Distribution Agreement In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature: Date:

_____ _____

[Allayna DeHond]

Interventions to Prevent Intimate Partner Violence Perpetration by Men and Boys in Lower- and Middle-Income Countries: A Systematic Review

By

Allayna DeHond

Master of Public Health

Hubert Department of Global Health

_____

Ameeta Kalokhe, MD, MSc

Committee Chair

Interventions to Prevent Intimate Partner Violence Perpetration by Men and Boys in Lower- and Middle-Income Countries: A Systematic Review

By

Allayna DeHond

BS

University of Rochester

2014

Thesis Committee Chair: Ameeta Kalokhe, MD, MSc

An abstract of

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

in partial fulfillment of the requirements for the degree of

Master of Public Health

In Global Health

2021

Abstract

Interventions to Prevent Intimate Partner Violence Perpetration by Men and Boys in Lower- and Middle-Income Countries: A Systematic Review

By Allayna DeHond

Background: Intimate partner violence (IPV) affects the health and wellbeing of women across the globe, with the greatest burden of IPV encountered by women in low- and middle-income countries (LMICs). In recent years there has been a growing number of primary prevention interventions targeting IPV perpetration by men and boys. This systematic review aims to summarize the studies published to date, examining the efficacy of such primary prevention interventions in LMICs, exploring the populations studied, intervention theory, components, and delivery, and to identify gaps in the existing literature.

Methods: PudMed, EMbase, and PsychINFO were systematically searched for peer-reviewed articles, published between January 2001 and October 2020, that examined the efficacy of primary prevention interventions aiming to reduce IPV perpetration by men/boys in LMICs. Eligibility criteria included: English language, report of quantitative male IPV perpetration outcome, and study of an intervention delivered to men/boys. Study population, setting, and design, intervention components, outcome assessment methods, and IPV perpetration results were extracted from articles meeting eligibility criteria. The quality of studies was assessed using Effective Public Health Practice Project (EPHPP) tool.

Results: Seventeen articles representing 16 studies met inclusion criteria. Interventions took place in 8 different countries and utilized common methods such as community mobilization, group education sessions, and trained peer facilitators. Interventions ranged in duration from 2 months to 4 years and the most common supporting theory use was the Social Cognitive Theory. Of these 16 studies, 9 (56%) reported significant effects on at least one form of IPV perpetration. Using the EPHPP quality assessment tool, 9 studies (56%) received strong ratings, 2 (13%) received moderate ratings, and 5 (31%) received weak ratings.

Conclusions: This review highlighted several interventions targeting perpetration of IPV by men/boys that were effective, the majority of which were evidence-based, grounded in theory, and targeted multiple levels of the socio-ecological model. Key gaps in the literature, that should be the focus of future studies, include extending intervention studies to LMICs outside the 8 represented here, possibly by adapting and testing IPV prevention interventions that demonstrated efficacy, and for establishment of standardized IPV perpetration definitions, outcome measures, and tools.

Interventions to Prevent Intimate Partner Violence Perpetration by Men and Boys in Lower- and Middle-Income Countries: A Systematic Review

By

Allayna DeHond

BS

University of Rochester

2014

Thesis Committee Chair: Ameeta Kalokhe, MD, MSc

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

in partial fulfillment of the requirements for the degree of

Master of Public Health

In Global Health

2021

Acknowledgements

I would like to give my utmost gratitude to Dr. Ameeta Kalokhe. This thesis would not have been possible without her continued guidance, feedback, and encouragement. I am so thankful for all you have done to support me in this process, as well as the mentorship you have provided throughout. Thank you.

I would also like to thank my friends, family, and partner for their love and support that has helped me make it to where I am today. Thank you all.

Acronyms

CDC	Centers for Disease Control and Prevention
EPHPP	Effective Public Health Practice Project
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
ITT	Intention to Treat
LMIC	Lower- and Middle-Income Country
RCT	Randomized Controlled Trial
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
VAW	Violence Against Women
WHO	World Health Organization

Table of Contents

Introduction

Intimate partner violence (IPV) affects women across the globe, with nearly one-third of women experiencing IPV in their lifetime (Coll, Ewerling, Garcia-Moreno, Hellwig, & Barros, 2020). According to the WHO, IPV is defined as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" (P. A. H. O. World Health Organization, 2012). Physical violence is the use of physical force that can cause harm, injury, or death and can include hitting, choking, grabbing, use of a weapon, etc. Sexual violence is any sexual act "that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse." Lastly, psychological violence is the use of both verbal and non-verbal communication to mentally or emotionally harm or exert control over another person (Breiding, Basile, Smith, Black, & Mahendra, 2015). Psychological IPV is sometimes also called emotional or verbal IPV.

While men do experience IPV it is at much lower rates than women. Women are often both emotionally and economically dependent on their partners which makes them more likely to be stuck in an abusive relationship (World Health Organization, 2002). They also might stay in a violent relationship due to stigma associated with divorce, fear of retaliation towards herself or her children, and hope that her partner will change (P. A. H. O. World Health Organization, 2012). IPV can lead to both short- and long- term physical and mental health consequences for those experiencing it (Campbell, 2002). As there are multiple forms of IPV there are also multiple pathways by which IPV can cause adverse health outcomes. Physical violence can result in injury, disability, and even death. Sexual violence can lead to mental health problems, STIs, and unwanted/complicated pregnancies (World Health Organization, 2013). Psychological violence can lead to increased stress, depression, and anxiety that can then manifest into

substance abuse and cardiovascular diseases (World Health Organization, 2013). Women who experience IPV are more likely to have low-birth-weight babies, more likely to experience depression, and in some countries at least 1.5 times more likely to get HIV or other STIs (World Health Organization, 2013).

Women in every country experience IPV however, a WHO multi-country study found that rates of IPV prevalence were highest in low- and middle-income countries (LMICs) in Africa, Eastern Mediterranean, and South-East Asian regions. The global estimate for IPV prevalence amongst ever-partnered women was 30% yet in many LMICs the prevalence was around 37%, whereas in high income countries the prevalence is estimated at approximately 23% (World Health Organization, 2013). Another study found that in most LMICs women who were younger and of lower socio-economic status were more vulnerable to IPV (Coll et al., 2020).

It wasn't until 1996 that the World Health Assembly declared violence as a worldwide public health problem (Dahlberg & Mercy, 2009). Violence prevention is now categorized into three levels: Primary prevention which aims to prevent violence before it occurs, secondary prevention or the initial response to violence including emergency services, STI treatment, and initial counseling, and tertiary prevention which is long-term care for both the victims and perpetrators, such as rehabilitation and trauma reduction (World Health Organization, 2002). One main reason that there have not been many primary violence prevention programs in the past is that violence has previously been seen more as an issue for law enforcement and not as a public health issue. This is especially true in many cultures where certain forms or levels of violence are seen as acceptable and therefore, violence prevention is not seen as a priority (Lang, 2003b). Programming to prevent violence against women started out by focusing on support services for victims and improving the justice system's response to perpetrators of violence

against women. This was followed by some integration of violence prevention programming into existing HIV and reproductive health programs (Chibber & Krishnan, 2011; Ellsberg et al., 2015). While much of the work in violence prevention has focused on secondary and tertiary programs there has been a recent push to increase the efforts in primary prevention. These efforts include both individual and community level prevention programs that provide education on violence and support resources, empower women and girls with social and economic programs, structural interventions, and programs that target changes in gender norms and attitudes towards violence using education, community mobilization, and various other methods (Ellsberg et al., 2015; Harvey, Garcia-Moreno, & Butchart, 2007).

There is a need to bring men and boys in to address many of the persistent power imbalances and harmful gender norms form the root causes for gender-based violence (Harvey et al., 2007). Not only are men the main perpetrators of intimate partner violence, but they also hold power in structural, political, and social areas where decisions are being made to end violence against women (Lang, 2003a). As mentioned above much of the violence prevention programming in LMICs is tied in with reproductive health programming, most of which is targeted exclusively at young women (Chibber & Krishnan, 2011). However, men as the main perpetrators of violence were originally left out of most violence prevention efforts (Lang, 2003b). The first suggestions to promote men's behavior change programs as part of the violence prevention movement were met with concerns that these programs would be ineffective and take funds away from services for women (Pease, 2008). There is also often backlash from men when confronted what some see as an unfair accusation that can sometimes lead to increased rates of violence against women (Pease, 2008). To address these issues there has been a growing movement globally to engage men and boys in speaking out against and helping to prevent

gender-based violence (Minerson, Carolo, Dinner, & Jones, 2011).Working with men and boys to address overarching gender norms and power imbalances in a way that is marketed as benefiting the whole community, not just women.

Programs hoping to engage men and boys in IPV prevention need to be founded on frameworks and theories that target the determinants of IPV perpetration by men. Determinants include individual level factors such as lack of education, alcohol/drug abuse, acceptance of violence, and childhood experiences with violence (P. A. H. O. World Health Organization, 2012). Community and societal factors also need to be considered: inequitable gender norms, weak legal repercussions and community sanctions for IPV, poverty, the lack of social and financial power held by women, and a general acceptance of violence as a method to solve problems (P. A. H. O. World Health Organization, 2012).

However, while public health organizations have been implementing an increasing number of primary violence prevention programs aimed at men the data being collected is mostly from high-income countries with very little evidence on effectiveness of violence prevention interventions in LMICs (Ellsberg et al., 2015). Considering the backlash and negative effects that can come from introducing men into violence prevention programming there is a need to thoroughly examine these programs and their effects. This is especially true for IPV, where in addition to the individual and societal determinants of IPV perpetration mentioned above there are also relationship specific determinants that lead to IPV: lack of communication/conflict in the relationship, financial strain, infidelity, and disparities in education and power within the relationship (P. A. H. O. World Health Organization, 2012).

Prior systematic reviews and meta-analyses have been conducted around gender-based violence prevention programs. Many reviews do not focus specially on partner violence but

instead cover sexual violence in general, including both partner and non-partner sexual violence and sometimes physical and psychological violence (DeGue et al., 2014; Graham et al., 2019; Lundgren & Amin, 2015; Ricardo, Eads, & Barker, 2011; Wright, Zounlome, & Whiston, 2020). While there are similarities between partner and non-partner sexual violence, programs not targeting IPV specifically use different outcome measures and intervention methods. Of the reviews that look specifically at IPV many review programs for just targeted at adolescents (De Koker, Mathews, Zuch, Bastien, & Mason-Jones, 2014; Lundgren & Amin, 2015). This is especially true for reviews looking exclusively at programs for men and boys, partially because the large majority of evaluated studies are in high-income countries where most programs for males are done in school settings or with youth (Graham et al., 2019; Ricardo et al., 2011). Ricdardo et. al. included 65 studies in their review of sexual violence prevention programs for boys and young men and only 15% took place in LMICs (Ricardo et al., 2011). While there are a few reviews that are specific to IPV prevention programs in LMICs they do not limit their population to men and boys. One review by Signorelli et. al. looks just at primary healthcare interventions for IPV, Bourey et. al. reviews structural but not behavioral intervention for IPV, and both look at interventions for men and women (Bourey, Williams, Bernstein, & Stephenson, 2015; Signorelli et al., 2018).

This systematic review summarizes the existing studies examining programs targeted at men and boys aiming to prevent primary perpetration of IPV in LMICs and identifies existing gaps in prevention approaches. Specifically, through the review, we examine: What are the formats of delivery and components of these programs? Which populations and settings have been targeted? Which programs have been shown to be effective in preventing perpetration of IPV by men? How has efficacy been measured? What is the quality of study design in published

studies to date? The review concludes with a discussion around how these effective strategies could be integrated into future IPV prevention programming and identifies gaps in implementation and evaluation of IPV prevention programs for men in LMICs.

Methods

Study Selection

A systematic literature review of studies published from the previous 20-year period that examined the structure and efficacy of interventions aimed to prevent primary perpetration of IPV by boys/men in LMICs was conducted. The following criteria for inclusion in this review were applied:

- Peer-reviewed articles published in English between 2001 and 2020
- Reported an evaluation of an intervention that aims to prevent primary perpetration of at least one form of IPV (e.g., physical, sexual, psychological, or economic)
- Evaluated an intervention delivered to boys and/or men of any age
- Reported a quantitative outcome measuring self-reported IPV perpetration by male participants
- Intervention evaluated was conducted in a LMIC as defined by the World Bank

Any non-original work such as commentaries, reviews, and meta-analyses were excluded from this review. Interventions included could target females along with the males as long as outcomes were disaggregated by sex and male-only data was available. If an article did not present disaggregated data the author was contacted to request male-only data. Each author was contacted up to two times and given 2 weeks from the final correspondence to send disaggregated data for inclusion in the review. If the author could not be reached or failed to provide data, then that article was excluded. While boys and men can also be victims of IPV, evidence shows that girls and women make up the majority of the population targeted with IPV.

Further, while men and boys can also perpetrate or experience IPV in same-sex relationships, studies examining IPV perpetration in same-sex relationships by men were not included due to the paucity of such published intervention programs in LMICs and probable differences in intervention mechanisms of effect. All forms of study design and outcome measurement were accepted. Qualitative only studies were not included as doing so would require an application of different analytic strategies for cross-study comparisons. Also included were articles on interventions where the main purpose was not primary IPV prevention, however outcome data was collected on primary IPV prevention. For example, many couple's HIV prevention programs also have relevant IPV outcomes.

Search Terms				
IPV		Men		Intervention
"Intimate Partner Violence"		"Male"		"Health Promotion"
"Intimate Partner Abuse"		"Men"		"Intervention"
"Dating Violence"		"Boy(s)"		"Program"
"Dating Abuse"				"Effectiveness"
"Sexual Violence"				"Evaluation"
"Sexual Abuse"				
"Physical Violence"				
"Physical Abuse"	AND		AND	
"Psychological Violence"				
"Psychological Abuse"				
"Emotional Violence"				
"Emotional Abuse"				
"Spousal Violence"				
"Spousal Abuse"				
"Domestic Violence"				
"Domestic Abuse"				
"Familial Violence"				
"Familial Abuse"				

Table 1. Search Terms used in Databases.

In October 2020, systematic searches were conducted for peer-reviewed articles form three electronic databases: PubMed, PsychINFO, and EMbase. Search terms, as shown in table 1, were first identified from published systematic reviews and meta-analyses and were sorted into

three main themes: IPV, intervention, and men. To ensure each theme had a comprehensive and up-to-date list of terms, PubMed's MeSH database was utilized along with discussion of the terms with an Emory University research librarian as well the author's thesis mentor. The following fields were used when searching for terms in each database: Text Word for PubMed, Abstract for PsychINFO, and Title/Abstract/Keyword for EMbase. Filters for English language and publication date between 2001 and 2020 were applied to all searches.

Screening Filters	
Code	**Exclusion Criteria**
IPV	Article does not discuss the outcomes of an intervention that prevents IPV
PP	Intervention discussed does not prevent primary IPV
SR	Article is a systematic review, chapter review, etc.
LMIC	Intervention discussed was not conducted in a LMIC as defined by The World Bank
M	Intervention discussed did not include males as participants
Qual	Article does not present at least one quantitative outcome of IPV perpetration or related knowledge, attitudes, or behaviors
Dis	Outcome data is not disaggregated by sex if intervention was co-ed
Het	Article does not discuss heterosexual IPV perpetrated by men
Eval	Article does not report an outcome indicating self-reported IPV perpetration by men/boys

Table 2: Screening Filters.

All search results were uploaded to Covidence and duplicates were removed. A title/abstract review was then conducted by the primary author (AD) identifying potential articles for inclusion based on the established criteria (see table 2 for screening filters). When questions arose about specific articles or inclusion criteria, she consulted with her research mentor (ASK). Articles in which there was uncertainty around whether they fit eligibility criteria were pushed to the full text review stage for further consideration and discussion. Next a full text review of potential articles was completed by the primary author to identify articles that met all inclusion criteria. Eligible articles were included in the data extraction and ineligible articles excluded. Articles for which there was uncertainty about whether they met inclusion criteria were

discussed between the primary author and thesis mentor until consensus on eligibility was reached.

Additionally, the references cited in other relevant systematic reviews and meta-analysis were reviewed for more potentially relevant articles for inclusion. Systematic reviews and meta-analyses were considered relevant if they included partner or gender-based violence in the title. Articles selected and available through the Emory Library then went through a full text review and those that met all inclusion criteria were added to the review.

IRB approval was not required for this study as it did not involve human subjects' research.

Data Extraction and Quality Assessment

Eligible articles that met all inclusion criteria went through data extraction and quality assessment. The primary author extracted data from eligible articles into Microsoft Excel. The variables extracted were updated during the extraction of the first few articles to ensure all relevant information was being obtained. Extracted data included publication and study details such as objectives, study design, and funding sources. Data was extracted on the intervention itself including the curriculum used, intervention methods, control details, type of violence addressed, facilitators, setting, duration, population reached, and the supporting theory. Population descriptions were extracted for both the population receiving the intervention as well as the population included in the outcomes. Inclusion and exclusion criteria, recruitment, sampling, and retention information was extracted. Lastly outcome measures and results were extracted (methods used to assess outcomes related to IPV, timeframe over which outcomes were measured, IPV perpetration results, other IPV related outcome results).

The Effective Public Health Practice Project (EPHPP) Quality Assessment (QA) Tool was used for QA of included studies as it is not limited to RCTs like many other QA tools (Armijo-Olivo, Stiles, Hagen, Biondo, & Cummings, 2012). The EPHPP is made up of eight sections each containing two to four questions. The eight sections are selection bias, study design, confounders, blinding, data collection methods, withdrawals and drop-outs, intervention integrity, and analyses. Six of the sections are each given a rating of strong, moderate, or weak based on the answers to the questions in each section and then each article is given an overall rating. Articles can be rated strong (no weak section ratings), moderate (one weak section rating), or weak (two or more weak section ratings) (McMaster University, 2018).

RESULTS

Article Yield

The initial search across PubMed, PsychINFO, and EMbase search engines yielded a total of 8,392 articles. After 1,884 duplicates were removed the remaining 6,508 went through title and abstract screening. Of these 5,499 (or 84%) were excluded for not presenting outcomes from a program to prevent IPV, 489 (or 8%) were excluded due to the evaluated program targeting secondary or tertiary IPV prevention and not primary IPV prevention, 128 (or 2%) were excluded due to not being conducted in an LMIC, 62 (or 1%) were excluded due to presentation of non-original data (systematic review, chapter review, etc.), 11 (or <1%) were excluded due to not targeting any males with the program, 1 (or <1%) was excluded for presenting exclusively qualitative results, and 1 (or <1%) was found to be a duplicate. This left 317 that went through full text review. Of the 317 that had the full text analyzed for inclusion criteria, 105 (or 33%) were excluded due to not being conducted in an LMIC, 75 (or 24%) were excluded for not presenting outcomes from a program to prevent IPV, 47 (or 15%) were excluded for not including self-reported IPV perpetration as an outcome, 25 (or 8%) were excluded for presenting exclusively qualitative results, 16 (or 5%) were excluded due to presentation of non-original data (systematic review, chapter review, etc.), 15 (or 5%) were excluded due to the evaluated program targeting secondary or tertiary IPV prevention and not primary IPV prevention, 6 (or 2%) were excluded for not providing sex disaggregated results, 6 (or 2%) were found to be duplicates, and 5 (or 2%) were excluded due to not targeting any males with the program. Thus, the final yield of articles meeting eligibility was 17. Full screening results are shown in the Prisma diagram (figure 1) below.

Additionally, the references of 17 review articles related to violence prevention were explored for additional potential articles for inclusion, but no additional articles meeting the eligibility criteria were found.

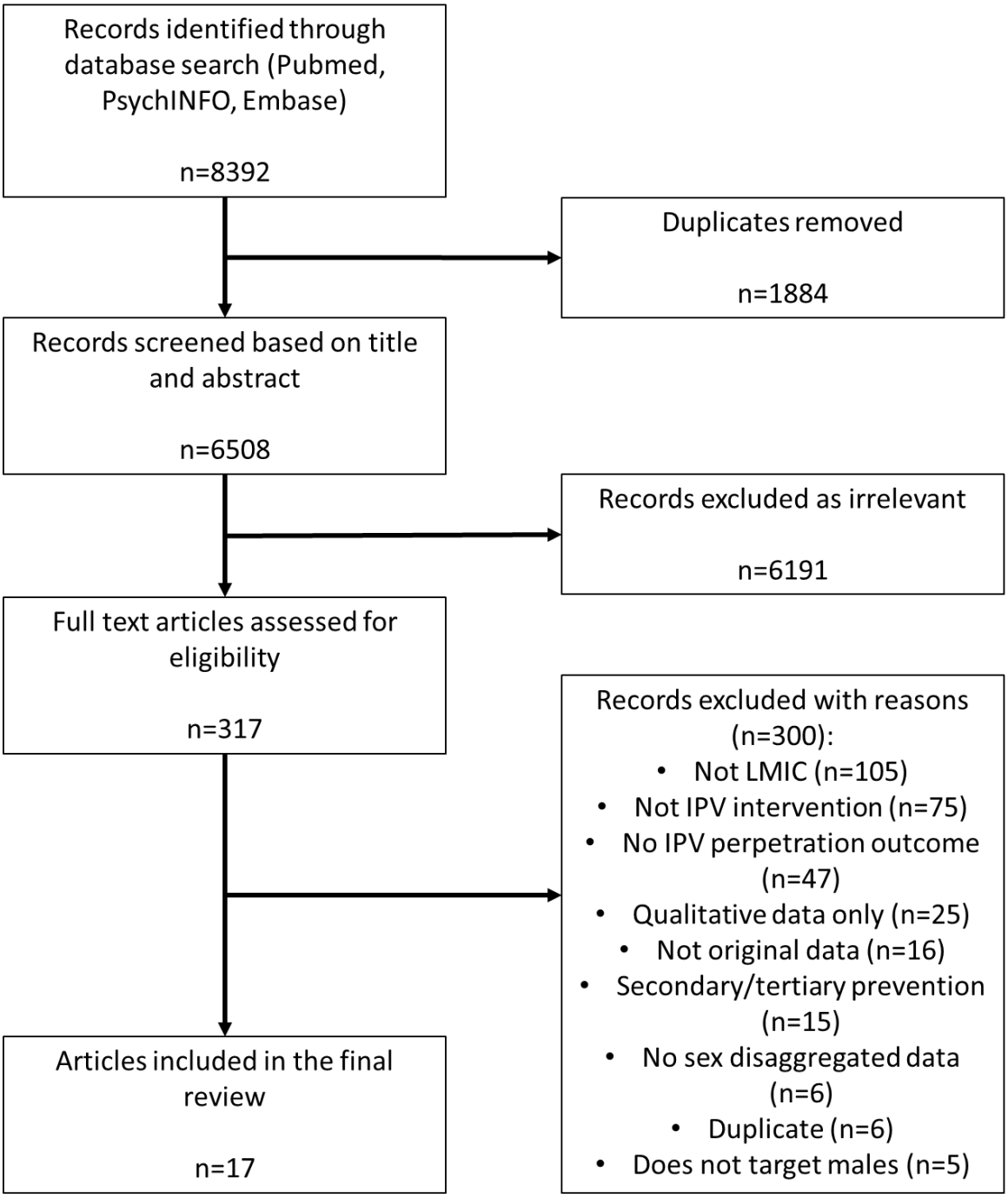

Figure 1: PRISMA diagram of study selection for review.

Study Design

The 17 reviewed articles reported evaluations of 16 interventions. Study characteristics are shown in Table 4 below. All articles, except for one (Chatterji, Heise, Gibbs, & Dunkle, 2020), reported on a single intervention. Of the studies reviewed 12/16 (or 75%) were cluster randomized control trials (cRCTs), 1/16 (or 6%) was an individual level randomized control trial (RCT), and 3/16 (or 19%) were quasi-experimental trials. One quasi-experimental study was the Male Norms Initiative in Ethiopia which randomly allocated 3 sub-cities of Addis Ababa to either of the 2 intervention arms or control arm and then targeted youth group members within the sub-cities for the intervention (Julie Pulerwitz et al., 2015). Another quasi-experimental design was used in the True Love study in Mexico City. They chose to implement the intervention in 2 at-risk schools, selecting a sample of students from each school to participate in the intervention activities and using propensity score matching in their analysis (Sosa-Rubi, Saavedra-Avendano, Piras, Van Buren, & Bautista-Arredondo, 2017). The last quasi-experimental trial was the REAL study which started out as an RCT. Unfortunately, due to confidentiality concerns participants assigned to intervention versus control were not tracked, leading the study team to use endline data on participation to compare exposed men, men who attended at least 1 individual and 1 group mentoring session, versus unexposed men, men who did not attend at least 1 of each type of mentoring session (Ashburn, Kerner, Ojamuge, & Lundgren, 2017).

Cluster RCTs used a variety of units of randomization: 5/13 (or 38%) randomized by villages/communities (Gibbs et al., 2020; Gottert et al., 2020; Halim et al., 2019; Rachel Jewkes et al., 2008; Pettifor et al., 2018), 3/13 (or 23%) by sectors/sites (Abramsky et al., 2016; Chatterji, Stern, Dunkle, & Heise, 2020; Wagman et al., 2015), and 1/13 (or 8%) each by social

camps (Maman et al., 2020), health centers (Nadkarni et al., 2017), villages (Sharma, Leight, Verani, Tewolde, & Deyessa, 2020), neighborhoods (Christofides et al., 2020), and districts (Ogum Alangea et al., 2020).

Follow-up assessments for trials were conducted between 3 months (Nadkarni et al., 2017) and 4 years (Abramsky et al., 2016) after baseline assessment with an average follow-up time of 22.8 months post-baseline. The majority (10/16 or 63%) of the trials conducted follow-ups between 12-24 months post-baseline. The comparison groups for the studies were as follows: no intervention (5/16 or 31%), delayed intervention (3/16 or 19%), shortened/other health topic intervention (3/16 or 19%), usual care (2/16 or 13%), a portion of the whole intervention (2/16 or 13%), and 1 trial (or 6%) did not report what the comparison group received. Comparison groups receiving usual care included control participants in the SHARE integrated IPV and HIV program who received routine HIV prevention and treatment services and control participants in the CAP alcohol counseling program who had a consultation with the physician at the health facility (Nadkarni et al., 2017; Wagman et al., 2015). The usual care in CAP was enhanced as the program team provided the physicians with the screening results as well as a WHO guideline document on harmful drinking (Nadkarni et al., 2017).

Study Population

The 16 interventions studied targeted a variety of populations: whole communities (10/16 or 63%), individuals/small groups (10/16 or 63%), community leaders (7/16 or 44%), and professionals such as health care workers, law enforcement officials, and school staff (4/16 or 25%). Around half of the interventions (9/16 or 56%) had multiple components targeting two or three different populations. Of the 10 interventions that targeted individuals either in one-on-one or small group sessions: 4 (or 40%) intervened on male only individuals/groups (Ashburn et al.,

2017; Maman et al., 2020; Nadkarni et al., 2017; Julie Pulerwitz et al., 2015), 4 (or 40%) on single-sex groups of men and women (Gibbs et al., 2020; Halim et al., 2019; Rachel Jewkes et al., 2008; Sharma et al., 2020), 2 (or 20%) on couples (Chatterji, Stern, et al., 2020; Sharma et al., 2020), and 2 (or 20%) on mixed-sex (non-partnered) groups (Rachel Jewkes et al., 2008; Sosa-Rubi et al., 2017).

While many of the studies included men and women in the outcomes, we herein only report on outcomes related to the males. The number of males included in the outcomes ranged from 336 to 5,201 with a mean of 1,399. Of the 16 interventions 8 (50%) had less than 1,000 males included in the outcomes, 5 (31%) had between 1,000 and 2,000, and the remaining 3 (19%) had over 2,000. The mean age of men included in the outcomes (13/16 studies provided a mean age) ranged from 16.4 (Sosa-Rubi et al., 2017) to 42 (Nadkarni et al., 2017). Two interventions, the Males Norms Initiative and True Love, specifically targeted youth, with mean ages 19 and 16.4 years, respectively (Julie Pulerwitz et al., 2015; Sosa-Rubi et al., 2017). All other studies targeted more general populations or took random household samples for their outcome, and had mean ages of men between 23 and 42 years.

Study Setting

Five trials (31%) were conducted in South Africa (One Man Can/CHANGE, Tsima, Stepping Stones, Stepping Stones and Creating Futures (SS-CF), unnamed intervention) (Chatterji, Heise, et al., 2020; Christofides et al., 2020; Gibbs et al., 2020; Gottert et al., 2020; Rachel Jewkes et al., 2008; Pettifor et al., 2018), three (19%) in Uganda (REAL Fathers Initiative, Safe Homes and Respect for Everyone (SHARE), SASA!) (Abramsky et al., 2016; Ashburn et al., 2017; Wagman et al., 2015), two (13%) in Tanzania (Vijana Vijiweni II, Together to End Violence Against Women (TEVAW)) (Halim et al., 2019; Maman et al., 2020), two (13%) in Ethiopia (Male

Norms Initiative, Unite for a Better Life (UBL)) (Julie Pulerwitz et al., 2015; Sharma et al., 2020), and one each (6%) in Rwanda (Indashyikirwa) (Chatterji, Heise, et al., 2020; Chatterji, Stern, et al., 2020), India (Counseling for Alcohol Problems (CAP)) (Nadkarni et al., 2017), Ghana (Rural Response System (RSS)) (Ogum Alangea et al., 2020), and Mexico (Amore…pero del Bueno (True Love)) (Sosa-Rubi et al., 2017). Studies were conducted in urban (3/16 or 19%), peri-urban (3/16 or 19%), and rural (6/16 or 38%) communities. The remaining 4/16 (or 25%) did not specify the type of community. A few studies specifically targeted regions where HIV and/or IPV rates were higher than the national average (Chatterji, Stern, et al., 2020; Pettifor et al., 2018). Interventions were implemented within multiple settings: communities (10/16 or 63%), existing community groups (4/16 or 25%), schools (1/16 or 6%), and health facilities (1/16 or 6%). More detailed descriptions of study settings are provided in table 3.

First Author (year)	Study design	Target Population	Study Setting	IPV Perpetration Assessment Method
Maman (2020)	Cluster RCT	Men at least 15 years old that are part of a social camp.	Camps - organized networks of men with governance where men socialize in Dar es Salaam, Tanzania	Adapted version of the WHO VAW instrument.
Ashburn (2017)	Quasi-Experimental	Young fathers, aged 16-25, with toddler aged children (1-3 years old).	Attiak sub-county, Amuru district in the Northern post-conflict region of Uganda.	Adapted measures from the Conflict Tactics Scale.
Pulerwitz (2015)	Quasi-Experimental	Boys 15-24 recruited from youth groups. Entire Communities.	Youth centers and communities in 3 low-income sub-cities of Addis Ababa, Ethiopia.	Adapted version of the WHO VAW instrument.
Chatterji (2020)	Cluster RCT	Couples attending CARE VSLAs. Entire communities.	Districts in the Eastern, Northern and Western provinces of Rwanda, in predominantly rural. Chosen based on high IPV rates and existing CARE VSLA program.	Adapted version of the WHO VAW instrument.
Pettifor (2018)	Cluster RCT	Adult community members aged 18-35, especially men.	Villages in the rural Bushbuckridge sub-District in Mpumalanga province of South Africa with high HIV rates.	Measures from a World Health Organization questionnaire adapted for South Africa.
Nadkarni (2017)	RCT	Male problem drinkers recruited from Primary Health Centers.	Primary Health Centers in the North District of Goa, India.	Intervention specific
Abramsky (2016)	Cluster RCT	Entire communities.	Rubaga and Makindye Divisions of Kampala, Uganda.	Intervention specific.
Sharma (2020)	Cluster RCT	Men, women, and couples.	Mareko, Meskan, Silte, and Sodo districts in rural Ethiopia.	Adapted version of the WHO VAW instrument.

First Author (year)	Study design	Target Population	Study Setting	IPV Perpetration Assessment Method
Christofides (2020)	Cluster RCT	Entire communities.	A peri-urban township near Johannesburg, South Africa.	Adapted version of the questionnaire from the South African Medical Research Council's Study on Men's Health and Relationships.
Wagman (2015)	Cluster RCT	Entire communities.	Communities in Rakai, Uganda.	Adapted measures from the Conflict Tactics Scale.
Ogum Alangea (2020)	Cluster RCT	Entire communities.	20 communities in 4 districts in Ghana. Districts in which previous VAW work was done were excluded.	Adapted version of the WHO VAW instrument.
Gottert (2020)	Cluster RCT	Entire communities.	Bushbuckridge rural sub-district in Mpumalanga, South Africa.	Measures from a World Health Organization questionnaire adapted for South Africa.
Jewkes (2008)	Cluster RCT	Young men and women in selected communities. Mostly students.	70 villages in the Eastern Cape province of South Africa.	More than one episode of physical or sexual intimate partner violence since last interview.
Gibbs (2020)	Cluster RCT	Young people residing in urban informal settlements.	Informal settlements in urban eThekwini Municipality, KwaZulu-Natal Province, South Africa that lacked provision of electricity/water.	Adapted version of the WHO VAW instrument.
Halim (2019)	Cluster RCT	Couples. Community leaders.	Communities in Karatu District, Arusha Region in Northern Tanzania.	Adapted version of the WHO VAW instrument.
Sosa-Rubi (2017)	Quasi-Experimental	10th grade students. School staff.	Public High schools in Mexico City.	Conflict in Adolescent Dating Relationships Inventory (CADRI).

Table 3: Characteristics of included studies.

Intervention Characteristics

Interventions were based on multiple theories of change and some were even adapted from other interventions. Of the studies that mentioned a specific theory of change as the basis for the intervention, 2 used Social Cognitive Theory (Ashburn et al., 2017; Halim et al., 2019), 2 were based off the Ecological Model for Violence (Abramsky et al., 2016; Chatterji, Stern, et al., 2020), and 1 each used the Theory of Gender and Power (Julie Pulerwitz et al., 2015), the Stages of Change Theory (Wagman et al., 2015), the Socio-Ecological Model (Halim et al., 2019), the Theory of Gender Transformation (Sharma et al., 2020), Motivational Enhancement theory (Nadkarni et al., 2017), and the Behavioral Theoretical Framework (Sosa-Rubi et al., 2017). Tsima, CHANGE, and one other unnamed intervention, all conducted in South Africa, were based on Sonke's One Man Can Campaign, which uses its own theory of change (Christofides et al., 2020; Gottert et al., 2020; Pettifor et al., 2018). Indashyikirwa in India was adapted from the SASA! Intervention conducted in Uganda, with the addition of a couple curriculum (Abramsky et al., 2016; Chatterji, Stern, et al., 2020). Also presented in this review are two different trials of the Stepping Stones program. Both were conducted in South Africa; however, one is the core Stepping Stones intervention and the other trial looks at a combined intervention of Stepping Stones with the Creating Futures program (Gibbs et al., 2020; Rachel Jewkes et al., 2008).

Intervention program content included the following topics: Gender-Based/Intimate-Partner Violence (14/16 or 88%), Relationships/communication/conflict resolution (12/16 or 75%), Gender Norms (12/16 or 75%), HIV/AIDS (8/16 or 50%), Sexual Reproductive Health (6/16 or 38%), Alcohol abuse (3/16 or 19%), Financial Literacy (2/16 or 13%), and Leadership (2/16 or 13%). Some of the interventions focused in on just one or two topics, such as CAP that addressed just alcohol abuse and conflict resolution (Nadkarni et al., 2017), whereas SS-CF was

a combination of two interventions and covered nearly all of the topics listed above (Gibbs et al., 2020). Interventions also used differing modes of delivery for their content. The two most prominent modes of delivery were active participation (11/16 or 69%) and community outreach/discussions (10/16 or 63%). Also used were posters (6/16 or 38%), live performances (4/16 or 25%), counseling (4/16 or 25%), and mentoring (1/16 or 6%).

Interventions were facilitated by either trained peers (12/16 or 75%), professionals/program staff (9/16 or 56%), or a combination of the two (5/16 or 31%). Specifics on facilitators can be found in table 4. All programs with single sex sessions were taught by facilitators of the same sex except for CAP which did not specify the sex of its counselors (Nadkarni et al., 2017). All programs that had a targeted entire community and used trained peer facilitators/mobilizers trained both men and women. A few of the programs that had individual sessions and targeted the community pulled participants from the individual component to be trained as peer outreach. For example, Vijana Vijiweni II had professionals do the microfinance training but pulled 20% of male camp members to be trained as peer health leaders in their camps (Maman et al., 2020) and Indashyikirwa trained some of the couples that went through their 21 session curriculum to be community activists (Chatterji, Stern, et al., 2020). Facilitator training ranged from a few weeks to a few months. Of the most intensive facilitator trainings at least 2 were for the programs based on Sonke's One Man Can community mobilization model and included the month-long community mobilizer training for the unnamed intervention in South Africa and CHANGE which trained its community mobilizers for a few months (Christofides et al., 2020; Pettifor et al., 2018). The last program based on this model did not report the length of facilitator training (Gottert et al., 2020). The longest facilitator training was

for the CAP program, requiring a 2 week training, 6 month internship, and test to become a program counselor (Nadkarni et al., 2017).

Interventions ranged in implementation duration from 2 months (Rachel Jewkes et al., 2008; Nadkarni et al., 2017) to 4 years (Wagman et al., 2015) with an average duration of 17 months. Of the 10 interventions that conducted sessions with individuals/small groups the average number of sessions conducted was 14.3 and with a mean total exposure of 35.4 hrs. The intervention with the most sessions was TEVAW (Halim et al., 2019) with 25 sessions while CAP (Nadkarni et al., 2017) had the least number of session with only 4 sessions totaling around 3 hours of exposure. Indashyikirwa had the highest total exposure time at 69 hours (Chatterji, Stern, et al., 2020).

First Author (year)	Intervention Name	Intervention Components [Methods, Topics, Facilitators, Duration]	Theory behind intervention
Maman (2020)	Vijana Vijiweni II	• Men only group microfinance trainings and peer health leadership. • Business development, entrepreneurship, financing, GBV, HIV, SRH, communication, leadership. • Local microfinance institute; project team members; trained peer health leaders. • 5-day microfinance training with weekly meetings and booster training every 6 months. Ongoing peer health education. 2 years total.	N/A
Ashburn (2017)	REAL Fathers Initiative	• Men only mentoring program and community poster campaign. Individual and group sessions. • Non-violence discipline, conflict resolution, parenting skills, communication skills. • Volunteer mentors selected by the young fathers and trained by Save the Children International. • Meetings twice/month for 6 months. Meetings were 40-90 mins long.	Social Cognitive Theory
Pulerwitz (2015)	Male Norms Initiative	• Interactive group education (1 arm) and Community mobilization and engagement activities (both arms). • Gender norms, HIV, SRH, IPV. • Project staff and peer educators. • 8 group sessions, 2-3 hours each over a 4-month period. Community portion took place over 6 months.	Theory of Gender and Power
Chatterji (2020)	Indashyikirwa	• Couple's group sessions and community activism, including the creation of women's safe spaces. • Gender, power, violence, alcohol abuse, sexuality. • Project staff; some couples from group sessions trained as community activists. • 21 couple's sessions. 16 sessions to train community activists. 2.5 years of implementation.	Ecological Model of Violence
Pettifor (2018)	Unnamed intervention	• Community mobilization. Short group workshops. • Gender, power, violence, alcohol abuse, HIV, healthy relationships, human rights. • Project staff; trained volunteer groups called Community Action Teams (CATs). • 2 years.	Based on Sonke's One Man Can intervention specific theory of change

First Author (year)	Intervention Name	Intervention Components [Methods, Topics, Facilitators, Duration]	Theory behind intervention
Nadkarni (2017)	Counseling for Alcohol Problems (CAP)	• Psychological counseling treatment. • Alcohol abuse, peer pressure, handling difficult emotions. • Trained counsellors • Maximum of 4 sessions (30-45 minutes each) delivered weekly or biweekly.	Motivational Enhancement Theory
Abramsky (2016)	SASA!	• Community mobilization. • Gender, violence, HIV. • Project staff; trained community activists. • 2.8 years.	Ecological Model for Violence
Sharma (2020)	Unite for a Better Life (UBL)	• Men's, women's, and couples group sessions, integrated into the Ethiopian coffee ceremony. • Gender norms, sexuality, communication, conflict resolution, IPV, HIV. • Trained same-sex facilitators. • 14 sessions (~38 hours total) over 7 months.	Theory of Gender Transformation
Christofides (2020)	Community Health Action for Norms and Gender Equity (CHANGE)	• Community mobilization. Short group workshops. • Gender, power, violence, sexuality, HIV, healthy relationships, alcohol abuse, GBV. • Project manager; trained community mobilizers; Community Action Team (CAT) volunteers. • CATs tried to do 5 hours of programming a week over 1.5 years.	Based on Sonke's One Man Can intervention specific theory of change
Wagman (2015)	Safe Homes and Respect for Everyone (SHARE)	• Community mobilization. • IPV, HIV, SRH, gender, alcohol abuse. • Trained staff; trained community volunteers and counselling aides. • 4 years.	Stages of change
Ogum Alangea (2020)	Rural Response System (RRS)	• Community mobilization. • Violence, wife's property rights, gender. • Trained Community Based Action Teams (COMBATs) made up of respected community members. • 18 months.	N/A

First Author (year)	Intervention Name	Intervention Components [Methods, Topics, Facilitators, Duration]	Theory behind intervention
Gottert (2020)	Tsima	• Community mobilization. Short group workshops. • Gender, power, HIV, communication, healthy relationships, human rights. • Program managers; trained community mobilizers; trained volunteer Community Action Teams (CATs). • 3 years.	Based on Sonke's One Man Can intervention specific theory of change
Jewkes (2008)	Stepping Stones.	• Same-sex group sessions (a few mixed sex). • SRH, HIV, GBV, communication. • Trained same-sex project staff. • 13 3 hour long same-sex sessions and 3 mixed sex sessions (~50 hours) over 6-8 weeks.	N/A
Gibbs (2020)	Stepping Stones and Creating Futures (SS-CF)	• Single-sex group sessions. • Gender, SRH, HIV, relationships, GBV, goal setting, finances, employment. • Project staff. • 21 sessions, each 3 hours long, twice a week.	N/A
Halim (2019)	Together to End Violence Against Women (TEVAW)	• Group training for men (2 arms). Gender dialogues for community leaders (1 arm). Women's saving and lending groups (control + both arms). • Gender, violence. • Project staff; community volunteers. • 25 sessions for men's training. 2-day workshop for community leaders.	Socio-Ecological Model and Social Cognitive Theory
Sosa-Rubi (2017)	Amor…pero del bueno (True Love)	• Classroom curriculum, schoolwide activities, and staff training. • Gender, dating norms, violence, communication. • Project staff; volunteer students. • Classroom curriculum included 16-hour long sessions. Staff training was five 4-hour workshops. Schoolwide activities were implemented over 16 weeks.	Behavioral Theoretical Framework

Table 4: Intervention names and components from included studies.

Analysis and Outcomes

Of the 16 programs, 7 (44%) assessed the effect on the entire community, 7 (44%) assessed the effect on direct participants in the program, and 2 (13%) assessed both the direct participant and the community as a whole. The majority of studies (13/16 or 81%) used an exclusively Intention to Treat (ITT) analysis, while 1 (6%) study just used Per Protocol and 2 (13%) used both analysis methods.

This paper is looking primarily at self-reported IPV perpetration as the outcome of interest. The majority of studies included (11/16) reported some form of self-reported IPV perpetration as a primary outcome and the other 5 reported it as a secondary outcome. Multiple types of IPV perpetration were measured and reported: physical (14/16 or 88%), sexual (12/16 or 75%), economic (4/16 or 25%), psychological (7/16 or 44%), severe (3/16 or 19%), and combination/overall violence (5/16 or 31%). The majority of studies (9/16 or 56%) use an adapted version of the WHO Violence Against Women (VAW) instrument to measure IPV perpetration in the form of physical, sexual, and psychological abuse, and/or deprivation/neglect (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Other tools used include the Conflict Tactics Scale (2/16 or 13%), a tool from the South African Medical Research Council's Study on Men's Health and Relationships (1/16 or 6%), the Conflict in Adolescent Dating Inventory (1/16 or 6%), and 3 (19%) studies used measures that were created to be intervention-specific (shown in table 4). Some measures used were dichotomous (yes or no) to using a type of violence on a partner in the past, and others measured the number of times violence was used in a time period. Severe violence was measured as a combination of any two types of violence or perpetration of any one type of violence more than once in the designated time period (Christofides et al., 2020; Ogum Alangea et al., 2020). Time periods over which violence perpetration were measured

included the past year (11/16 or 69%), the past 6 months (2/16 or 13%), and the past 3 months (3/16 or 19%). Studies also used different methods to collect the data on IPV perpetration; 8 (50%) of the studies used surveys conducted by interviewers, 5 (31%) used some form of computer assisted self-surveys, 2 (13%) did not report their method, and SASA! (6%) used an anonymous card put in an envelope at the end of their survey (Abramsky et al., 2016).

Other IPV related outcomes that were assessed by studies included gender norms/attitudes (10/16 or 63%), IPV justification/attitudes (4/16 or 25%), male controlling behaviors (3/16 or 19%), violence norms/attitudes (2/16 or 13%), couple's communication (1/16 or 6%), knowledge of violence (1/16 or 6%), and attitudes towards women's control in sex/relationship (1/16 or 6%).

IPV Perpetration Results

Compared to baseline and/or the comparison group, 8 of the 16 studies (50%) reported a statistically significant difference in the predicted direction for at least one IPV perpetration indicator (see table 5 for all results). The Male Norms Initiative in Ethiopia reported a significant decrease in physical or sexual violence for male youth in both intervention arms, Community Engagement (CE) only and CE + Interactive Group Education (GE), as well as a significant decrease in any IPV (physical, sexual, or psychological) in just the CE only arm (Julie Pulerwitz et al., 2015). SASA!, the community mobilization program in Uganda, reported that perpetration of partner violence (of unspecified type) decreased in intervention communities and increased in comparison communities resulting in a significant 61% lower reported prevalence by men in intervention communities at endline (Abramsky et al., 2016). The REAL fathers mentoring intervention in Uganda reported that men who attended at least 1 individual and 1 group mentoring session were significantly less likely than men in the control group to perpetrate

psychological, verbal, or any (physical, psychological, or verbal) IPV at endline and long term follow up (Ashburn et al., 2017). UBL in Ethiopia reported a significant reduction in both sexual as well as physical/sexual IPV perpetration in the men only intervention arm in their intention to treat analysis. They also reported a significant reduction in physical, sexual, and physical/sexual IPV perpetration in the post-hoc analysis of highly adherent respondents in the men only intervention arm (Sharma et al., 2020). The Rural Response System (RRS) in Ghana reported a significantly lower prevalence of emotional IPV perpetration among male community members in intervention sites at endline (Ogum Alangea et al., 2020). Men in the combination intervention of Stepping Stones and Creating Futures (SS-CF) in South Africa reported significantly less physical, economic, and severe IPV perpetration at 24 months follow-up than men in the comparison group in an ITT analysis. Men included in the per protocol analysis for SS-CF reported significantly less physical, sexual, and severe IPV perpetration at 24 month follow-up as well (Gibbs et al., 2020). TEVAW in Tanzania reported a significant reduction in their within group analysis for physical IPV perpetration by men in the arm with both male peer group trainings and community leader dialogs (Halim et al., 2019). The school based intervention, True Love, in Mexico reported significant reduction of psychological IPV perpetration among male students in the arm receiving both the school level activities as well as the classroom curriculum (Sosa-Rubi et al., 2017).

The other 8/16 studies (50%) found no significant differences between control and intervention condition in any of their IPV perpetration outcomes measured. They instead reported on trends towards decreases in IPV perpetration. A program implemented in South Africa reported trends towards decreases in physical/sexual IPV perpetration for both intervention and comparison groups over the study period (Pettifor et al., 2018). The CAP

program to address alcohol problems in India reported trends towards less prevalence of physical IPV perpetration by men in the intervention group at endline than men in the control group (Nadkarni et al., 2017). UBL reported trends towards lower prevalence of sexual and physical/sexual IPV perpetration by men in the couples' study arm and trends towards lower prevalence of physical and emotional IPV perpetration by men in both the couples' and men's study arms compared to control at 24 month follow-up (Sharma et al., 2020). The CHANGE program in South Africa reported trends towards reductions in physical, sexual, and severe IPV perpetration across intervention and comparison clusters (Christofides et al., 2020). The combination HIV and IPV prevention program SHARE in Uganda reported that men's perpetration of emotional, physical, and sexual IPV trended towards decreasing in both intervention and comparison groups and perpetration of forced sex with a partner also trending towards decreasing just in the intervention groups (Wagman et al., 2015). The Stepping Stones study targeting HIV and HSV-2 in South Africa reported trends towards decreases in physical/sexual IPV perpetration in both arms with trends towards lower prevalence in the intervention arm at both 12 and 24 month follow-up (Rachel Jewkes et al., 2008). SS-CF reported decreasing trends in sexual and emotional IPV perpetration by men in both intervention and comparison groups at 24 month ITT follow-up as well as trends towards decreases in economic and emotional IPV perpetration by men in their per protocol analysis (Gibbs et al., 2020). True Love reported trends towards decreases in physical, sexual, and psychological IPV perpetration across both intervention arms (Sosa-Rubi et al., 2017).

While most interventions reported decreases in IPV perpetration a couple of the interventions reported trends towards increases in some forms of IPV perpetration. The microfinance and peer health program, Vijana Vijiweni II in Tanzania, reported increasing trends

in physical/sexual IPV perpetration for men in intervention and comparison groups at 30 month follow-up (Maman et al., 2020). Indashyikirwa in India, a couples education and community activism program, reported trends towards increases in physical, economic, and physical/sexual IPV as well as forced sex with main partner among men in both intervention and comparison communities at endline (Chatterji, Stern, et al., 2020). While RRS in Ghana reported a significantly lower prevalence of emotional IPV perpetration at endline in intervention versus comparison males they actually saw trends towards increases in sexual, severe, and emotional IPV perpetration in both groups at endline. Authors explained in the discussion that this could be due to use of community surveys that interviewed different men at baseline and endline. For physical IPV perpetration men in the intervention communities trended towards a decrease over time while men in the comparison communities trended towards an increase (Ogum Alangea et al., 2020). The Tsima study in South Africa reported a decreasing trend in physical/sexual IPV perpetration among 18-29 year-olds in both in intervention and comparison groups over time and an increasing trend among 30-49 year-olds in both groups (Gottert et al., 2020). TEVAW reported trends showing that men in both intervention groups were less likely than men in the comparison group to perpetrate physical, sexual, and emotional IPV but were more likely to perpetrate economic IPV (Halim et al., 2019).

The final article included in this review is a secondary analysis of data from the Indashyikirwa and SS-CF studies that breaks down the results into IPV perpetration cessation, reduction, and prevention. “Cessation” was defined as having a baseline perpetration of at least one act of IPV and an endline of no IPV perpetration. “Reduction” was defined as having an endline IPV perpetration less than the baseline and “Prevention” as having no IPV perpetration at both baseline and endline. This study found that both interventions showed significant effects in

reduction of physical/sexual IPV. Indashyikirwa also showed significant effects in reduction and cessation of sexual IPV and cessation of physical IPV. SS-CF also showed significant effects in prevention of sexual IPV (Chatterji, Heise, et al., 2020).

	Type of Intimate Partner Violence						
Intervention	**Physical**	**Sexual**	**Psychological**	**Economic**	**Physical/Sexual**	**Any**	**Severe**
Vijana Vijiweni II					NS		
REAL Fathers	NS		S[1]			S[1]	
Male Norms Initiative					S	S[2]	
Indashyikirwa	S[3]	S[4]		NS	S[5]		
Unnamed					NS		
CAP	NS						
SASA!						S	
UBL	S[6,7]	S[7]	NS		S[7]		
CHANGE	NS	NS					NS
SHARE	NS	NS	NS				
RRS	NS	NS	S	S			NS
Tsima					NS		
Stepping Stones					NS		
SS-CF	S	S[8]	NS	S	S[5]		S
TEVAW	S[9]	NS	NS	NS		NS	
True Love	NS	NS	S[10]				

Table 5: Program effects for various IPV perpetration outcomes. (NS = Not Significant, S = Significant, 1 = for men who attended at least one individual and one group mentoring session, 2 = significant only in CE study arm, 3 = only significant in IPV "cessation" as defined by Chatterji et. al., 4 = only significant in IPV "reduction" and "cessation" as defined by Chatterji et. al., 5 = only significant in IPV "reduction as defined by Chatterji et. al., 6 = significant in post-hoc analysis only, 7 = significant only for Men's study arm, 8 = only significant in IPV "prevention" as defined by Chatterji et. al., 9 = significant only in within group analysis for Group 2 study arm, 10 = significant only for SCC,IL-1 study arm)

Quality Assessment

Of the 16 studies assessed 9 (56%) received strong ratings based on the EPHPP quality assessment tool, 2 (13%) received moderate ratings, and 5 (31%) received weak ratings. For the EPHPP category of selection bias 7/16 (or 44%) scored strong, 6/16 (or 38%) scored moderate, and 3/16 (or 19%) scored weak. In the study design category 10/16 (or 63%) scored strong, 4/16 (or 25%) scored moderate, and 2/16 (or 13%) scored weak. For confounders 9/16 (or 56%) scored strong, 5/16 (or 31%) scored moderate, and 2/16 (or 13%) scored weak. For blinding 1/16 (or 6%) scored strong, 14/16 (or 88%) scored moderate, and 1/16 (or 6%) scored weak. In the category of data collection methods 12/16 (or 75%) scored strong and 2/16 (or 13%) each scored moderate and weak. For withdrawals and drop-outs 9/16 (or 56%) scored strong, 6/16 (or 38%) scored moderate, and 1/16 (or 6%) scored weak. Lastly in intervention integrity 5/16 (or 31%) scored strong, 8/16 (or 50%) scored moderate, and 3/16 (or 19%) scored weak. Refer to table 6 for specifics on how each study scored in each category.

	Selection Bias	Study Design	Counfounders	Blinding	Data Collection Methods	Withdrawals and Drop-outs	Intervention Integrity	Global Rating
First Author (year)	Rate this section [1: Strong, 2: Moderate, 3: Weak]	Rate this section [1: Strong, 2: Moderate, 3: Weak]	Rate this section [1: Strong, 2: Moderate, 3: Weak]	Rate this section [1: Strong, 2: Moderate, 3: Weak]	Rate this section [1: Strong, 2: Moderate, 3: Weak]	Rate this section [1: Strong, 2: Moderate, 3: Weak]	Rate this section [1: Strong, 2: Moderate, 3: Weak]	Global Rating for this paper [1:Strong (no weak ratings), 2:Moderate (one weak rating), 3: Weak (2 or more weak ratings)]
Maman (2020)	1	1	1	2	1	1	2	Strong
Ashburn (2017)	3	3	1	2	1	1	3	Weak
Pulerwitz (2015)	2	2	3	3	2	2	2	Weak
Chatterji (2020)	1	1	1	2	1	1	2	Strong
Pettifor (2018)	1	1	2	2	1	1	2	Strong
Nadkarni (2017)	3	1	1	1	3	1	1	Weak
Abramsky (2016)	1	2	1	2	2	1	1	Strong
Sharma (2020)	1	1	1	2	1	1	2	Strong
Christofides (2020)	3	1	3	2	1	2	3	Weak
Wagman (2015)	2	2	1	2	1	2	3	Strong
Ogum Alangea (2020)	1	1	2	2	1	1	1	Strong
Gottert (2020)	1	2	2	2	1	1	2	Strong
Jewkes (2008)	2	1	1	2	3	2	2	Moderate
Gibbs (2020)	2	1	1	2	1	2	2	Strong
Halim (2019)	2	1	2	2	1	2	1	Strong
Sosa-Rubi (2017)	2	3	2	2	1	3	1	Weak

Table 6: EPHPP Quality Assessment ratings for included studies. (Intervention integrity is not included in the Global Rating as per EPHPP guidelines.)

Discussion

This scoping systematic review presented a systematic search and summary of 17 existing studies that examined 16 programs targeted at men and boys aiming to prevent primary perpetration of IPV in LMICs. This summary included the formats of delivery and components of these programs, the populations and settings that have been targeted, a quality assessment of the study design and data collection tools use, and a presentation of results that have shown certain programs to be effective in prevention of IPV perpetration by men.

There appears to be a growing interest globally in the implementation and evaluation of IPV prevention programs targeted at men and boys. This is apparent from the publishing data of the articles yielded for this review. We included articles published between January 2001 and October 2020 however only 1/17 (6%) was published before 2010 and 8/17 (47%), close to half of the articles, were published in 2020. It's important that we analyze and compare this new data coming out of LMICs to improve future IPV prevention programming and implement in a way that works in the context of LMICs.

Setting

Of the 16 interventions presented in this review the majority (88%) were conducted in Africa and only in 6 of the 54 countries in Africa. Only 2 interventions (13%) were conducted in other regions, CAP in India and True Love in Mexico. There are a lack of evaluations of IPV interventions targeting men in LMICs in Asia, South and Central America, Europe and the Middle East where there are also high rates of IPV (Coll et al., 2020).

Population

Interventions included in this review represented a mix of individual and community based intervention with many programs targeting multiple levels of the socio-ecological model (CDC, 2021). However less than half (44%) of the interventions specifically targeted community leaders and/or professions who interact with violence prevention, such as health care workers or law enforcement officials. This is a major gap as changing societal gender norms has been found to be a major determinate for violence prevention and community leaders and decision makers have strong influence over these norms (Herstad, 2009). Of the studies that had significant results (9) all except for 2 engaged at least two groups in the population (individuals, entire community, community leaders). Only 2 of the 16 interventions (13%) specifically engaged couples together however both had significant results in IPV perpetration reduction (Chatterji, Heise, et al., 2020; Chatterji, Stern, et al., 2020; Sharma et al., 2020). However the UBL intervention only had significant results in the arm for men only and not their couples arm bringing up the question of why the intervention was effective for men alone but not men learning with their partners (Sharma et al., 2020).

Another consideration when it comes to the population targeted by these interventions is that only 2 programs (True Love and the Male Norms Initiative) specifically targeted youth/teens. Both studies of the Stepping Stones program also targeted young men and women but not specifically teens. This is interesting as in high income countries a majority of the primary sexual violence or IPV prevention programs are aimed and secondary and tertiary school-aged students (Ricardo et al., 2011). Why is it that in LMICs organizations have not narrowed their population to younger men? We know that in some regions, such as South Asia, there are social taboos around discussing sexual relationships with school-aged children

(Zohourian et al., 2020). However, there have been programs in multiple countries successful at influencing gender norms with younger men as that is when they are building their ideas of what it means to be a man and this merits further investigation in the context of other LMICs (Kaufman & UNFPA).

Facilitators

Programs were facilitated by a mix of implementing organization program staff and trained community members. All of the interventions that had a community mobilization component trained local members of the community to enact that portion of the program. This is in line with findings from a recent review by Minckas, Shannon, and Mannell on the community mobilization as a method to prevent violence against women. They recommend that for violence prevention programs to be sustainable that community members need to participation and have ownership of the prevention strategies (Minckas, Shannon, & Mannell, 2020).

However, when it comes to training of community members as change agents and facilitators, we also need to consider scalability and cost. Longer trainings, such as those for the CAP intervention and all the programs based on Sonke's One Man Can program, are expensive, time-consuming and not easy to scale to larger areas. Also, none of the aforementioned programs, that had facilitators trainings that ranged from 1 month to 6 months, reported any significant results for IPV perpetration. A better option might be the method that was used by Indashyikirwa or True Love where the "community mobilizers" were individuals that had already went through the individual component of the program and therefore needed minimal extra training (Chatterji, Stern, et al., 2020; Sosa-Rubi et al., 2017).

Intervention Duration

Programs ranged widely in duration and number of sessions. While both shorter (4 months) and longer (30 months) interventions showed success when it came to programs with group or individual learning sessions early trends appear to show that programs with a longer duration and/or more sessions are more effective. The 3/10 (30%) programs with group/individual sessions that did not report significant results for IPV prevention included the two with the smallest number of sessions, CAP with 4 and Vijana Vijiweni II with 5, and the two with the shortest total duration, Stepping Stones and CAP which both only lasted 2 months (Rachel Jewkes et al., 2008; Maman et al., 2020; Nadkarni et al., 2017).

Theory and Adaptations

Interventions were based on a wide range of theories, though only 7/16 studies (44%) explicitly stated the theory that the intervention they were studying was based on. Of note was that of these 7 studies, 6 reported significant results for IPV perpetration. This suggests that interventions founded on an accepted behavior change theory are more effective than those that are not. There were also a few interventions adapted from the same base intervention. Tsima, CHANGE, and an unnamed intervention were all based on Sonke's One Man Can Campaign (Christofides et al., 2020; Gottert et al., 2020; Pettifor et al., 2018). While all 3 studies were conducted in South Africa, one in a peri-urban setting and the other two in rural settings, none reported significant effects on IPV perpetration by men. Whereas Indashyikirwa, which was adapted for Rwanda from the proven effective SASA! intervention in Uganda, showed some significant effects on IPV perpetration. This might suggest that it is better to adapt an intervention that is known to be effective at reducing IPV perpetration for a new context rather than implementing an unproved intervention from a similar context.

Analysis

The time to last follow-up varied between studies however the majority (63%) went up to at least 2 years from baseline assessment. These extended periods of follow-up can be very important for understanding long-term intervention effectiveness. This proved especially true in the SS-CF study where data from the 12 month follow-up showed trends towards the intervention group reporting less physical and severe IPV and then at the 24 month follow-up these were significant results (Gibbs et al., 2020). While knowledge and attitudes can change quickly, behavior change often takes more time (Arlinghaus & Johnston, 2018). The opposite can also occur, when the intervention is removed, behaviors can revert without constant reinforcement (Coskun, Zimmerman, & Erbug, 2015).

Some studies included a per protocol or post-hoc analysis to determine if outcomes were different for highly adherent respondents. This proved useful in the UBL study as they only found significant results for physical IPV perpetration in the post-hoc analysis of men who had participated in at least 85% of sessions (Sharma et al., 2020). This tells us that those who actually receive nearly the entire curriculum will make the behavior change and that in the next iteration of this intervention they should try some new implementation strategies to increase attendance. It is important for researchers to conduct process evaluations and track intervention fidelity alongside outcome evaluations.

The Tsima study broke down their results into sub-groups of men based on age; young men (18-29) and older men (30-49). While they did not report any significant results, they reported opposite trends in the two groups, with young men trending towards a decrease in violence perpetration and older men trending towards an increase. This underscores the

importance of subgroup analyses to understand whether the interventions vary among different groups of men, and whether programs may need to be modified to be more age specific.

Chatterji et. al. decided that instead of looking at demographic characteristics of the participants they would look at how Indashyikirwa and SS-CF affected men coming to the program with different baseline levels of violence perpetration (Chatterji, Heise, et al., 2020). Breaking down IPV prevention into "cessation", "reduction", and "prevention" proved to show that Indashyikirwa, which reported no significant IPV perpetration results in their primary analysis, actually had significant effects in 3 forms of IPV but only for certain sub-groups of men. SS-CF also showed some additional significant results in this secondary analysis in "reduction" and "prevention" (Chatterji, Heise, et al., 2020). Possibly, in the future, organizations could benefit from implementing a variety of programs or program components with smaller sub-groups of men based on their baseline levels of violence.

Quality Assessment and Study Design

The majority of included studies were RCTs (13/16) which are becoming more common as they are the most rigorous evaluation method and the best for proving causality. However, data from other forms of study design can also be useful which is shown by the 3 quasi-experimental designs included in this review. All three studies reported at least one significant result for IPV perpetration reduction (Ashburn et al., 2017; Julie Pulerwitz et al., 2015; Sosa-Rubi et al., 2017). Non-RCT studies are susceptible to selection bias, wherein there are inherent differences between people who self-select to participate in an intervention and people who do not. Data from these studies can still be used however to show that interventions are effective within a willing population and demographics from these studies can be used to identify which populations need to be targeted with further programs. There are also analysis methods that can

be used to help make up for the lack of randomization which was shown in the True Love study that used propensity score matching in their analysis (Sosa-Rubi et al., 2017).

That being said, all 3 studies with a quasi-experimental design received weak ratings in the EPHPP quality assessment. None of the other interventions with weak or moderate quality assessment ratings had any significant results. Overall, the majority of studies (56%) had high quality ratings. For studies with weak or moderate ratings, this was often because of limitations associate with selection bias or confounders. All 5 RCT studies reporting significant results received strong quality assessment ratings.

IPV Perpetration measures

In the 16 intervention studies included in this review 4 standard and 4 program specific tools to measure IPV were used. The variability in tools used to assess IPV perpetration limits cross-study comparisons. For example, how can we compare physical violence outcomes if one study defines it with a single question and one uses a set of 5 questions? Or if one assesses IPV perpetration over the past 3 months and one over the past 12 months? Fortunately, many in this review (56%) used the WHO Violence Against Women tool. As the global push to end violence against women continues, we need to decide on a tool and ensure that it is both reliable and valid. Unfortunately, this is very difficult as Follingstad points out in her article detailing some of the challenges associated with measuring violence. These include issues of agreement on how to conceptualize violence, the need to include context in which a behavior occurs to minimize overreporting, debate on whether quantitative or qualitative methods are best, the need for instruments to be standardized verses specific to the population, and questions on the accuracy of self-reporting (Follingstad, 2017). It is understandable that one tool will not work for all contexts, as the manifestations of violence can be culturally-specific (e.g., gun violence in the

United States). Possibly researchers should use a combination of standardized and culturally specific tools to assess IPV. The issue of self-report is a major limitation in the study of IPV perpetration prevention programs as studies have shown that when asked about sensitive topics, like partner violence, respondents are not always forthcoming. They may skew their answers based on what they think the interviewer or study team wants to hear (Follingstad, 2017).

Another issue with the measure of IPV perpetration pre- and post- intervention is that knowledge of what violence is can affect a respondent's answers. As Follingstad stated, it is hard to define violence and not everyone agrees on what is and is not a violent act (Follingstad, 2017). This author wonders if the included studies that reported trends in increasing violence perpetration at endline were actually due to an increase in violence or was it because respondents were more informed of what constituted as an act of IPV and had underreported at baseline due to ignorance. Perhaps studies should add a question specifically asking men if they have increased or decreased their violence perpetration over the past year for comparison.

Strengths/Limitations

This scoping review included multiple strategies that contributed to the strength of the review. Firstly 3 search engines were used for the initial article yield which helped lead to a more complete list of possible articles to include. Due to this there were 8,392 articles in the initial yield. Another strength was that the terms used in the systematic search were sourced from prior systematic reviews and meta-analyses on similar topics. Lastly a major strength of this review is that it looked at studies across different study designs, whereas many reviews limit to just RCTs.

While this review has many strengths it also has some important limitations. Firstly, only peer reviewed articles were included due to a limit on the time that it would take to search

through the grey literature and program documents. This was apparent when two relevant studies were found in the secondary search for articles to include from relevant reviews that were identified in the initial screening. The two articles were organizational reports on the Male Norms Initiative in Ethiopia, which was included in this review via another article, and the Yaari-Dosti intervention in India (J Pulerwitz et al., 2008; J Pulerwitz et al., 2010). These two studies and potentially others that were published at program reports from CBOs and NGOs were not included in this review due to this limitation. Nor did this review look at articles published in languages other than English which restricts inclusion to only studies being conducted by English-speaking researchers or teams with dedicated translation. This review also did not look at qualitative data, which could have provided a more in-depth understanding of mechanisms of effect of the programs or barriers and facilitators associated with implementation of the intervention programs. Also, only male reports of IPV perpetration were reported in this review. These reports were not cross-validated with female partner reporting of IPV experience as studies do not often collect this data as recommended by the WHO guidelines. The WHO guidelines recommend that only one respondent per household should answer questions pertaining to domestic violence to not put other members of the household in danger of repercussions if it becomes known that they could have disclosed experience of violence (World Health Organization, 2001). Lastly the largest limitation of this review was that only the primary author (AD) completed the article screening, full text review, data extraction, and quality assessment. To help address the lack of multi-rater confirmation for these processes when question arose during the process (e.g., regarding uncertainty with including an article), she consulted with her research mentor (ASK).

Implications for Public Health

This review leads to some important implications for the future of violence prevention research. Researchers need to track the outcomes from violence prevention programs longitudinally with longer follow-up periods. Many of these primary violence prevention programs operate by providing knowledge in the hopes that it will lead to behavior change. To track if these programs have long-term efficacy and are sustainable, studies should follow-up with participants for at least 1 year after program completion, and ideally longer.

This systematic review underscores the importance of interventions to be theoretically-grounded, evidence-based, and culturally-tailored to be effective. Future intervention design and validation studies should ensure methodologic rigor to incorporate these practices. A recent review on effective VAW prevention program elements by UKAID recommends that programs either take ample time for formative research and training or utilize a program that already has supporting efficacy data (R Jewkes et al., 2020). Interventions should be evidence based but also formatted for the context. Future research needs to be done to test if school-based programs that have been shown to be effective in high-income countries could work in LMICs. Similarly, primary IPV prevention interventions demonstrating efficacy in LMICs should be adapted and tested in high-income settings where IPV prevention is also necessary.

There is also a need for standardized definitions and measures of violence that can be used and adapted across programs for ease of comparison. Violence researchers and the WHO should collaborate to put forth recommendations on a standardized IPV measurement scale (e.g., the WHO VAW tool and the Conflict Tactics Scale). Also, when measuring IPV, organizations should consider secondary measures on knowledge and attitudes as well as longer-term follow up to check the sustainability of their programs.

Conclusions

This scoping review of IPV prevention programs for men in LMICs presents an overview of the field and early understanding of effective tools for IPV prevention. In promising news, the number of studies that were published through 2020 shows an increasing trend in robust evaluations of IPV prevention programs in LMICS that has been missing in the past. A wide variety of men's IPV prevention interventions are being implemented globally with an increasing focus on community mobilization. Over half (56%) of these have shown effectiveness in reduction of men's perpetration of at least one form IPV, showing that primary prevention programs can be successful at reducing IPV perpetration.

On the other hand, nearly half (44%) did not prove effective at reducing IPV perpetration by men and boys. This shows that organizations aiming to implement a new IPV prevention program should first consult the scientific literature to determine which program may be most effective and adaptable to their context. They should pay particular attention to the studies in this review which have demonstrated that certain programs are only effective in sub-groups of men.

Future research should include extending intervention studies to LMICs outside the 8 countries represented here, possibly by adapting and testing IPV prevention interventions that have demonstrated efficacy, and establishing standardized IPV perpetration definitions, outcome measures, and tools.

References

Abramsky, T., Devries, K. M., Michau, L., Nakuti, J., Musuya, T., Kiss, L., . . . Watts, C. (2016). Ecological pathways to prevention: How does the SASA! community mobilisation model work to prevent physical intimate partner violence against women? *BMC Public Health, 16*, 339. doi:10.1186/s12889-016-3018-9

Arlinghaus, K. R., & Johnston, C. A. (2018). Advocating for Behavior Change With Education. *Am J Lifestyle Med, 12*(2), 113-116. doi:10.1177/1559827617745479

Armijo-Olivo, S., Stiles, C. R., Hagen, N. A., Biondo, P. D., & Cummings, G. G. (2012). Assessment of study quality for systematic reviews: a comparison of the Cochrane Collaboration Risk of Bias Tool and the Effective Public Health Practice Project Quality Assessment Tool: methodological research. *J Eval Clin Pract, 18*(1), 12-18. doi:10.1111/j.1365-2753.2010.01516.x

Ashburn, K., Kerner, B., Ojamuge, D., & Lundgren, R. (2017). Evaluation of the Responsible, Engaged, and Loving (REAL) Fathers Initiative on physical child punishment and intimate partner violence in Northern Uganda. *Prevention Science, 18*(7), 854-864. doi:10.1007/s11121-016-0713-9

Bourey, C., Williams, W., Bernstein, E. E., & Stephenson, R. (2015). Systematic review of structural interventions for intimate partner violence in low- and middle-income countries: organizing evidence for prevention. *BMC Public Health, 15*, 1165. doi:10.1186/s12889-015-2460-4

Breiding, M., Basile, K., Smith, S., Black, M., & Mahendra, R. (2015). *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0*. Retrieved from Atlanta (GA): https://www.cdc.gov/violenceprevention/pdf/ipv/intimatepartnerviolence.pdf

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336. doi:10.1016/s0140-6736(02)08336-8

CDC. (2021). The Social-Ecological Model: A Framework for Prevention. Retrieved from https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

Chatterji, S., Heise, L., Gibbs, A., & Dunkle, K. (2020). Exploring differential impacts of interventions to reduce and prevent intimate partner violence (IPV) on sub-groups of women and men: A case study using impact evaluations from Rwanda and South Africa. *SSM Popul Health, 11*, 100635. doi:10.1016/j.ssmph.2020.100635

Chatterji, S., Stern, E., Dunkle, K., & Heise, L. (2020). Community activism as a strategy to reduce intimate partner violence (IPV) in rural Rwanda: Results of a community randomised trial. *J Glob Health, 10*(1), 010406. doi:10.7189/jogh.10.010406

Chibber, K. S., & Krishnan, S. (2011). Confronting intimate partner violence: a global health priority. *Mt Sinai J Med, 78*(3), 449-457. doi:10.1002/msj.20259

Christofides, N. J., Hatcher, A. M., Rebombo, D., McBride, R. S., Munshi, S., Pino, A., . . . Jewkes, R. K. (2020). Effectiveness of a multi-level intervention to reduce men's perpetration of intimate partner violence: a cluster randomised controlled trial. *Trials, 21*(1), 359. doi:10.1186/s13063-020-4185-7

Coll, C. V. N., Ewerling, F., Garcia-Moreno, C., Hellwig, F., & Barros, A. J. D. (2020). Intimate partner violence in 46 low-income and middle-income countries: an appraisal of the most vulnerable groups of women using national health surveys. *BMJ Glob Health, 5*(1), e002208. doi:10.1136/bmjgh-2019-002208

Coskun, A., Zimmerman, J., & Erbug, C. (2015). Promoting sustainability through behavior change: A review. *Design Studies, 41*, 183-204. doi:10.1016/j.destud.2015.08.008

Dahlberg, L., & Mercy, J. (2009). History of violence as a public health issue. *AMA Virtual Mentor, 11*(2), 167-172. Retrieved from https://www.cdc.gov/violenceprevention/pdf/history_violence-a.pdf

De Koker, P., Mathews, C., Zuch, M., Bastien, S., & Mason-Jones, A. J. (2014). A systematic review of interventions for preventing adolescent intimate partner violence. *J Adolesc Health, 54*(1), 3-13. doi:10.1016/j.jadohealth.2013.08.008

DeGue, S., Valle, L. A., Holt, M. K., Massetti, G. M., Matjasko, J. L., & Tharp, A. T. (2014). A systematic review of primary prevention strategies for sexual violence perpetration. *Aggress Violent Behav, 19*(4), 346-362. doi:10.1016/j.avb.2014.05.004

Ellsberg, M., Arango, D. J., Morton, M., Gennari, F., Kiplesund, S., Contreras, M., & Watts, C. (2015). Prevention of violence against women and girls: what does the evidence say? *The Lancet, 385*(9977), 1555-1566. doi:10.1016/s0140-6736(14)61703-7

Follingstad, D. R. (2017). The Challenges of Measuring Violence Against Women. *SAGE Publications*.

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO Multi-country Study on Women's Health and Domestic Violence against Women. Initial results on prevalence, health outcomes and women's responses*. Retrieved from https://www.who.int/reproductivehealth/publications/violence/24159358X/en/

Gibbs, A., Washington, L., Abdelatif, N., Chirwa, E., Willan, S., Shai, N., . . . Jewkes, R. (2020). Stepping Stones and Creating Futures intervention to prevent intimate partner violence among young people: Cluster randomized controlled trial. *Journal of Adolescent Health, 66*(3), 323-335. doi:10.1016/j.jadohealth.2019.10.004

Gottert, A., Pulerwitz, J., Haberland, N., Mathebula, R., Rebombo, D., Spielman, K., . . . Kahn, K. (2020). Gaining traction: Promising shifts in gender norms and intimate partner violence in the context of a community-based HIV prevention trial in South Africa. *PLoS One, 15*(8), e0237084. doi:10.1371/journal.pone.0237084

Graham, L. M., Embry, V., Young, B. R., Macy, R. J., Moracco, K. E., Reyes, H. L. M., & Martin, S. L. (2019). Evaluations of Prevention Programs for Sexual, Dating, and Intimate Partner Violence for Boys and Men: A Systematic Review. *Trauma Violence Abuse*, 1524838019851158. doi:10.1177/1524838019851158

Halim, N., Steven Mzilangwe, E., Reich, N., Badi, L., Simmons, E., Servidone, M., . . . Messersmith, L. J. (2019). Together to end violence against women in Tanzania: Results of a pilot cluster randomized controlled trial to evaluate preliminary effectiveness of interpersonal and community level interventions to address intimate partner violence. *Glob Public Health, 14*(12), 1653-1668. doi:10.1080/17441692.2019.1609062

Harvey, A., Garcia-Moreno, C., & Butchart, A. (2007). *Primary prevention of intimate-partner violence and sexual violence: Background paper for WHO expert meeting May 2-3, 2007*. Retrieved from https://www.who.int/violence_injury_prevention/publications/violence/IPV-SV.pdf

Herstad, B. (2009). *A Call to Act: Engaging Religious Leaders and Communities in Addressing Gender-based Violence and HIV*. Retrieved from Washington, DC:

Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Puren, A., & Duvvury, N. (2008). Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: Cluster randomised controlled trial. *BMJ: British Medical Journal, 337*(7666). doi:10.1136/bmj.a506

Jewkes, R., Willan, S., Heise, L., Washington, L., Shai, N., Kerr-Wilson, A., & Christofides, N. (2020). Effective design and implementation elements in interventions to prevent violence against women and girls. *What Works To Prevent VAWG? Global Programme Synthesis Product Series. South African Medical Research Council, Pretoria*. Retrieved from https://www.whatworks.co.za/documents/publications/373-intervention-report19-02-20/file

Kaufman, M., & UNFPA. *Engaging Men, Changing Gender Norms: Directions for Gender-Transformative Action*. Retrieved from https://www.unfpa.org/sites/default/files/resource-pdf/Advocacy%20Brief-%20Gender%20Norms-1.pdf

Lang, J. (2003a). *Elimination of violence against women in partnership with men*. Retrieved from Background document for UNESCAP's subregional training workshop on Elimination of Violence Against Women in Partnership with Men, New Delhi, India, 2–5 December:

Lang, J. (2003b). *Working with men to end gender-based violence: Lessons for the South Asian context*. Retrieved from Background document for UNESCAP's subregional training workshop on Elimination of Violence Against Women in Partnership with Men, New Delhi, India, 2-5 December:

Lundgren, R., & Amin, A. (2015). Addressing intimate partner violence and sexual violence among adolescents: emerging evidence of effectiveness. *J Adolesc Health, 56*(1 Suppl), S42-50. doi:10.1016/j.jadohealth.2014.08.012

Maman, S., Mulawa, M. I., Balvanz, P., McNaughton Reyes, H. L., Kilonzo, M. N., Yamanis, T. J., . . . Kajula, L. J. (2020). Results from a cluster-randomized trial to evaluate a microfinance and peer health leadership intervention to prevent HIV and intimate partner violence among social networks of Tanzanian men. *PLoS One, 15*(3), e0230371. doi:10.1371/journal.pone.0230371

McMaster University. (2018). Effective Public Health Practice Project. Retrieved from https://merst.ca/ephpp/

Minckas, N., Shannon, G., & Mannell, J. (2020). The role of participation and community mobilisation in preventing violence against women and girls: a programme review and critique. *Glob Health Action, 13*(1), 1775061. doi:10.1080/16549716.2020.1775061

Minerson, T., Carolo, H., Dinner, T., & Jones, C. (2011). Issue Brief: Engaging Men and Boys to Reduce and Prevent Gender-Based Violence. Retrieved from http://menengage.org/wp-content/uploads/2014/04/WRC-statement-on-men-and-GBV.pdf

Nadkarni, A., Weobong, B., Weiss, H. A., McCambridge, J., Bhat, B., Katti, B., . . . Patel, V. (2017). Counselling for Alcohol Problems (CAP), a lay counsellordelivered brief psychological treatment for harmful drinking in men, in primary care in India: a randomised controlled trial. *The Lancet, 389*(10065), 186-195. doi:10.1016/S0140-6736(16)31590-2

Ogum Alangea, D., Addo-Lartey, A. A., Chirwa, E. D., Sikweyiya, Y., Coker-Appiah, D., Jewkes, R., & Adanu, R. M. K. (2020). Evaluation of the rural response system intervention to prevent violence against women: findings from a community-randomised controlled trial in the Central Region of Ghana. *Glob Health Action, 13*(1), 1711336. doi:10.1080/16549716.2019.1711336

Pease, B. (2008). Engaging Men in Men's Violence Prevention: Exploring the Tensions, Dilemmas and Possibilities. *Australian Domestic & Family Violence Clearinghouse*. Retrieved from https://www.researchgate.net/publication/268441430_Engaging_Men_in_Men's_Violence_Prevention_Exploring_the_Tensions_Dilemmas_and_Possibilities/citations

Pettifor, A., Lippman, S. A., Gottert, A., Suchindran, C. M., Selin, A., Peacock, D., . . . MacPhail, C. (2018). Community mobilization to modify harmful gender norms and reduce HIV risk: results from a community cluster randomized trial in South Africa. *J Int AIDS Soc, 21*(7), e25134. doi:10.1002/jia2.25134

Pulerwitz, J., Hughes, L., Mehta, M., Kidanu, A., Verani, F., & Tewolde, S. (2015). Changing gender norms and reducing intimate partner violence: Results from a quasi-experimental intervention study with young men in Ethiopia. *American Journal of Public Health, 105*(1), 132-137. doi:10.2105/AJPH.2014.302214

Pulerwitz, J., Mahendra, V. S., Khandekar, S., Singh, A. K., Das, S. S., Mehra, S., . . . Barker, G. (2008). *Promoting gender equity as a strategy to reduce HIV risk and gender-based violence among young men in India*. Retrieved from Horizons Final Report

Washington, DC:

Pulerwitz, J., Martin, S., Mehta, M., Castillo, T., Kidanu, A., Verani, F., & Tewolde, S. (2010). *Promoting Gender Equity for HIV and Violence Prevention: Results from the Male Norms Initiative Evaluation in Ethiopia*. Retrieved from Washington, DC:

Ricardo, C., Eads, M., & Barker, G. (2011). Engaging Boys and Men in the Prevention of Sexual Violence.

Sharma, V., Leight, J., Verani, F., Tewolde, S., & Deyessa, N. (2020). Effectiveness of a culturally appropriate intervention to prevent intimate partner violence and HIV transmission among men, women, and couples in rural Ethiopia: Findings from a cluster-randomized controlled trial. *PLoS Med, 17*(8), e1003274. doi:10.1371/journal.pmed.1003274

Signorelli, M. C., Hillel, S., de Oliveira, D. C., Ayala Quintanilla, B. P., Hegarty, K., & Taft, A. (2018). Voices from low-income and middle-income countries: a systematic review protocol of primary healthcare interventions within public health systems addressing intimate partner violence against women. *BMJ Open, 8*(3), e019266. doi:10.1136/bmjopen-2017-019266

Sosa-Rubi, S. G., Saavedra-Avendano, B., Piras, C., Van Buren, S. J., & Bautista-Arredondo, S. (2017). True Love: Effectiveness of a school-based program to reduce dating violence among adolescents in Mexico City. *Prevention Science, 18*(7), 804-817. doi:10.1007/s11121-016-0718-4

Wagman, J. A., Gray, R. H., Campbell, J. C., Thoma, M., Ndyanabo, A., Ssekasanvu, J., . . . Brahmbhatt, H. (2015). Effectiveness of an integrated intimate partner violence and HIV prevention intervention in Rakai, Uganda: analysis of an intervention in an existing cluster randomised cohort. *Lancet Glob Health, 3*(1), e23-33. doi:10.1016/S2214-109X(14)70344-4

World Health Organization. (2001). *Putting women first: ethical and safety recommendations for research on domestic violence against women.* . Retrieved from Geneva: https://www.who.int/gender/violence/womenfirtseng.pdf

World Health Organization. (2002). *World report on violence and health*. Retrieved from https://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf?ua=1

World Health Organization. (2013). Global and regional estimates of violence against women: prevalence and health effect of intimate partner violence and non-partner sexual violence. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/85239/9789241564625_eng.pdf;jsessionid=F54E7C3BE4C834FE65841EF2D93F2F0A?sequence=1

World Health Organization, P. A. H. O. (2012). Understanding and addressing violence against women. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf?sequence=1

Wright, L. A., Zounlome, N. O. O., & Whiston, S. C. (2020). The Effectiveness of Male-Targeted Sexual Assault Prevention Programs: A Meta-Analysis. *Trauma Violence Abuse, 21*(5), 859-869. doi:10.1177/1524838018801330

Zohourian, T., Hakim, N., Dorcius, P. M., Shaheen, R., Rao, I. R., Carter, R., . . . Madhivanan, P. (2020). Attitudes, beliefs, and norms about sex and sexuality among young Indian male adults: A qualitative study. *Indian J Sex Transm Dis AIDS, 41*(1), 35-38. doi:10.4103/ijstd.IJSTD_133_15