GBV AoR HELPDESK

Research, Evidence and Learning Digest

Intimate Partner Violence (IPV) in Emergencies

IPV is one of the most common forms of violence against women and girls (VAWG) and includes physical, sexual, and emotional abuse and controlling behaviours by an intimate partner. IPV can affect women of all ages and results in short and long-term physical, sexual and reproductive, and mental health problems that can be severe and life-threatening. Global estimates indicate that about 1 in 3 (35%) women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime and this rate can be much higher in emergencies. Humanitarian crisis may exacerbate pre-existing forms of VAWG, including IPV. Until recently, IPV in emergencies has been a relatively neglected issue and more evidence and action is required to effectively address IPV in humanitarian settings. This evidence digest focuses on emerging research in relation to IPV in emergencies, with a focus on 1) the prevalence and drivers or predictors of IPV; 2) approaches to prevent IPV; and 3) interventions to respond to IPV. Notably, however, evidence of promising practices on multi-sectoral responses to IPV in humanitarian crisis is limited. Links to relevant IPV research, guidance and tools are provided at the end.

Select evidence on the prevalence and drivers or predictors of IPV in emergencies

While data is lacking, available evidence indicates that IPV is the most common form of gender-based violence (GBV) in humanitarian settings. Recent research suggests that IPV is more prevalent than non-partner sexual violence during emergencies but receives less attention. Conflict, displacement, accompanying shifts in gender roles and responsibilities, breakdown in family and community protection mechanisms and poverty are some of the key contributing factors associated with increased levels of IPV in emergencies.

What works to prevent and respond to violence against women and girls in conflict and humanitarian settings? (Murphy, M., Arango, D., Hill, A., Contreras, M., MacRae, M., and Ellsberg, M., 2016)

This evidence review was part of initial research on the What Works: Violence Against Women and Girls in Conflict and Humanitarian Crises initiative.[i] The objective of the review was to provide a succinct overview of existing evidence on the prevalence of VAWG, including IPV, during emergencies and share promising and emerging practices to prevent and respond to VAWG in humanitarian action. The evidence review found that little is known about the prevalence of different forms of VAWG in humanitarian settings and that the existing evidence base is weak.

Even so, the review highlighted that although sexual violence prevalence is high during crisis, several studies have shown that women are at an even greater risk of IPV during emergencies. The evidence review included a desk review by Stark and Ager (2011) which analysed 14 studies and found that reported rates of IPV were often higher than non-partner sexual violence in humanitarian settings.

The evidence review was careful to emphasize that prevalence data is not necessary to take action to address different forms of VAWG in humanitarian response. While stressing the need for further evaluations of programming focused on responding to and preventing IPV during crisis., the review found that some evidence of effective interventions is emerging – both from lessons learned in humanitarian settings as well as from approaches in non-emergency settings that may be adapted, and that the most effective programmes

to reduce IPV target underlying gender unequal norms and power structures throughout the entire community, including engaging with men and boys.

Private violence, public concern: Intimate partner violence in humanitarian settings (International Rescue Committee (IRC), 2015)

This report examines the nature and drivers of IPV in humanitarian settings and is based on research carried out by the IRC in 2014 in Domiz camp in Iraq, Dadaab camp in Kenya, and Ajuong Thok settlement in South Sudan. The research focused on three key questions: 1) What are the drivers and nature of IPV in humanitarian settings?; 2) How do displaced women experience intimate partner violence?; and 3) What do women recommend to improve prevention and response to IPV?

The research shows that IPV in humanitarian settings is fundamentally driven by pre-existing gender inequalities. Across the three settings, four additional contributing factors for IPV were identified as common:

- **Rapidly changing gender norms triggered by displacement.** Displacement resulted in significant shifts in gender roles and responsibilities that altered social dynamics. Women's access to new opportunities can create tensions in the home, especially as men's opportunities may diminish. Some men adapt, while others use violence to reassert power and control.
- **Women's separation from their parents and families.** Displacement breaks down family and community structures, dramatically reducing safety options for women. Women reported that their partners were more likely to exert violence with increased impunity because family members were no longer present.
- **Forced marriage and re-marriage.** During displacement, marriage is viewed as an opportunity to secure economic support and protection. Child marriage put adolescent girls in positions of extreme dependence which may increase risks of IPV. Forced marriages, including re-marriages, are often conducted with unequal economic and social bargaining power between families and these disadvantages also increase risks of IPV.
- **Poverty and substance abuse.** Extreme poverty is correlated with increased stress and tension between intimate partners. This, combined with the shifting power dynamics resulting from women's nascent income-earning opportunities, can become a contributing factor to men's justification of the use of violence. In addition, research found that men who use substances like alcohol and khat were more likely to use violence.

Physical violence was the most common type of violence reported, and women consulted also experienced psychological and sexual violence. Women are often prohibited from interacting with family and friends, which increases their isolation.

Recommendations for humanitarian actors to improve IPV prevention and response include directly engaging with women and girls to inform the design, implementation, and evaluation of IPV interventions; establishing a coordinated response across health, psychosocial and protection services; providing safety options; considering family-level interventions that integrate IPV and child maltreatment responses; providing economic and social programmes for survivors and those at risk; and influencing social norms.

Disability and Violence against Women and Girls (Dunkle, K., van der Heijden, I., Stern, E., Chirwa, E., 2018)

This study was conducted by the DFID-funded What Works to Prevent VAWG programme. It draws on evidence from quantitative impact evaluations of VAWG prevention interventions across 12 countries and 58 in-depth qualitative interviews with women and men with disabilities participating in What Works VAWG prevention programmes in Ghana, Rwanda, South Africa and Tajikistan. This report finds that:

- **Living with a disability increases a woman's risk of IPV**. In low and middle-income countries, women with disabilities are two-four times more likely to experience IPV than women without disabilities. For example, among women with disabilities under 40 years old, 61.5% had experienced physical or sexual IPV in the past year, compared to 35.2% of women without disabilities.
- **The risk of IPV and non-partner sexual violence increases with the severity of the disability**. For example, 36% of women without a disability had experienced past year IPV. This rose to 55% for women with moderate disabilities and 59% for women with severe disabilities.
- **Disability-related stigma was a key barrier to women and girls with disabilities accessing support following instances of IPV.**

Preventing Household Violence: Promising Strategies for Humanitarian Settings (Asghar, K., Rubenstein, B., and Stark, L.., 2017)

This systematic literature review was conducted to identify predictors of household violence in humanitarian settings as part of the Transforming Households: Reducing Incidence of Violence in Emergencies (THRIVE) project, co-led by the UN Children's Fund (UNICEF) and the CPC Learning Network at Columbia University. The THRIVE project is aimed at identifying linkages between Violence against Women (VAW) and Violence against Children (VAC) at the household level, with the goal of supporting GBV and Child Protection actors in humanitarian settings to be better coordinated in efforts to address IPV.

For the literature review, predictors of household violence were defined as any individual, household, or community-level exposure that increases or decreases risks associated with physical, sexual, or emotional violence between two or more people living together. This systematic review highlighted four predictors common to both VAW and VAC: *conflict exposure, alcohol and drug use, income and economic status, mental health/coping strategies, and limited social support*. This finding confirmed the intersection of predictors of household violence in emergencies across VAW and VAC and the potential for integrated interventions.

The review also makes recommendations for practitioners and researchers to improve violence prevention and response programming and address gaps in household violence interventions in emergencies. These include developing holistic interventions that work with multiple actors in the family to prevent violence; looking at the ways programming affects different sub-groups within households e.g. age, household dynamics, specialised needs in the household. Additionally, it recommends that the negative unintended consequences of interventions should always be considered. For example, awareness-raising may lead to a decrease in some forms of violence, but other forms of violence may be used in their place. Finally, this review identified a clear need for better knowledge generation, management and sharing of learning and good practice among GBV and Child Protection actors, alongside increased funding to document and evaluate interventions.

Intimate Partner Violence among Women with Disabilities in Uganda (Valentine, A., Akobirshoev, I., Mitra, M., 2019)

This study conducted analysis on cross sectional data from the 2011 and 2016 Uganda Demographic and Health Surveys. It found that disability is a factor that increases the risk of IPV for women. For example:

- 64% of Ugandan women with disabilities, compared to 55% of women without disabilities, had reported ever experiencing physical, sexual or emotional IPV.
- 49% of women with disabilities reported experiencing physical violence, 32% reported experiencing sexual violence, and 51% reported experiencing emotional violence, compared to 39%, 22%, and 39% of women without disabilities respectively.
- After controlling for sociodemographic and household characteristics, women with disabilities were 1.4 times more likely to experience physical violence, 1.7 times more likely to experience sexual violence and 1.4 times more likely to experience emotional violence in the form of IPV than their peers without disabilities.

"I See That It Is Possible" Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings (Woman's Refugee Commission and International Rescue Committee, 2015).

This study documents the key findings and lessons learned from a project to identify barriers to access to services for survivors of GBV including IPV and to pilot and evaluate solutions for promoting disability inclusion in GBV programmes across conflict-affected settings. Participants provided input into the design of activities and tools developed to understand what worked and what change mattered most to them.The study involved 25 focus group discussions, interviews with people with disabilities and their caregivers, and consultations with humanitarian actors across Ethiopia, Burundi, Jordan and the Northern Cucasus in the Russian Federation.

- This research found that women with physical disabilities who are isolated in their homes are at high risk of rape and IPV, with some being subjected to sexual violence on a repeated and regular basis and by multiple perpetrators.
- Female caregivers also reported sexual, physical and emotional violence perpetrated by their intimate partners.

- Married women with disabilities reported that their husbands often prevented their participation in family activities out of shame and embarassment.
- Married women with disabilities also reported that their husbands often have extra-marital relationships. This leads to both "humiliation" and concerns regarding their health since they feel unable to negotiate safe sex with their partners.
- Concerns were raised that support services for survivors of sexual violence may only become aware of violence committed against women and girls with mental and intellectual disabilities in cases where they become pregnant.

Barriers to Access and Participation:

- Increased dependence on perpetrators in contexts of displacement was cited as a reason women with disabilities were at higher risk of IPV and felt less able to access support.
- Negative attitudes and discrimination against women with disabilities from GBV service providers, family and community members was cited as a key barrier to their ability to access support services.
- The tendency of people not to believe survivors with disabilities, lack of confidentiality and the risk of further stigmatization and marginalization were reported as reasons many survivors with disabilities did not seek services and assistance following their experiences of violence.
- Women and girls with disabilities are often underestimated by GBV prevention programme managers, perceived to be unable to participate and benefit from GBV prevention activities and so are often not invited to join.
- Inadequate transportation and a lack of appropriate communication for people who are deaf or have intellectual disabilities were also cited as barriers to access and participation.
- Caregivers of people with disabilities were also often excluded from GBV prevention activities and services, because they were unable to leave the people they provide care for.

Select evidence of approaches to prevent IPV in emergencies

Successful interventions to reduce IPV need to address the root causes and underlying risk factors to change harmful attitudes and behaviours that perpetuate violence and should target both men and women to affect meaningful change. Increasingly, prevention programming focuses on supporting economic and social empowerment[ii], challenging social norms, implementing community-based programmes including awareness-raising campaigns and creating more protective environments. Evidence on effective IPV prevention interventions for humanitarian contexts has emerged in recent years.

Community-Based Approaches to Intimate Partner Violence (The Global Women's Institute and World Bank, 2016)

This review presents evidence of interventions demonstrating effective community mobilisation approaches successful in transforming harmful gender norms to reduce IPV including SASA!, Somos Diferentes, Somos Iguales, Engaging Men in GBV Prevention, Stepping Stones, Program H, SHARE, and IMAGE. While not specifically focused on humanitarian settings, it outlines the basic components to adapt successful interventions to different contexts including emergencies. The review highlighted recent findings that programmes involving community mobilisation and/or economic empowerment paired with gender equality training significantly reduce rates of IPV. While the interventions reviewed vary in methods, they are based on common approaches that can be adapted to different settings and cultures. Successful community-based interventions permeate multiple levels of society, engage key stakeholders and foster collective action to challenge gender norms within entire communities.

Community-based, multi-sectoral and culturally adapted interventions increase ownership of outcomes. Longer term investment in programmes allows for more sustained capacity building and the creation of networks that are critical for reducing IPV. Through educational and behaviour change approaches, these programmes foster collective action and build community capacity to challenge gender norms leading to reductions in IPV.

The report also provides guidance and recommendations on how to adapt successful interventions to different contexts. These include local stakeholder participation in developing adaptations, engaging a cross section on the

community, rigorous monitoring and evaluating, ensuring access to survivor-centered care and promoting cooperation and exchange among implementers. It also recommends longer term responses to address the root causes of violence and capacity building to ensure sustainability.

The guidance further details six essential steps to contextualizing community-based interventions to prevent IPV in different contexts. These involve understanding violence in the setting and selecting the methodology best suited to the context; identifying suitable, selecting high-priority locations considering community need and readiness; developing a network of local partners; formalising a locally appropriate programme design; preparing programme materials; and finalising outreach and dissemination plans promptly.

Working with men to prevent intimate partner violence in a conflict-affected setting: a pilot cluster randomized controlled trial in rural Côte d'Ivoire
(Hossain, M., Zimmerman, C., Kiss, L., Abramsky, T., Kone, D., Bakayoko-Topolska, M., Annan, J., Lehmann, H., Watts, C., 2014)

This research conducted by the London School of Hygiene and Tropical Medicine measured the impact of the IRC's men's discussion groups (MDGs) intervention in Cote d'Ivoire in 2014 as part of the IRC *Men and Women in Partnership Initiative.*[iii] The MDGs were a four-month series of weekly sessions designed to confront gender biases and discriminatory beliefs that influence men's decision to use violence, to educate men about the consequences of GBV, and to provide them with conflict management skills to avoid violence. Researchers identified pairs of communities already receiving a comprehensive set of GBV services from the IRC, and randomly selected half of them to receive the MDG intervention. All communities received community-based prevention programmes. Intervention communities also received the 16-week IPV prevention MDGs.

Overall, the MDGs contributed to a decline in physical IPV and/or sexual IPV: women whose partners had enrolled in the programme reported a decrease in both physical and sexual violence over the 12- month period after the programme ended. Men's attitudes about violence changed after enrolling in the discussion groups with participating men reporting decreased intentions to use physical IPV and improved attitudes toward sexual IPV. However, these findings did not reach statistical significance.

Significant differences were found between men in the intervention and control arms' reported ability to manage conflict and their participation in gendered household tasks. Men in the discussion groups learned to avoid violent behaviour. Participants were more likely to use newly learned skills to control negative emotions and diffuse their inclinations towards violence. The MDGs were effective in increasing men's involvement in some household chores normally performed by women, such as cooking, cleaning and caring for children.

Key learning indicates that: interventions focused on transforming beliefs and attitudes should target both men and women to effect meaningful change; success in recruiting and sustaining men's participation in violence prevention programmes does not depend on financial incentives; and efforts to engage men in violence prevention must emphasise that violence does not result from anger--violence is a choice, and men can make the decision to avoid violence.[iv]

Select evidence of interventions to respond to IPV in emergencies

Women who experience IPV have complex needs and may require services from many different sectors. Survivor-centred healthcare, psychosocial support, legal, community-based, and other multi-sectoral strategies are needed to respond to and mitigate the consequences of IPV. However, in humanitarian contexts, evidence of effective multi-sectoral interventions to respond to IPV is significantly lacking. More investment, research and learning is required to inform IPV responses in emergencies. Promising practices from non-humanitarian contexts can be applied to emergency settings, especially in relation to health services for survivors. Evidence indicates that the best way to improve services to survivors is to implement system-wide reforms including policies and infrastructure; trainings and support; information, education, communication (IEC) materials; written protocols and referral pathways; data collection systems; monitoring and evaluation to assess the quality of service provision. [v]

The health-systems response to violence against women
(García-Moreno, C., Hegarty, K., d'Oliveira, A., Koziol-McLain, J., Colombini, M., Feder, G., 2014)

This paper is based on a detailed literature review of evidence on health-care responses to VAWG in five diverse countries (Lebanon, India, Spain, Brazil and South Africa), and on consultations with those involved in the planning or delivery of services in resource-poor settings.

The review highlights the critical role of health systems in preventing, responding to and mitigating the effects of intimate partner and sexual violence. Health-care providers are often the first and sometimes only point of contact for survivors to seek help. The study notes that health systems need to strengthen the role of providers as part of a multisectoral response The appropriate response by health-care providers will vary depending on a survivor's level of recognition or acknowledgment of the violence, the type of violence, and the entry point or level of care where the survivor is identified.

Actions by health-care providers include identification, initial supportive response to disclosure or identification of IPV, and provision of clinical care, follow-up, referral, and support for women experiencing IPV, in addition to comprehensive post-rape care and support for survivors of sexual violence. The review then describes the components of a comprehensive health-system approach that helps health-care providers to identify and support women subjected to intimate partner or sexual violence. It provides an overview of the core components (or building blocks) of a health system response: service delivery, health workforce, health information, infrastructure and access to essential medicines, financing, and leadership and governance.

Challenges and lessons learned from different contexts to integrate effective care for women experiencing violence in policies and processes are outlined. The review makes recommendations to build health system responses that can enable providers to address IPV and sexual violence, including developing protocols, capacity building, effective coordination between agencies, and strengthening referral networks. While not specific to emergency settings, the same components of an effective health system response are applicable. The review concludes that additional research is needed to identify what works, assess promising practices, and develop new strategies for prevention and response with a focus on low-income and middle-income settings.

Intimate partner violence: the end of routine screening
(Jewkes, R., 2013)

While health professionals have an important role in responding to IPV and providing care to survivors, evidence to support the identification of asymptomatic women through routine screening by health professionals is weak. This paper provides a comprehensive review of the evidence base related to routine screening. It analysed findings from a range of sources including WHO, the Canadian Task Force, and the UK's Health Technology Assessment Programme that concluded there was insufficient evidence to recommend routine screening.

Findings from the WEAVE study, a large and rigorously designed randomised controlled trial of screening and counselling for women who had experienced IPV were also analysed. This study was designed to assess a psycho-behavioural intervention that began with the postal screening of nearly 20,000 female patients for fear of their partner in the previous 12 months. Those who responded and screened positive were invited for 30-minute counselling sessions with their family doctor, or usual care depending on study group. 52 doctors (and their 272 female patients) were randomly allocated to either intervention or control. Primary outcomes were quality of life, mental health, and safety planning and behaviours. Findings from the study showed no difference between groups in any of these primary outcomes. Conclusions from this and other large trials concurred that activities to identify asymptomatic abused women do not improve the health status of those screened.

However, the need to develop an appropriate health sector response to IPV remains, and further research is needed. This paper stresses that the findings of the WEAVE trial and other studies do not show a lack of value in asking female patients about IPV in circumstances in which it might be directly associated with the presenting complaint, injury or condition. The necessity of health-care providers to open a dialogue on intimate partnerships, including violence, to allow women the opportunity to seek help is recommended. This should be part of the clinical assessment of all women suspected to be experiencing or at risk of IPV. Appropriate information and follow up interventions then need to be then provided.

Developing and testing new health-care responses in diverse settings is recommended. The paper suggests further research to assess the low up-take of counselling to identify and overcome barriers and also examine men's role in IPV prevention. While not specific to humanitarian settings, key lessons learned can be applied to develop innovative and effective health-care responses that do not involve routine screening.

Men and intimate partner violence: From research to action in Bangladesh, Nepal and Pakistan (Samuels, F., Jones, N., Gupta, T., with Ghimire, A., Karmaliani, Naved, K., Yount, K., 2017)

This research used literature reviews, analysis of existing quantitative information and primary qualitative data to explore the underlying drivers, triggers, risks and influencing factors for IPV in Nepal, Bangladesh and Pakistan. It aimed to understand the multi-level drivers of male perpetration of IPV; to determine which types of policy and programming are tackling male perpetration and the associated implications for policy and practice of IPV to strengthen responses; and to investigate how broader political economy dynamics shape attitudes, behaviours and service provision on IPV. This study presents some relevant cross-country findings that highlight multiple challenges in the IPV response.

In all three countries, under-reporting of IPV is widespread due to stigma, fear, the fact that IPV is deemed a 'private' family matter, lack of awareness of available support services, and poor treatment by police and other service providers. Despite efforts to raise awareness on violence, services are lacking. Government agencies and departments are understaffed and under-resourced, there is a lack of training and sensitisation for staff dealing with survivors of IPV, and poor coordination and leadership. In all three countries, the provision of medical, legal and psychosocial services to meet the needs of women and girls is at the forefront of the response to IPV. Non-governmental organisations (NGO) and the government are both heavily involved. Services vary between countries and can range from shelters (e.g. one-stop centres in Bangladesh), trauma centres, helplines, crisis centres (e.g. Pakistan) and NGO-driven services like learning/resource centres/vocational centres, women- friendly hospitals. Overall, the research concludes that the programming infrastructure to respond to IPV is relatively more robust in Bangladesh and Nepal compared to Pakistan, where responses are highly fragmented. Even so, in all countries programming tends to be very limited in coverage and duration and is neither integrated nor sufficiently intensive to be transformational.

The study makes recommendations for programming approaches to better respond to the multi-level influences of IPV. Specifically related to IPV response, these include establishing a national coordinating agency or inter-agency working group; mapping and engaging strategically with key institutions at different levels to work within and across the legal and justice system (formal and informal structures), as well as related sectors (health, education etc.) to strengthen awareness of, access to and capacity of service providers to prevent, and respond to IPV; enhancing IPV referral systems across sectors; improving reporting of IPV to test and strengthen justice and police systems; and developing cross-country learning around promising practices

Case Study: No Safe Place: A Lifetime of Conflict Affected Women and Girls in South Sudan (What Works, 2017)

As part of the DFID-funded What Works Programme, this report produced by the Global Women's Institute at the George Washington University, IRC, and Care International highlights how the most common form of violence documented in VAWG research in South Sudan was abuse within the home, committed by husbands or partners. This was the first large-scale, population-based study of VAWG in South Sudan. The study used quantitative and qualitative methods to explore the situation of women and girls in five settings in South Sudan: Juba City, Juba County, Rumbek Centre, two Protection of Civilian (PoC) sites in Juba, and one PoC site in Bentiu. Up to 65% of women and girls surveyed reported experiencing physical and/or sexual violence in their lifetime – double the global average. One in three women have experienced sexual violence from a non-partner. Over 50% reported that the first incident of sexual violence occurred before they left adolescence, demonstrating that violence begins early in the lives of women and girls in South Sudan.

IPV was the most common form of GBV reported. The prevalence of IPV in this study is among the highest reported in both the region and the world. A key finding is that women and girls are overwhelmingly at greatest risk of physical, sexual and emotional violence within their own homes, primarily at the hands of family members and intimate partners. Lifetime prevalence of physical IPV was high in all sites: 42% in Juba City; 44% in Juba PoCs; and 73% in Rumbek. Sexual violence by a partner was also found to be very common. Experiences of conflict were found to be significantly associated with increased rates, frequency and severity of IPV. The physical and psychological consequences for women experiencing IPV are serious and range from injury to death, including suicide. Pervasive discriminatory practices such as bride price, early and forced marriage and polygamy, in addition to years of war, have created an environment where VAWG is common with many subjected to violence at the hands of family members from infancy. The report emphasizes the urgent necessity for humanitarian efforts to not only provide direct services for survivors but also address the root causes of violence to ensure prevention and empowerment efforts challenge attitudes that perpetuate GBV. Investment in specific programmes targeting the unique needs of adolescent girls and supporting women's groups to build local capacity to improve the status of women are also recommended.

Additional Research, Practical Tools and Resources

Research on IPV in emergencies

Conflict and Crisis, The Global Women's Institute, George Washington University
Evaluating the communities care program: best practice for rigorous research to evaluate gender-based violence prevention and response programs in humanitarian settings (2018)
Global and regional estimates of violence against women. Prevalence and health effects of intimate partner violence and non-partner sexual violence (2013)
Interventions for Prevention of Intimate Partner Violence Against Women in Humanitarian Settings: A Protocol for a Systematic Review (2017)
Let me know die before my time. Domestic Violence in West Africa (2012)
Preventing violence against women and girls in conflict (2014)
Systematic review of structural interventions for intimate partner violence in low- and middle-income countries: organizing evidence for prevention (2015)
Transforming Households: Reducing Incidence of Violence in Emergencies (THRIVE)
Trauma exposure and IPV experienced by Afghan women: Analysis of the baseline of a randomised controlled trial (2018)
Understanding and addressing violence against women: Intimate Partner Violence (2012)
What Works: Violence Against Women and Girls in Conflict and Humanitarian Crises
What works to prevent violence against women and girls - Evidence Reviews Paper 3: Response mechanisms to prevent violence against women and girls (2015)
What Works Evidence Review: The relationship between poverty and intimate partner violence (2017)
What works to prevent partner violence: An evidence overview (2011)

Practical tools and resources to address IPV in emergencies

Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings [forthcoming 2019]
Communities Care: Transforming Lives and Preventing Violence (2017)
Engaging Men through Accountable Practice (EMAP) Resource Package (2016)
Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook (2014)
Interagency Gender-based Violence Case Management Guidelines (2015)
Re-thinking Power Adaptation of SASA! Beyond Borders (2017)
Implementing SASA! in Humanitarian Settings: Tips and Tools
WHO Respect Framework (2019)

The GBV AoR Help Desk

The GBV AoR Helpdesk is a technical research, analysis, and advice service for humanitarian practitioners working on GBV prevention and response in emergencies at the global, regional and country level. GBV AoR Helpdesk services are provided by a roster of GBViE experts, with oversight from Social Development Direct. Efforts are made to ensure that Helpdesk queries are matched to individuals and networks with considerable experience in the query topic. However, views or opinions expressed in GBV AoR Helpdesk products do not necessarily reflect those of all members of the GBV AoR, nor all of the experts of SDDirect's Helpdesk Roster.

Contact the Helpdesk

You can contact the GBViE Helpdesk by emailing us: enquiries@gbviehelpdesk.org.uk, and we will respond to you within 24 hours during weekdays.

The GBViE Helpdesk is available 09.30- 17.30 GMT, Monday to Friday.

[i] The What Works to Prevent Violence Against Women and Girls is a global programme funded by the UK Department for International Development which seeks to understand and address the underlying causes of violence across Africa, Asia and the Middle East. It includes a component on What Works: Violence Against Women and Girls in Conflict and Humanitarian Crises to build evidence on how to prevent and respond to VAWG in conflict and humanitarian settings.
[ii] The July 2019 GBV AoR Evidence Digest 'GBV in Emergencies and Livelihoods' presents detailed evidence, learning and best practices to address IPV in emergencies using economic empowerment approaches.
[iii] The 'Men & Women in Partnership Initiative', was developed to influence inequitable gendered attitudes, behaviours and expectations among men with the ultimate aim of reducing IPV.
[iv] This research informed the Engaging Men through Accountable Practice (EMAP) intervention that aims to engage men as agents of change while being accountable to women's voices in their communities to prevent violence. The IRC is currently undertaking a rigorous Evaluation of Engaging Men through Accountable Practice across 30 communities in North and South Kivu, Democratic Republic of Congo (DRC).
[v] WHO (2012) Understanding and addressing violence against women: Intimate Partner Violence