Primary Mediators of Program Reductions in Sexual Assault

Based on theory and prior evidence, we hypothesized that the EAAA program would reduce completed and attempted rapes through changes in three key mechanisms—risk detection, self-defense self-efficacy, and direct resistance. As expected, the three primary mediators worked together in producing the program's effects on sexual assault.

We explicitly included two of the hypothesized primary mediators, risk detection and self-defense efficacy, because they were key aspects of Nurius and Norris's cognitive ecological model, the theory upon which the AAA approach and the EAAA program are built. Risk detection is involved in the primary appraisal of a social situation involving an acquaintance as dangerous and, therefore, in need of a response. Self-defense self-efficacy is involved in the

secondary appraisal of a coercive sexual situation as something that can be overcome by, or coped with, using women's own resources. Improving risk detection is generally viewed as a necessary goal of an intervention but not sufficient to lead to better outcomes (Vitek et al., 2018). After all, one could see danger and not know what to do, say, or the options available to take actions, leading to passivity or non-response (Macy et al., 2006; Nurius et al., 2004). Self-efficacy is critical to people being able to implement changes in their lives (Bandura, 1977), and past research has shown that confidence is related to an increased likelihood of women responding assertively in sexual assault situations (Vitek et al., 2018).

However, knowing more about one's options and effective responses and being willing to use them are also important to action. Because expanding these available resources (i.e., women's knowledge and capabilities) is theorized to reduce barriers to resistance (Rozee & Koss, 2001), we also included women's selection of, and willingness to use, the resistance strategies known to be the most effective in an acquaintance sexual assault situation, namely, direct, forceful verbal and physical strategies (e.g., Tark & Kleck, 2014).

This model supports the necessity of designing resistance programming to influence all three primary mediator components of the AAA model (Rozee & Koss, 2001). The multiple mediation analysis shows how risk detection, self-defense self-efficacy, and direct resistance strategies operate when they are considered together. Risk detection and direct resistance are correlated. After all, if danger is not detected, assertive or forceful actions will not be taken, and vice versa. Self-defense self-efficacy and direct resistance are also correlated. This makes sense for exactly the reason that we, and other researchers (Hollander, 2016, 2018; Rozee & Koss, 2001), argue for their inclusion in the model. Specifically, they are both necessary for resistance to be undertaken. A woman who lacks the general confidence in her ability to take action to stand up for or defend herself is unlikely to report that she would use defensive actions in a specific situation. Similarly, high confidence that she could problem-solve and defend herself in an acquaintance situation could be misplaced, if she is unable to detect risk in the early stages of the situation, when more defensive options are available compared to later stages, or if she lacks knowledge of likely effective strategies.

Altogether, these findings support Rozee and Koss's (2001) AAA conceptualization and claims that women would benefit substantially from increased ability to assess danger in acquaintance situations, overcome emotional obstacles to acknowledge risk and feel prepared and confident knowing that resistance is possible, and then to take action using their own judgment and the best strategies available to them. Even though we measured risk detection and direct resistance in response to hypothetical situations, these factors together with self-defense self-efficacy explained the lower levels of completed and attempted rape

reported by the women across the year following program participation. Therefore, the content and activities within EAAA, which increased knowledge of sexual assault risk cues in men's behavior and in social situations, increased theoretical and practical knowledge of effective resistance strategies in acquaintance situations, and enhanced women's confidence in their own judgment and abilities (Senn et al., 2017) all play important roles in reducing sexual victimization.

Secondary Mediators of Program Reductions in Sexual Assault

Detection of danger is extremely difficult in acquaintance social situations where building friendships or intimate relationships, studying, partying, or otherwise having fun are the focus of the interactions, and coercive and controlling strategies usually start slowly and escalate (Norris et al., 1996; Norris et al., 1999; Nurius, 2000; Nurius & Norris, 1996). Based on the research literature, we added three potential secondary mediators affected by the EAAA program to the theoretical model: women's perceptions of their own general risk of sexual assault, belief in rape myths, and the pernicious myths that hold rape victims responsible. The analysis strongly supported the indirect role of all three in achieving program improvements in sexual victimization through enhancing women's ability to detect risk, one of the primary mediators. However, unlike our test of mediation for the sexual assault outcomes, which is based on prospective data, our test of the mediation of the primary mediators was cross-sectional, disallowing conclusions of causality. Nevertheless, these findings provide evidence of how improvements in one of the primary mediators, risk detection, might be accomplished by the program's content and process.

We used only a single item measure of perception of own general risk of sexual assault, which made underestimation of effects more likely (e.g., Beal & Dawson, 2007). Despite this, increasing women's perceptions of their own general risk of acquaintance sexual assault was an important link in the chain to better risk detection in a specific situation. Vitek et al. (2018) have suggested that the optimism bias may be related to all three stages of the AAA model, not just risk detection. In our test of the full (all paths) model, which failed to improve mediation, paths from perception of general risk to the other primary mediators, self-defense self-efficacy and direct resistance (representing the final two stages of the AAA conceptualization and secondary appraisal and coping in the cognitive ecological model), were not supported. Although a test of Vitek et al.'s hypothesis with a more nuanced and robust measure should be attempted in the future, our analysis suggests that the model works extremely well when the benefits of increasing perception of one's own general risk modestly are presumed to act through increasing risk detection.

As expected, the secondary mediators were inter-related. Reducing women's already low general rape myths, which include but extend beyond victim-blaming attitudes, may allow them to appreciate the gendered social reality and see themselves as potentially vulnerable to acquaintance sexual assault. In the analysis, lowered general rape myth acceptance was directly related to higher perception of one's own general risk, and then through that perception of personal risk contributed to improvements in risk detection. We suspect that undermining the general rape myths that focus on excluding known men from being considered as perpetrators could be responsible for this contribution to risk detection. EAAA's ability to reduce woman-blaming beliefs specifically was also important. It was indirectly related to increased risk detection through women's higher acknowledgment of their personal risk of acquaintance sexual assault. Both the content and philosophy of EAAA as well as the rigorous training process for facilitators aim to ensure that woman-blaming is interrupted and undermined as it arises during the group intervention. This program feature proves to be very important in improving participants' risk detection through lower general and specific rape myths.

To be clear, we are not calling for a return to the problematic past practice of entirely, or primarily, focusing sexual assault prevention on undermining rape myths (Morrison et al., 2004). Unsurprisingly, given the complicated nature of the cultural discourses about sexual assault and women's varied experiences, as well as the tenuous link between attitudes and behavior (Fishbein & Ajzen, 2011), reducing negative attitudes about rape alone does not reliably increase bystander behaviors or reduce victimization or perpetration (DeGue et al., 2014; Fenton et al., 2016). This was confirmed in our analysis as direct pathways from attitudes to the sexual assault outcomes were not supported. Nevertheless, we have shown that even though women hold relatively low levels of belief in rape myths and victim-blaming and there is no direct link to reduced sexual assault, reducing belief in rape myths appears to have specific benefits for women's resistance to sexual assault. It is related to improved risk detection in acquaintance situations. Faster and more accurate detection of danger is necessary for the benefits of any resistance, risk reduction, or self-defense program to be fully realized.

Attempted Versus Completed Rape

Our analyses were focused on two categories of sexual assault. First, we applied the model to the completed (oral, anal, and vaginal) rape outcome, which is central to most studies of sexual assault prevention. The mediation model explains the EAAA program's effects across the diverse perpetrator tactics assessed by the SES. Similar to other studies of university students' experiences, a large proportion of these rape experiences involved alcohol (Abbey, 2011; Klein et al., 2018; Krebs et al., 2009). Nonetheless, because past research has demonstrated that alcohol consumption impairs

risk detection (e.g., Parks et al., 2016) and response/resistance (e.g., Davis et al., 2004; Stoner et al., 2007) to sexual coercion, future research could explore the specific ways in which EAAA resistance education contributes to, and might be limited in, reducing alcohol-involved sexual assaults specifically.

Second, we tested the same theoretical model for attempted rape. However, the model tested was based on theory and evidence primarily derived from research on completed rape. Despite this, the same mediation model predicted a large proportion of the program-produced reduction in attempted rape. This suggests there is substantial overlap in the mechanisms that explain EAAA's positive effects in reducing both completed and attempted rapes. A somewhat lower percentage of mediated effect was found for attempted rape (76% vs. 95%), which suggests that there may be room for other mediators to be added to the model when considering attempted rape. We provide some possible explanations for the results involving attempted rape based on the current study and past research to guide future research.

Women cannot control whether men in their social environments will be coercive, so reductions in attempted rape victimization mean that some men who were coercive were not able to execute their plans or increase their level of intrusion. Reductions in attempted rape may have been accomplished by women detecting early warning signs from verbal indications of men's attitudes (e.g., sexual entitlement) or behavior (e.g., attempts to socially isolate them) and leaving the situation before the men became coercive. This requires trusting their instincts or perceptions at earlier stages, something that we did not directly measure. Further, they may have used forceful verbal or physical strategies that interrupted the trajectory of coercion (e.g., "you are crowding me, MOVE AWAY" or a wrist-release to make him let go as he grabbed her wrist to try to move her to a more isolated location). Women tend to match their force to the force being used against them (Tark & Kleck, 2014), so detailed study of the forms of direct resistance corresponding with particular instances of attempted rape may offer some clues to what works some or most of the time. Alternatively, or in addition, women may have engaged in other strategies to undermine risk factors that enhance perpetrators' advantages (e.g., isolation) that are not included in the direct resistance measure (e.g., called a friend to join them at the party when a guy who was in attendance made them feel uncomfortable; Anderson et al., 2016). Thus, our findings for attempted rape can be explained (at least in part) by components of the AAA model.

However, because some (24%) of the program effect for attempted rape was not explained by the model, we likely need to look beyond the AAA model to explain the program's success in reducing attempted rape. A combination of quantitative and qualitative research with women who have taken resistance programs may be needed for further theory development.

Directly measuring the benefits of the fourth unit's positive sexuality enhancement of the AAA model could also improve our understanding of how EAAA works to reduce attempted rape. This unit contributes to resistance education by challenging societal messages that women's sexual desires are of lesser importance than are those of men. It addresses the absence of high-quality sexual education and discussion of women's sexual desires in society at large (Fine, 1988; Fine & McClelland, 2006) and how normative (hetero)sexual practices put men's (presumed) sexual needs ahead of women's (Hollway, 1984). This latter discourse, in particular, has been implicated in acquaintance sexual assault (Gavey, 2005). Due to participant burden, we did not measure women's awareness of their own desires and values or their confidence in asserting these in various situations, although earlier work has shown benefits (Senn et al., 2011). For heterosexual and bisexual women, who constituted the majority of the sample, increases in sexual knowledge and confidence would be expected to contribute to faster risk detection, particularly identification of sexual pressure and other coercive tactics.

In general, it may be wise for future researchers to do what we did not, that is, to think through the theoretical model for *attempted* rape specifically from the start. In this way, additional constructs could be identified and measured. We encourage researchers to include analysis of attempted rape experiences and avoid treating them as "non-events" (Cermele, 2010) or as less important (Hollander & Rodgers, 2014) when evaluating prevention programs and testing theoretical models so that we hone our broader sexual assault prevention knowledge and skills.

Strengths and Limitations

Our study's prospective design provided many benefits and allowed us to test the influence of mediators at one point in time (post-test) on subsequent sexual victimization. As a result, we could infer causality for that outcome. However, we could only do a cross-sectional analysis of the relationship of the secondary mediators with the primary mediator, risk assessment. Although risk detection was related to the attitudes and beliefs serving as secondary mediators and these attitudes and beliefs improved after participation in the program, we cannot conclude that the improvements in risk detection were produced by the changes in attitudes and beliefs. Further research is needed.

Our sample size was large, our retention was high (>97%), and our conclusions are based on the responses of women with and without rape experiences prior to their participation in the research. Despite these strengths, our sample was not large enough to reliably evaluate the model separately for women with and without prior sexual victimization experience (i.e., to test whether victimization moderates the mediation model). We explore similarities and differences in EAAA's program effects for individual outcomes by prior

victimization elsewhere (Senn et al., in press), but await future research with larger samples for this more complex analysis.

Our test of the theoretical model was applied to a large and diverse sample of university students who identify as women. We are working now to expand the populations who may benefit from resistance programming of this type and would then be able to test whether the same or similar mediation model applies. We are currently adapting EAAA for younger girls and will be evaluating the adapted version in an RCT. We are also working with other scholars to lay the groundwork for an adaptation of the EAAA model specifically for trans-identified students, if it is appropriate.

The field has many good measures but needs more in the domains key to women's resistance to sexual violence and several measures, which we used as the best available, have limitations. Perception of personal risk is clearly important to women's ability to detect risk as we were able to conclude this even with an imperfect single-item measure. Still, there is a need for a multi-item measure of perception of sexual assault risk (and the related optimism bias) with good psychometric properties. We join other researchers (e.g., Vitek et al., 2018) in also calling for improved measurement of risk detection. Testa et al. (2006), building on the work of others (Davis et al., 2004; Norris et al., 1999), developed the strong measures of risk detection and direct resistance used in our research. However, participants are responding to a specific two-part scenario of a dating interaction with a coercive man. Scenarios for acquaintance situations that are relevant for women who do not date men, due to their sexual identity or cultural/religious/political background, are needed. Moreover, an ability to measure and then collapse across responses to multiple situations and contexts would strengthen the measurement of the constructs. Other available risk perception measures (Messman-Moore & Brown, 2006) could also be improved with more scenario options. Currently, once these measures have been used in a longitudinal study, they cannot be presented again because the "end of the story" is now known. This is a limitation for understanding how program effects are mediated for the longer term.

Our analysis was also limited by our failure to include measures of implied mediators. For example, we presumed that if women improved their risk detection and used more direct, forceful resistance strategies, they had overcome at least some of the known obstacles to assessing, acknowledging, and acting to resist acquaintance sexual assault. Our analyses would have been improved by measuring changes in women's endorsement of known obstacles and assessing whether this process variable acts as a primary or secondary mediator. We also did not measure what is variously described as relationship investment or motivation to maintain relationships with men, yet this is the hypothesized origin of one specific psychological barrier to acknowledging danger and/or resisting men they know, particularly for heterosexual women (Macy et al., 2007; Norris et al., 2018; Nurius

et al., 2004). EAAA explicitly acknowledges this motivation (and its positive roots) and uses various approaches to undermine its application in circumstances where risk cues have been detected. Explicit measurement of this barrier for acquaintance rape resistance may have improved the model.

Some researchers have suggested that the experience of learning physical and verbal self-defense changes how women experience their bodies, including their sense of inhabiting and having ownership of them (i.e., embodiment; see Piran, 2016) and that this can lead to increased demands that boundaries be respected and resistance when boundaries are violated (Hollander, 2004; Hollander, 2014). Inclusion of measures of embodiment and of experiences setting and protecting boundaries might both be fruitful additions for future research. Qualitative research with young women who have experienced the program could also potentially expand our knowledge of other ways in which this type of education affects them.

Practice Implications

The current study builds on our previously published research in offering important insights for practitioners of empowerment self-defense. Previous analysis showed that a relatively small number of hours (3 of 12) of instruction focused on verbal and physical self-defense in acquaintance situations is sufficient to increase confidence and willingness to use the strategies that research has shown are most likely to be effective. Current findings show that these two benefits also contribute to reductions in attempted and completed rape. Detecting risk in social situations and men's behavior is neither obvious nor easy because of the emotional obstacles to seeing danger when it is present in acquaintance situations. Our findings show, however, that significant attention must be paid to this kind of risk detection to achieve these dramatic benefits. Finally, our findings demonstrate the importance of creating a self-defense learning environment that directly contradicts woman-blaming and rape myths.

In recent years, sexual violence prevention researchers have come together in calling for universities to develop comprehensive sexual violence prevention plans, including both targeted and universal (bystander) prevention programming to achieve meaningful change (e.g., Bonar et al., 2020; Orchowski et al., 2018). By contrast, in the current political climate with burgeoning roles and responsibilities and limited resources, university administrators who are responsible for developing prevention policies and staff in prevention roles may feel pressured to offer a single, one-size fits all, online or in person prevention program for students. The current study provides compelling evidence to defend the implementation of theoretically grounded, evidence-based prevention practices. The findings show the specific mechanisms by which resistance education on campus works to empower women and reduce the likelihood that they will experience sexual violence. Specifically, offering sexual assault knowledge and

challenges to rape myths and perceptions that sexual violence can only occur to others and not oneself lays the foundation for effective education. However, this is not enough. Achieving large reductions in attempted and completed rape requires that program content and practices build on this foundation by improving risk detection in social interactions with acquaintances, providing a context within which women can safely identify and reduce emotional obstacles to risk detection and resistance, and increasing women's repertoire of effective strategies and confidence to interrupt and resist sexual coercion and sexual assault attempts. Providing even more benefit than we demonstrated may be possible through enhanced programming; providing less is not defensible.

Conclusion

The chained multiple mediation analysis showed that the hypothetical model underlying the EAAA program explains the dramatic reductions in sexual violence experienced by program participants. Sexual assault is not inevitable (Bevacqua, 2000; Radtke et al., 2020). Empowering students who identify as women with knowledge and skills and providing a place and time for application and practice can make a profound difference in their lives. Although we await cultural change and interventions that can prevent sexual violence perpetration reliably and substantially, resistance education for women should be one critical piece of all comprehensive sexual assault prevention plans.

Authors' Note

This study was registered with ClinicalTrials.gov (Identifier NCT01338428). This article is based on data published in Senn et al. (2015) and Senn et al. (2017). The trial protocol was published in Senn et al. (2013).

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Notes

1. Rozee and Koss (2001) also suggested a new direction for prevention for young men which has not been taken up to our knowledge.
2. This represents the important half of the two parts of the optimism bias, the gap between own and other estimates (optimism bias). This gap is being narrowed for women in the program

group only ($p < .001$) by the improvement in women's own perception of risk (unpublished analysis). As such, it is appropriate to connect this change to the optimism bias.

3. Reduction in other forms of sexual assault was also observed. Due to space limitations, we focus on attempted and completed oral, vaginal, and anal rape due to their greater impacts on women's mental and physical health.
4. There was no evidence of sleeper effects.

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Violence against women and girls 1



Prevention of violence against women and girls: what does the evidence say?

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In this Series paper, we review evidence for interventions to reduce the prevalence and incidence of violence against women and girls. Our reviewed studies cover a broad range of intervention models, and many forms of violence—ie, intimate partner violence, non-partner sexual assault, female genital mutilation, and child marriage. Evidence is highly skewed towards that from studies from high-income countries, with these evaluations mainly focusing on responses to violence. **This evidence suggests that women-centred, advocacy, and home-visitation programmes can reduce a woman's risk of further victimisation, with less conclusive evidence for the preventive effect of programmes for perpetrators.** In low-income and middle-income countries, there is a **greater research focus on violence prevention, with promising evidence on the effect of group training for women** and men, community mobilisation interventions, and combined livelihood and training interventions for women. Despite shortcomings in the evidence base, several studies show large effects in programmatic timeframes. Across different forms of violence, effective programmes are commonly participatory, engage multiple stakeholders, support critical discussion about gender relationships and the acceptability of violence, and support greater communication and shared decision making among family members, as well as non-violent behaviour. Further investment in intervention design and assessment is needed to address evidence gaps.

Introduction

Violence against women and girls is a global human rights violation and a substantial development challenge. It affects women throughout the world, and crosses cultural and economic boundaries. WHO estimates that more than 30% of women worldwide have experienced either physical or sexual partner violence.^{1,2} 7% of women worldwide have experienced non-partner sexual assault.³ About 100–140 million girls and women worldwide have undergone female genital mutilation (FGM) and more than 3 million girls are at risk for FGM every year in Africa alone.⁴ Nearly 70 million girls worldwide have been married before the age of 18 years, many of them against their will.^{5,6} The effect of violence against women and girls on their health and welfare, their families, and communities is substantial.^{7–9} The costs of violence against women and girls, both direct and indirect, are a staggering burden for households and economies.¹⁰

In the past 20 years, much research has been dedicated to the extent of violence against women and girls and understanding the underlying causes and risk factors associated with violence perpetration and victimisation.¹¹ There has also been enormous growth in the quantity and breadth of interventions in diverse settings, including in health care, justice systems, and social campaigns to address violence against women and girls worldwide. The first generation of interventions mainly focused on provision of support services for survivors of violence, and sought to reduce perpetrators' impunity and increase the effectiveness of the justice system. A second generation of programming, mainly in low-income and middle-income countries, has had a greater focus on violence prevention. These interventions developed organically, often linked to

Key messages

- Evidence for interventions is highly skewed towards high-income countries, and response, rather than prevention. Most research has been done in intimate partner violence, with far less evidence on how to prevent other forms of violence.
- In high-income countries, response interventions have shown greater success in improvements in physical and mental health outcomes for survivors of violence and increased use of services, but evidence for their effectiveness to reduce revictimisation is weak. Much research has been done on interventions for perpetrators, with little evidence of effectiveness.
- In low-income and middle-income countries, there is increasing emphasis on prevention of different forms of violence against women and girls, including intimate partner violence, non-partner sexual assault, female genital mutilation, and child marriage. Assessments of programmes indicate that it is possible to prevent violence, with some interventions achieving large effects in programmatic timeframes. Successful programmes engage multiple stakeholders with multiple approaches, aim to address underlying risk factors for violence including social norms that condone violence and gender inequality, and support the development of non-violent behaviours.
- The specialty of violence prevention is at an early stage. Further investment is needed to expand the evidence base for what interventions are effective in different contexts, assess a broader range of intervention models, and explore issues of intervention cost, sustainability, and scalability.

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Panel: Systematic review of reviews on interventions to reduce violence against women and girls¹⁴

We used the results of a 2014 systematic review of reviews¹⁴ to identify assessments of interventions to reduce all forms of violence against women and girls. The review of reviews identified 58 reviews and 84 rigorously evaluated interventions (using experimental or quasi-experimental methods) that aimed to reduce one or more forms of violence against women. We examined the studies identified in the review of reviews and extracted relevant information including sample size, outcomes, and effect sizes. From these, we identified 21 studies with significantly positive results. We also searched relevant electronic databases and supplemental sources (search terms available in the appendix) and did outreach to more than 30 experts in the specialty to identify recently published and unpublished studies that had not been identified through the review of reviews. Through this process, we identified six more rigorously evaluated studies with significantly positive or highly promising results. Our Series paper summarises the findings from more than 100 reviews and evaluations.

From the systematic review of reviews,¹⁴ evidence for effective interventions was highly skewed towards high-income countries. More than 80% of the rigorous evaluations were done in six high-income countries (Australia, Canada, Hong Kong, New Zealand, the UK, and the USA), comprising 6% of the world's population. The USA alone accounted for two thirds of all the intervention studies. The search strategy included all forms of violence against women and girls mentioned in the definition established by the UN General Assembly (1993),¹⁵ including child and forced marriage, child sexual abuse, female genital mutilation, femicide, intimate partner violence, non-partner sexual assault, and trafficking. However, rigorous intervention evaluations were only identified for four types of violence: intimate partner violence, non-partner sexual assault, female genital mutilation, and child marriage.

Intimate partner violence was the subject of more than two thirds (58 of 84) of the rigorously evaluated interventions, followed by non-partner sexual assault with 17 studies and nine studies addressing harmful traditional practices (either female genital mutilation or child marriage). Only one study addressed multiple forms of violence (intimate partner violence and female genital mutilation). No studies meeting our inclusion criteria were related to trafficking or child sexual abuse. Among the interventions to prevent non-partner sexual assault, most were implemented with college students; no studies addressed sexual violence in conflict settings.

The types of violence against women and girls studied varied according to geographic location. In high-income countries, most of studies (51 of 66) dealt with intimate partner violence, followed by non-partner sexual assault with 15 studies. By contrast, half of the studies in low-income and middle-income countries (nine of 18) addressed child marriage or female genital mutilation, followed by intimate partner violence (seven), with non-partner sexual assault and multiple types of violence each represented by one study.

Among the 84 studies with available data, about two thirds (52) focused on responses to violence against women and girls at the individual level, and the remaining 32 interventions focused on prevention at the community or group level. Interestingly, the proportion of studies focusing on prevention was much lower in high-income countries (16 of 66) compared with low-income and middle-income countries where nearly all of the studies (16 of 18) focused on prevention. Most of the interventions targeted women alone (38) or women and men (17). 22 studies targeted only men, most of which were interventions for men who assault women (18).

HIV prevention efforts, and have used many approaches. These include large-scale campaigns, sophisticated education-entertainment or so-called edutainment programmes, skills building and economic empowerment programming, community mobilisation, and participatory group education efforts, aiming to change attitudes and norms that support violence against women and girls, empowering women and girls economically and socially, and promoting non-violent, gender-equitable, behaviours. Not much research has been done to assess the effectiveness of these programmatic efforts, particularly in low-income and middle income countries.^{12,13} Despite the scarcity of empirical research, a small, but promising, body of evidence shows either significant or highly promising positive effects in reductions or prevention of violence against women and girls.

In this Series paper, we review available evidence for what works to reduce the prevalence and incidence of violence against women and girls (panel). The studies

cover a range of interventions, and many forms of violence against women and girls, ranging from violence in armed conflict and intimate partner relationships, to FGM and child marriage. We used a broad focus to allow cross-learning across interventions and types of violence.

When we synthesise the findings, we use the terms prevention and primary prevention to refer to interventions that work with individuals or communities irrespective of their history of violence. These interventions seek both to prevent violence from occurring in individuals who have not experienced it before and to reduce reoccurrence in those who have already experienced or used violence. We use the term response and secondary prevention interchangeably to refer to interventions that specifically target either women who have already experienced some form of violence or male perpetrators, with the aim of reducing revictimisation or recidivism.

Intervention evidence from high-income countries

Introduction

In practise, although reduction of some form of violence against women and girls was a stated aim of all of the studies identified through the systematic review of reviews (panel),¹⁴ most studies identified from high-income countries focused on responses to violence. We also identified evidence from prevention programmes for school and university sexual violence.

Women-centred interventions for survivors of violence

We reviewed 22 rigorously evaluated interventions that provided services to women who experienced intimate partner violence.^{16–19} These interventions, often referred to as women-centred, use a combination of strategies, including psychosocial support, advocacy and counselling, and home visitation to provide women with resources and support to reduce their future risk of violence, and to improve their physical and psychological health and wellbeing. Most of the interventions take place in health-care services such as family planning or antenatal care, in which women with histories of intimate partner violence are identified through routine inquiry.^{19–22} Basic psychosocial support by health providers usually includes danger assessments, safety planning, information about rights and available resources, and referral to specialised services.

As described by García Moreno and colleagues²³ in the second paper in this Series, there is evidence that some health-sector-based interventions can have some positive outcomes for women and their children such as reductions in depression.^{16,24–27} However, only two studies report significant decreases in violence. Randomised control trials done in Washington, DC, and Hong Kong in pregnant women with histories of intimate partner violence showed significantly lower rates of violence revictimisation among women who received a psychosocial intervention, compared with women in control groups.^{28,29} Two other intervention models, involving advocacy and home visitation interventions, have also had promising results to reduce intimate partner violence victimisation.^{30–32} These interventions include psychosocial support and the provision of additional assistance by a trained layperson, to help women identify and access services. Usually, these studies have a longer duration and greater intensity than have health services-based interventions alone. For example, Hawaii's Healthy Start Programme was designed mainly to prevent child abuse and neglect and to promote child health and development in newborn babies from families at risk of poor child outcomes. A 3 year follow-up study showed lower rates of intimate partner violence victimisation in mothers given the intervention compared with controls (appendix).^{33,34}

Interventions for perpetrators

Although several high-income countries have implemented extensive court-mandated programmes to reduce recidivism in male perpetrators, there is little evidence of

programme effectiveness. Of 18 rigorous studies identified through Arango and colleagues¹⁴ systematic review of reviews (panel), only two studies reported any significantly positive results (appendix).^{14,35,36} Interventions for men who assault their female partners typically involve some type of group education lasting from 8 weeks to 24 weeks. Common approaches include the Duluth Model, a feminist approach that engages men in discussions around power and control, as well as cognitive behavioural therapy and anger management, both of which mainly focus on the use of violence itself, rather than on underlying beliefs.³⁷ Some newer approaches have also been tested, such as combining these interventions with substance abuse programmes, couples therapy, or culturally adapted programmes for specific populations. The findings from these studies have been inconclusive.^{38,39}

Reports about interventions for men who assault their female partners indicate a general decrease in recidivism in men who complete the full training. However, there are important methodological weaknesses in the available evidence base. Most studies reviewed the histories of men who were court-mandated to such treatment as a result of a domestic violence arrest, and compare recidivism (measured either as new arrests, or spousal reports of violence) among men completing the programme to men who dropped out or never attended at all. Overall, these programmes have very high dropout rates, with few consequences for failure to complete the programme. Since men who drop out are likely to be less motivated to change than are those who complete the programme, it is not possible to identify how much of the change can be attributed to the intervention itself.^{39–42}

School-based interventions

Most prevention programmes for intimate partner violence and non-partner sexual assault in high-income countries are school-based group training interventions. Evidence from these programmes has not been encouraging, but there have been a few exceptions. The Healthy Relationships programme in Canada was tested in two settings: one with male and female high school students and the other in the community with male and female at-risk young people. Both studies showed significant reductions in both perpetration and victimisation of dating violence in both boys and girls in the intervention groups compared with the control groups (appendix).^{43,44} Studies of two well known interventions, Shifting Boundaries and Safe Dates, reported a reduction in dating violence in adolescents. Neither investigators reported results separately by sex of the victim or perpetrator, and so it is not clear whether the effect was similar for boys and girls.^{45,46}

Only two of 17 rigorously assessed school-based interventions to reduce non-partner sexual assault had significantly positive results.^{14,47,48} Both were done in the USA, in female college students, and focused on sexual assaults by acquaintances or so-called date rape. It is

See Online for appendix

not yet clear whether these programmes could be meaningfully applied to other settings or populations.^{49–51} Some of the interventions with null findings were very brief (for example, a 1 h educational session), which likely contributed to the absence of positive findings.

High-level policy commitment and legislative reform

Although many of the programme evaluations described above did not show reductions in violence against women and girls during the relatively short periods of study follow-up, the potential cumulative effect of these interventions should not be overlooked. According to the US Bureau of Justice, the rate of intimate partner violence in the USA fell by 53% between 1993 and 2008 and the number of intimate partner homicides of women decreased by 26%. Many experts attribute this decline to the Violence against Women Act (VAWA), first authorised by Congress in 1994, which provides funding for many of the programmes mentioned above.⁵² The Act originally authorised US\$1.6 billion in funding in 5 years and has been reauthorised three more times since then. A study of more than 10 000 jurisdictions between 1996 and 2002 showed that jurisdictions that received VAWA grants had significant reductions in the numbers of sexual and aggravated assaults compared with jurisdictions that did not receive VAWA grants.⁵³

Promising practices in low-income and middle-income countries

Legislative and justice sector responses

Until recently, programmes in low-income and middle-income countries to prevent violence against women and girls followed the tendency of those in high-income countries to focus mainly on increases in women's access to justice through better legislation and training of judges and police and to provide survivors of violence with coordinated emergency services. Although the number of countries with domestic violence legislation has grown exponentially as a result (from four to 76 between 1993 and 2013),⁵⁴ implementation is a serious problem. Most domestic violence laws are not accompanied by budget allocations and there is often resistance to the laws from male-dominated judiciary and police.^{55–57}

One of the most prominent public policies to address violence against women and girls in low-income and middle-income countries is the establishment of specialised police stations for women and girls, particularly in Latin America and south Asia. In Latin America, 13 countries have women's police stations, and in Brazil alone there are more than 300 such stations.⁵⁸ They vary a great deal according to the type of services they provide and the quality of these services. Although they have undoubtedly raised visibility around the issue of violence against women and girls, and have led to increased reporting of violence in some settings,

there is little evidence as yet for effectiveness. Qualitative research suggests that training and improved legislation alone do not improve outcomes for women or reduce violence at a community level, and that system-wide changes are needed to improve the enforcement of laws.¹²

Health sector approaches and one-stop centres

As discussed in the second paper in this Series,²³ the health sector in low-income and middle-income countries has been slower to engage on the issue of violence against women and girls. One common approach has been the establishment of one-stop centres, which aim to provide comprehensive care for survivors of violence against women and girls. Many of the centres are located in hospitals, such as the Thuthuzela care centres in South Africa, the family support centres in Papua New Guinea, and the Malaysian one-stop centres.⁵⁹ In Latin America, they are frequently stand-alone centres run by women's rights activists, and, in some cases, by the national or municipal governments—eg, Ciudad Mujer (city of women) in El Salvador or the Centros Emergencia Mujer (women's emergency centres) in Peru. Most one-stop centres provide services for both intimate partner violence and sexual violence. However, in much of sub-Saharan Africa, the demand for sexual assault services and access to post-exposure prophylaxis to prevent HIV infection after rape has spurred the creation of post-rape care centres in many hospitals, which are not necessarily linked with services for intimate partner violence.⁶⁰ As with the women's police stations, there is enormous variation in the level of funding, accessibility, and quality of services provided, and little evidence exists for their effectiveness to reduce violence against women and girls or to mitigate the negative consequences for survivors.

Violence prevention programmes

There has been a much greater emphasis on violence prevention in low-income and middle-income countries. Many models of violence prevention emerged from HIV programming and the growing recognition that gender inequality and violence underpin many women's vulnerability to HIV. As we describe below, prevention programmes use a wide range of approaches, including group training, social communication, community mobilisation, and livelihood strategies. Most interventions use more than one approach, and many target underlying risk factors for violence, such as poverty, women's economic dependence on men, low education, and inequitable norms for male and female behaviour. Whereas women and girls were originally their focus, programmes are now also target men and boys or both men and women. Programmes are moving from trying to achieve change in groups of individuals to trying to achieve change at a community level.¹¹

Group-based training interventions to empower women and girls

Most violence prevention programmes in low-income and middle-income countries use participatory group training, which consists of a series of educational meetings or workshops with targeted groups of individuals. The goal of such programmes is not only to prevent violence against women and girls, but also to address underlying expectations about male and female

roles and behaviour, and to support the development of new skills for communication and conflict resolution through a process of critical reflection, discussion, and practice. There is a wide range of training durations, target groups, and components. Violence against women and girls prevention components are often embedded in programmes that aim to improve sexual and reproductive health, or livelihood programmes such as microfinance or vocational training.

	Study details	Summary of intervention	Population	Outcome	Effect size	p value	Results
Group training for women and girls							
Bandiera et al, 2012 ⁶¹	2-year RCT ITT analysis of more than 4800 adolescent girls; interviews were done in 2008, follow-up surveys in 2010	Assessment of Empowerment and Livelihood for Adolescents Programme; designed to improve the cognitive and non-cognitive skills of adolescent girls through adolescent development clubs	Adolescent girls (aged about 14–20 years)	Reports of having had sex unwillingly	OLS -0.171	p<0.01	A reduction of about 17% (from a baseline of 21%) shows that almost no girls living in communities where ELA programme operates report having sex unwillingly
Erulkar et al, 2009 ⁶²	Quasi-experimental analysis done between 2004–06; used χ^2 tests, proportional hazard models, and logistical regression	Berhane Hewane was a 2-year pilot project that sought to reduce child marriage in rural Ethiopia (Amhara) by supporting girls to stay in school and group training	Girls aged 10–14 years	Ever married; married in the past year	HR 0.1	p<0.001; p<0.001	At baseline, the likelihood of having ever been married among girls aged 10–14 years decreased with years of education. At the endpoint, girls in the intervention group were much less likely than were girls at the control site to have gotten married. However, among girls aged 15–19 years, those in the intervention area had a higher likelihood of having gotten married
Pande et al, 2006 ⁶³	Quasi-experimental study in rural Maharashtra, India, 1997–2001. Bivariate and multivariate logistic regression used	A life skills course that sought to delay the age of marriage by 1 year. The course was taught 1 h in the evening each weekday for 1 year by an educated village woman	Girls aged 12–18 years who had not yet been married, with a particular focus on girls who were not in school or working	Proportion of girls (aged 11–17 years) married between 1997 and 2001	AOR 4.0	p<0.01	Between 1997 and 2001, the proportion of marriage in young girls (aged 11–17 years) steadily decreased in the intervention villages (including girls who did not participate in life skills training). Median marriage age increased from 16 years to 17 years. No significant changes were noted in the control group
Sarnquist et al, 2014 ⁶⁴	Quasi-experimental study in four neighbourhoods in informal settlements in Nairobi in 2012	Empowerment and self-defence intervention. 6 2-h intervention sessions for 6 weeks	Adolescent girls aged 13–20 years, attending secondary schools	Incidence of sexual assault (forced or coerced penetration and sexual harassment)	RR 1.61 (95% CI 1.26–1.86)	p<0.001	10.5 months after the intervention, the rate of sexual assault among the intervention group decreased by 60%, whereas no difference was shown for the comparison group. Disclosures of sexual assault also increased significantly in the intervention group but not in the comparison group
Group training for women and men							
Jewkes et al, 2008 ⁶⁵	Cluster RCT of 70 villages (clusters) in eastern Cape province of South Africa. Villages randomised to receive either Stepping Stones or 3 h intervention on HIV and safer sex. Analysis using generalised linear mixed models to compare differences at follow-up	Stepping Stones, a programme that uses participatory learning to build HIV risk awareness, knowledge, and communication. Group-based delivery of intervention, with separate groups for men and women. The intervention consisted of 50 h of training	Young men and women (aged 15–26 years), who were mostly attending schools	Men’s reports of perpetration of physical and or sexual IPV at 24 months post-intervention	AOR 0.62 (95% CI 0.38–1.01)	p<0.05	Reported IPV perpetration was significantly reduced among men in the intervention group compared with the control group at 24 months, but not at 12 months. No significant reduction in reported victimisation by women at 12 months or 24 months
Group training for men							
Verma et al, 2008 ⁶⁶	Quasi-experimental 3 group design in urban slums of Mumbai and in rural villages in Gorakhpur, 2006–07. Used multivariate logistic regression analysis	Individuals in the first group received a lifestyle social marketing campaign and group education sessions (LSMC plus GES). Individuals in the second group received only the group education sessions. The third group was the control	Young men aged 16–29 years, both unmarried and married (Mumbai) and young men aged 15–24 years (Gorakhpur)	Reported perpetration of physical or sexual IPV in the past 3 months	GES plus LSSM group in Mumbai AOR 0.176; GES group in Gorakhpur AOR 0.502	p=0.001; p=0.001	Young men in the intervention groups in Mumbai and Gorakhpur were about five times and two times, respectively, less likely to report perpetration of partner violence than those in the comparison sites. The levels of partner abuse rose in both comparison sites

(Table 1 continues on next page)

(Table 1 continues on next page)

	Study details	Summary of intervention	Population	Outcome	Effect size	p value	Results
(Continued from previous page)							
Community mobilisation for all							
Abramsky et al, 2014 ⁶⁷	A cluster RCT in 8 communities (4 intervention and 4 control) in Kampala; ITT analysis; 2007–12	SASA! Activist Kit for Preventing Violence against Women and HIV to change social norms, attitudes, and behaviours at a community level with the aim of reducing violence, gender inequity, and HIV vulnerability among women	Women who had an intimate partner in the past year	Physical IPV in the past 12 months (measured using the WHO Multi-Country Study instrument)	ARR 0.48 (95% CI 0.16–1.39)	..	Experience of physical IPV in the year was substantially lower in the intervention group than in the control group, although results were not significant. There was a higher level of intersite variation in the control group at follow-up than was recorded at baseline, which weakens the researchers' ability to obtain a significant result when analysed at the cluster level (although the effect size was large)
Diop et al, 2004 ⁶⁸	Quasi-experimental study of 40 villages in Senegal—20 participated in the intervention, 20 did not; began in 2001	Tostan, a community based educational programme in Senegal; consists of four themes: hygiene, problem solving, women's health, and human rights (including FGM); additional educational and community mobilisation activities were held in the communities	Women directly and indirectly exposed to intervention	Prevalence of women's experience of any type of violence in last 12 months; FGM prevalence among daughters aged 0–10 years	..	..	At endline, women who lived in the Tostan villages reported less violence in the past 12 months than did those in the comparison communities. The differences were significant for women who participated in the Tostan programme and those who did not, although participants had a greater decrease. The prevalence of FGM among girls aged 0–10 years reported by mothers in the Tostan communities was significantly lower than in the comparison villages
Wagman et al, 2014 ⁶⁹	Cluster RCT in Rakai, Uganda, between 2005–09; aPRR were calculated and Poisson multivariable regression used	SHARE intervention based on the transtheoretical model of behaviour change; five strategies of prevention were used, including: capacity building, advocacy, special events, community activism, and learning materials; those clusters who received the intervention were exposed to at least 9 days per month of violence prevention programming	Men and women aged 15–49 years	Physical IPV victimisation in 12 months among women; sexual IPV victimisation in 12 months among women	aPRR 0.80 (95% CI 0.68–0.93); aPRR 0.82 (95% CI 0.69–0.99)	..	The intervention resulted in significant reductions in physical and sexual IPV; reductions in emotional violence were borderline significant; there was no difference in men's reported perpetration between the groups; in addition, SHARE resulted in a significant increase in HIV disclosure and a reduction in HIV incidence among men and women

RCT=randomised controlled trial. ITT=intention to treat. OLS=ordinary least squares. HR=hazard ratio. NA=not available. AOR=adjusted odds ratio. RR=risk ratio. IPV=intimate partner violence. ARR=absolute risk ratio. FGM=female genital mutilation. aPRR=adjusted prevalence risk ratios.

Table 1: Group training and community mobilisation programmes in low-income and middle-income countries

RCT=randomised controlled trial. ITT=intention to treat. OLS=ordinary least squares. HR=hazard ratio. NA=not available. AOR=adjusted odds ratio. RR=risk ratio. IPV=intimate partner violence. ARR=absolute risk ratio. FGM=female genital mutilation. aPRR=adjusted prevalence risk ratios.

Table 1: Group training and community mobilisation programmes in low-income and middle-income countries

Two successful programmes in Uganda and Kenya sought to empower adolescent girls through training in life skills, self-defence, and vocational training (table 1).^{61,64} Findings from randomised control trials showed significant improvements in knowledge and behaviour in sexual and reproductive health in girls in the intervention group, and large reductions in coerced sex (in Kenya, sexual assaults decreased by 60% in girls in the intervention group compared with those in the control group). Training programmes for girls have also had some success in lowering rates of child marriage, although they are more likely to combine direct activities for girls with community level activities. Two programmes, one in India⁶³ and one in rural Ethiopia (the Berhane Hewan programme)⁶² used a comprehensive set of activities including intensive life skills training for unmarried girls, community conversations, mentorship, and community service activities to encourage parents to keep girls in school and to delay marriage. The Berhane Hewan programme also provided support for basic school supplies and an economic incentive (a goat) for

families whose daughters were still unmarried by the end of the programme. Both programmes showed some success in delay of the age of marriage by 1 or more years. The programmes yielded additional benefits by addressing of several drivers of early marriage, resulting in increased knowledge and skills in the girls and changes in attitudes in the community towards child marriage.

Group training that targets men and boys

As presented by in the third paper in this Series by Jewkes and colleagues,⁷⁰ there is a diverse range of interventions involving boys and men in violence prevention, although the evidence of their effectiveness is still limited. One successful programme, Yaari Dosti, was carried out in two sites in India.⁶⁶ The intervention was based on programme H, which was developed in Brazil,⁷¹ and investigators aimed to reduce male-perpetrated violence against women and girls by transforming gender inequitable norms through group training and social communication programmes. Young men in the intervention groups in Mumbai and

	Study details	Summary	Population	Outcome	Effect size	p value	Results
Duflo et al, 2006 ⁸²	3 group RCT in western Kenya; OLS regression analysis	Evaluation comparing 3 school-based HIV/AIDS interventions in Kenya	70 000 students from 328 primary schools	Teen marriage	OLS 0.014	p<0.10	Girls in schools where free uniforms were provided were 1.4 percentage points (or 12%) less likely to be married (not significant). No reduction in teen pregnancy was seen after training teachers in the HIV/AIDS curriculum in Kenya, however this increased the probability that a teen pregnancy occurred within a marriage
Gupta et al, 2013 ⁷⁶	Non-blinded RCT in north and northwestern rural Côte d'Ivoire; multi-level analysis. Both ITT and per protocol analysis. Items from the WHO Multi-Country Study were used to measure IPV	Both an 8 session 16 week gender dialogue group (GDG) and an economic empowerment group savings programme (VSLA) vs VSLA only	Partnered women aged 18 years and older (married or in a relationship with a man for at least 1 year) who had no previous participation in group savings programmes	Economic abuse; physical violence among women with high adherence to the intervention	AOR 0.39 (95% CI 0.25–0.60); AOR 0.45 (95% CI 0.21–0.94)	p<0.0001; p=0.04	Slightly lower odds of reporting physical or sexual violence (not significant) in groups given GDG. There were reductions (although not significant) in reporting of sexual and physical IPV. Women who attended more than 75% of the intervention sessions with their male partner showed a reduction in likelihood to report physical IPV, as compared with the women in the control group. No statistically significant reductions for sexual IPV and physical IPV or for sexual IPV alone
Haushofer et al, 2013 ⁸³	Two-level cluster RCT; OLS regression analysis	The Give Directly programme provided unconditional cash transfers to poor households in rural Kenya. Transfers were randomly assigned to be given to either men or women	1010 primary women in the household	Only physical IPV in the past 6 months; only sexual IPV in the past 6 months	OLS –0.07; OLS –0.05	p<0.1; p<0.05	No significant reductions for emotional abuse. Reduction in IPV was stronger when transfers made to women than to men
Hidrobo et al, 2013 ⁸⁴	RCT in women and Colombian refugees in northern Ecuador (seven urban centres in the provinces of Carchi and Sucumbíos). ANCOVA models and linear probability models	Cash, Food, and Voucher Program; households received 6 monthly transfers of vouchers, cash, or food	Women aged 15–69 years in relationships	Moderate physical violence in past 6 months; physical or sexual violence in past 6 months	ANCOVA –0.06; ANCOVA –0.06	p=0.02; p=0.03	Decreases in controlling behaviours and physical and sexual violence. Effects did not vary by mode of transfer. No significant effect on severe physical or emotional violence
Kim et al, 2007 ⁸⁵	Cluster RCT with 4 intervention and 4 control populations in rural South Africa	Combined group-based microfinance with additional participatory training in gender, violence, and HIV risk	Women in IMAGE groups vs comparable women in control communities	Rates of past year experience of physical or sexual violence by an intimate partner	AOR 0.45 (95% CI 0.23–0.91)	..	Women in the IMAGE groups were 55% less likely to experience physical or sexual violence by a partner in the past 12 months than were women in the comparison groups

RCT=randomised controlled trial. OLS=ordinary least squares. ITT=intention to treat. IPV=intimate partner violence. AOR=adjusted odds ratio. ANCOVA=analysis of covariance.

Table 2: Livelihood programmes in low-income and middle-income countries

Table 2: Livelihood programmes in low-income and middle-income countries

Gorakhpur were about five times and two times, respectively, less likely to report perpetration of physical or sexual partner violence in the previous 3 months than were participants in the comparison sites.

Other similar programmes targeting young men have been implemented globally, including the young men's initiative in the Balkans,⁷² Parivartan (targeting cricket coaches in India),⁷³ and the male norms initiative in Ethiopia.⁷⁴ Assessments of these interventions indicate promising outcomes in changes to young men's attitudes towards gender equality and the use of violence, but they did not result in significant behavioural changes. It is not clear why Yaari Dosti was more successful than the other interventions, but it could be related to the intensity and duration of the intervention, or that the other studies were underpowered. More

research is needed to understand what elements of the interventions with men and boys are key to achieve behavioural changes.⁷⁵

Group training with men and women: synchronising gender approaches

In response to the increasing recognition that both men and women should be engaged in efforts to prevent violence against women and girls, more programmes are using gender synchronised approaches that intentionally reach out to both men and women in a coordinated way. Stepping Stones is a widely adapted programme that uses participatory learning approaches with both men and women to build knowledge, risk awareness, communication, and relationship skills around gender, violence, and HIV. A cluster randomised

trial of young men and women in South Africa showed that at 2 years after the intervention, men's self-reported perpetration of physical and sexual intimate partner violence was significantly lower than were those from

men in control villages. The programme also achieved a significant reduction in infections with herpes simplex virus 2 in both men and women. No differences were noted in women's reports of victimisation from intimate partner violence between the intervention and control villages.⁶⁵

Some prevention methods used in non-conflict settings are now being adapted to conflict and post-conflict settings. Two studies from Côte D'Ivoire looked at the incremental effect on intimate partner violence when gender dialogue groups were added to an economic empowerment group savings programme for women. One of the studies showed a reduction in physical intimate partner violence in couples who attended more than 75% of the meetings, whereas the second study showed improvements in men's attitudes towards violence but no significant behavioural changes.^{76,77}

Community mobilisation

By contrast with group-training programmes, which seek to reduce violence in a targeted group of individuals, community mobilisation interventions aim to reduce violence at the population level through changes in public discourse, practices, and norms for gender and violence. Community mobilisation approaches are typically complex interventions that engage many stakeholders at different levels (eg, community men and women, youth, religious leaders, police, teachers, and political leaders). They use many strategies, from group training to public events, and advocacy campaigns such as the 16 Days of Activism Against Gender Violence (Nov 25–Dec 10).

The interventions often make use of social media, including mobile phone applications, such as Hollaback, Circle of Six, and Safetipin in India, to provide information about violence and neighbourhood safety, and to help women to report violence or to receive emergency help from friends and authorities.¹⁰ Community activists have partnered with innovative edutainment programmes such as Soul City, Sexto Sentido, and Bell Bajao, in the development of high-quality communication materials such as posters, street theatre, and radio and television programmes. Although there is no evidence that social communication programmes alone can prevent violence, rigorous assessments have shown significant changes in knowledge and use of services, attitudes towards gender, and acceptance of violence against women and girls, which can provide crucial support for local efforts.^{10,78–80}

Because of their complexity, community mobilisation programmes are challenging to evaluate, and very few rigorous assessments have been done. As described in the fourth paper of this series by Michau and colleagues,⁸¹ a small cluster randomised trial of the SASA! programme in Kampala, Uganda, showed highly promising (although non-significant) results, by reducing community prevalence of physical partner violence by 54% (table 2).⁶⁷ A similar programme in Rakai, Uganda, showed not only reductions in physical and sexual

Example		Type of violence	Evidence level	
			High-income countries	Low-income and middle-income countries
Response to violence against women				
Women-centred programmes for survivors*	Psychosocial counselling, post-exposure prophylaxis and emergency contraception as needed, risk assessment, referrals, safety planning	IPV, NPSA	Conflicting	Insufficient evidence
Perpetrators programmes*	Interventions for men who assault their female partners	IPV	Conflicting	Insufficient evidence
One-stop crisis centres	Multidisciplinary crisis centres (community or hospital based)	IPV, NPSA	Not applicable or no evidence	Insufficient evidence
Shelters	Safe accommodations that provide short-term refuge and other services	IPV	Insufficient evidence	Insufficient evidence
Women's police stations	Specialised police services for survivors of violence against women, can include psychosocial counselling and referrals	IPV, NPSA	Not applicable or no evidence	Insufficient evidence
Victim Advocacy*	Case management, connection to legal services and information	IPV	Promising	Insufficient evidence
ICT services	National emergency hotlines or mobile applications	IPV, NPSA	Insufficient evidence	Insufficient evidence
Population-based prevention				
Community mobilisation*	Participatory projects, community-driven development engaging multiple stakeholders and addressing gender norms	IPV, NPSA, FGM, CM	Not applicable or no evidence	Promising
Awareness-raising campaigns*	One-off information or media efforts, billboards, radio programmes, posters, television advertisements	IPV, NPSA, FGM, CM	Ineffective	Ineffective
Social marketing campaigns or edutainment plus group education*	Long-term programmes engaging social media, social media, mobile applications, thematic television series, posters, together with interpersonal communication activities	IPV, NPSA, FGM, CM	Insufficient evidence	Insufficient evidence
Group-based training or workshops for prevention of violence against women and girls				
Empowerment training for women and girls*	School or community programmes to improve women's agency. Can include other components such as safe spaces, mentoring, life skills, or self-defence training	IPV, NPSA, FGM, CM	Insufficient evidence	Promising
Men and boys norms programming*	School programmes and community workshops to promote changes in social norms and behaviour that encourage violence against women and girls and gender inequality	IPV, NPSA	Insufficient evidence	Conflicting
Women and men*	School or community workshops to promote changes in norms and behaviour that encourage violence against women and girls and gender inequality	IPV, NPSA	Insufficient evidence	Promising

(Table 3 continues on next page)

partner violence, but also reduced incidence of HIV/AIDS.⁶⁹ This model is now being adapted in other settings throughout sub-Saharan Africa and in Haiti.

Community mobilisation approaches have also been used successfully to reduce FGM and child marriage. Use of the Tostan model,⁶⁸ developed in Senegal, has been replicated in several countries in sub-Saharan Africa, with community-based education programmes that address a range of issues, including health, literacy, and human rights. Through these programmes, villagers identify priority issues for community action, and both FGM and intimate partner violence emerged as key issues. In many cases, villages have taken pledges to renounce FGM and to encourage neighbouring villages to do the same. A quasi-experimental assessment of the programme in Senegal noted that women in the intervention villages reported significantly less violence in the preceding 12 months than did women in the comparison villages.⁶⁸ Also, mothers of girls aged 0–10 years less frequently reported that their daughters had undergone FGM in the intervention villages.⁸⁶

Economic empowerment

Studies around the world have consistently shown associations between intimate partner violence and poverty at both a household and community (correlated with country wealth) level^{87,88} although the directionality and mechanisms for these associations are not clear. These findings have led some development practitioners to argue that increasing of women's economic opportunities should be a key strategy to reduce violence. However, the evidence for women's economic empowerment and its effect on violence is mixed, with research suggesting that increased access to credit and assets could either decrease or increase women's risk of intimate partner violence, depending on the context in which the women live.^{89–91} Increased access to assets could reduce a woman's risk of violence in many ways; potentially allowing financial autonomy enabling women to leave a violent relationship. It could also increase a woman's value to the household, and increase a woman's relative bargaining power within the relationship. More broadly, reductions in household poverty could reduce economic stress and so reduce potential triggers for conflict.

To test whether adding a gender training and HIV prevention component to microfinance programmes for women could contribute to reductions in intimate partner violence, investigators for the IMAGE study⁸⁵ combined livelihood and empowerment strategies to address gender issues, HIV, and violence in women living in rural South Africa. The intervention combined microfinance with ten participatory training and skills-building sessions on HIV, cultural beliefs, communication, and violence. After 2 years, a cluster-randomised trial showed a 55% reduction in reports of physical or sexual partner violence from women, with economic assessments that suggested

Example	Type of violence	Evidence level		
		High-income countries	Low-income and middle-income countries	
(Continued from previous page)				
Alternative rites of passage	Training for girls in life skills culminating in a ceremony without FGM	FGM	Not applicable or no evidence	Insufficient evidence
Economic and livelihoods				
Economic empowerment and income supplements*	Microfinance; vocational training or job placement; cash or asset transfers (eg, land reform)	IPV, NPSA, FGM, CM	Not applicable or no evidence	Conflicting
Economic empowerment and income supplements plus gender equality training*	Microfinance; vocational training or job placement; cash or asset transfers (eg, land reform) plus gender equality and violence prevention training	IPV, NPSA, FGM, CM	Not applicable or no evidence	Promising
Retraining for traditional excisors	Microfinance or vocational training	FGM	Not applicable or no evidence	Ineffective
System-wide approaches				
Screening*	Universal IPV screening among nurses and doctors at all visits	IPV, NPSV	Ineffective	Not applicable or no evidence
Home visitation and health worker outreach*	Visits by community health workers or nurses to households	IPV	Promising	Insufficient evidence
Justice and law-enforcement interventions	Mobile courts, increased enforcement, second response	IPV, NPSV	Ineffective	Not applicable or no evidence
Personnel training*	Sensitisation, identification, or response training with institutional personnel (eg, teachers, police officers, first responders, health professionals)	IPV, NPSA, FGM, CM	Ineffective	Ineffective
Infrastructure and transport	Improving the safety of public transport, street lighting	NPSA	Insufficient evidence	Insufficient evidence
Programmes will often incorporate multiple components and overlaps reflecting more than one intervention type. IPV=intimate partner violence. NPSA=non-partner sexual assault. FGM=female genital mutilation. CM=child marriage. *Classification based on rigorous trials including randomised controlled trials or quasi-experimental trials with comparison groups. Evidence classification adapted from WHO (2010). ²⁵				
Table 3: Effectiveness of intervention strategies to reduce violence against women and girls				

Table 3: Effectiveness of intervention strategies to reduce violence against women and girls

that the intervention is cost-effective.⁸⁵ IMAGE is being scaled up in South Africa and is being expanded to Tanzania and Peru.

Cash transfers

Although not designed to address violence against women and girls specifically, cash transfer programmes can contribute to reductions in both intimate partner violence and child marriage. Studies of unconditional cash transfer programmes in Kenya⁸³ and Ecuador⁸⁴ reported, in addition to large economic and nutritional benefits to households, significant reductions in rates of intimate partner violence in both settings (table 2). The study from Kenya noted that large transfers were associated with significant decreases in cortisol concentrations in both men and women,

suggesting that the reduction in intimate partner violence might be partly due to drops in household stress. In Ecuador, the investigators reported that the transfers did not lead to increased decision-making power for women in the household, and concluded that the effect on intimate partner violence could be due to reduced stress.

Financial or material incentives have also been used with promising results to reduce child marriage. The incentives include school uniforms, livestock, or cash transfers.^{62,82} Usually, these incentives are conditional on the girl staying in school or staying unmarried until the age of 18 years, although a programme in Malawi showed promising results in keeping girls in school and delaying marriage through unconditional cash transfers.⁹² An innovative programme established in 1994 in the State of Haryana, India, used savings bonds as an incentive to encourage parents not to marry their daughters before they were aged 18 years. Preliminary findings from continuing assessment indicate that beneficiary girls have achieved higher educational attainment compared with non-beneficiaries (table 3).⁹³

Discussion

In view of evidence for the high prevalence and severe health outcomes of violence against women and girls, it is troubling that rigorous data for what works to prevent violence are still scarce. Available intervention research is highly skewed towards studies done in high-income countries, and it largely focuses on response rather than prevention. Our Series paper suggests that, despite the crucial value of provision of timely and appropriate services to survivors of violence, little evidence exists that such programmes alone can lead to significant reductions in violence against women and girls.

The evidence base is limited by several methodological weaknesses. Many of the studies had very small sample sizes (commonly with few clusters in randomised controlled trials). For this reason, some of the null findings reported probably result from underpowered studies rather than a definite absence of intervention effect. There is also a very wide range of outcome measurements and timeframes, which makes comparisons difficult. Of concern, many studies did not control for potential confounding factors, which might result in some bias in the results. Most of the assessments identified did not include a long follow-up period, if any, making it difficult to establish whether changes are sustained over time.

There are several areas in which the evidence base is small or non-existent. We found no rigorous assessments of interventions to prevent trafficking, and a few evaluations from humanitarian and emergency situations. Few assessments have been done in indigenous or ethnically diverse populations or in older populations. With a few exceptions, the evaluations in this review did not measure cost-effectiveness of interventions, which is a pivotal decision point for those who wish to implement and adapt an intervention, particularly in low-resource

settings. There is little documentation on how interventions can be adapted to different settings.

Despite the shortcomings of the available evidence base, some promising trends emerge. Several studies show that it is possible to prevent violence against women and girls, and that large effect sizes can be achieved in programmatic timeframes. Multisectoral programmes that engage with multiple stakeholders seem to be the most successful to transform deeply entrenched attitudes and behaviours. Strong programmes not only challenge the acceptability of violence, but also address the underlying risk factors for violence including norms for gender dynamics, the acceptability of violence, and women's economic dependence on men. They also support the development of new skills, including those for communication and conflict resolution. Some of the studies showed potential benefits from integration of violence prevention into existing development platforms, such as microfinance, social protection, education, and health sector programming, which could allow scalability. Community mobilisation models also provide a means to achieve measurable community level effects. Importantly, there are several positive examples of impact from low-income and middle-income countries that could potentially be transferred to high-income countries.

Overall, the findings point to the imperative of greatly increasing investment in violence research and programme evaluation, particularly in low-income and middle-income countries. Alongside programmatic investment, it will remain important to support rigorous evaluations and guide international efforts to end violence against women and girls. As the specialty continues to develop, importance should be given to learning more about the costs of programmes and identification of models of intervention that can be delivered to scale.

Contributors

ME, DJA, MM, FG, and SK participated in the study design. FG and SK did the systematic review and double screened all abstracts and full texts version of reports and carried out data extraction. DJA, ME, MM, FG, SK, and MC participated in the data analysis. ME, DJA, and CW drafted the manuscript. All authors have commented on and edited the original draft, and all authors have read and approved the final version.

Declaration of interests

We declare no competing interests.

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