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The SVRI aims to promote research on sexual violence, and ensure sexual violence continues to be recognised as a public health priority. To achieve this goal, we engage in a number of diverse activities including: evidence-based communication and information; promoting donor and researcher involvement in supporting and undertaking research on sexual violence; building capacity in sexual violence research; and improving knowledge of sexual violence internationally to influence policy and service delivery.

In support of its goal, the SVRI hosts a bi-annual, international conference: The SVRI Forum. SVRI Forums provide a platform for researchers, practitioners and others to learn from each other’s work, discuss methodological issues, experiences and research findings, to network, share lessons, and to link research with policy and practice and disseminate new and exciting findings in the field. The Forums also offer targeted capacity building opportunities through pre-conference workshops, whilst the SVRI Forum research awards provide researchers an opportunity to be recognised for their efforts, and promote excellence in the field.

SVRI Forum 2013 is our third international conference. The two previous Forums were held in 2009 and 2011, as per the details below:

**SVRI Forum 2009:**

**Coordinated evidence-based responses to end sexual violence, 6 – 9 July 2009, Johannesburg, South Africa.** The SVRI’s first conference established the SVRI Forums as the global space to share, and highlight innovative research on sexual violence; to form new and re-visit existing partnerships and friendships, and to debate and discuss new ideas to move the field forward. Participants from over 28 countries attended the first SVRI Forum. The SVRI Forum 2009 report, presentations and other related materials can be accessed at: [http://svriforum2009.svri.org/](http://svriforum2009.svri.org/).

**SVRI Forum 2011:**

**Moving the agenda forward, 10 – 13 October 2011 in Cape Town, South Africa.** SVRI Forum 2011 brought together over 215 participants from 34 countries to build on lessons learned and key research priorities identified at SVRI Forum 2009. Prevention of sexual violence and improved responses for survivors were key priorities for presentation topics at SVRI Forum 2011. This Forum saw the launch of the SVRI Forum Mentoring Programme and greater effort was made to bring together policy makers, practitioners and researchers. Findings from research and community-based interventions presented at SVRI Forum 2011, set the agenda for our 3rd international conference, SVRI Forum 2013. The SVRI Forum 2011 report, presentations and related materials can be found online at: [http://www.svri.org/forum2011/](http://www.svri.org/forum2011/).
It is an honour to welcome you all to the SVRI Forum 2013: Evidence into action. I am especially excited to chair this conference, held for the first time in South East Asia in beautiful Bangkok, Thailand. SVRI Forum 2013 brings together more than 200 of the brightest minds in the field. The programme provides an exciting mix of innovative, ground-breaking research and interventions, and hosts workshops, side events such as launches and satellite meetings, oral and poster presentations.

The conference themes and programme build on the priorities identified at our two prior Forums. At this one, however, we have broadened the focus to include all forms of gender-based violence, not just sexual violence. Through this process the Forum provides researchers working on other aspects of gender-based violence and researchers focusing on sexual violence an opportunity to interact with each other. Similarly, in recognising the importance of linking violence against women and child abuse and neglect for strengthening our prevention efforts, we have worked hard to ensure representatives from the violence against women and child maltreatment disciplines participate in this event. These shifts reflect both a growth in the field and an evolution in the SVRI.

SVRI Forum 2013 themes are:
- Addressing sexual and intimate partner violence in low- and middle-income countries
- Child abuse and neglect
- HIV and sexual violence
- Trafficking for sexual exploitation
- Sexual and other forms of gender-based violence in conflict and crises
The growth and improvement in the quality of research being undertaken in the field over the past five years has been striking. This growth is mirrored in the Forum programme. For example, the SVRI Forum programme includes a number of presentations of rigorous evaluation studies on the impact of prevention interventions aimed at reducing sexual violence or partner violence, or studies aimed at improving mental health outcomes for survivors. Some of these presentations are based on interventions presented as promising at previous SVRI events – and now we are able to see the impact of these interventions. This increase in high quality research from the field illustrates a growth in skills and capacity among researchers, and commitment among policy makers and funders to promote using evidence for action.

Another important thread that has run through the past two Forums is the importance of addressing child abuse and neglect. It is pleasing to see an increased number of presentations on child abuse and neglect and how prevention through parenting interventions and school-based violence prevention programmes can break the cycle of violence in this year’s SVRI Forum programme. Sexual violence in conflict is also a major track in the programme, showcasing innovative research being done in some of the world’s most fragile settings. We are especially excited to hear about how mental health responses in conflict settings can work to reduce mental health problems and improve well-being of sexual violence survivors.

On behalf of the SVRI and Global Women’s Institute of George Washington University, I am also happy to announce the launch of the GBV Science Fair research contest. The aim of this contest is to promote cross-discipline sharing of research, creating partnerships and learning from each other’s work. Similarly, the SVRI Forum research awards and prize-giving continues to provide researchers with recognition of excellence in research.

Hosting the Forum in South-East Asia enables us to forge new friendships and networks to strengthen the SVRI’s reach in this region, and to acknowledge important new research being done in low- and middle-income countries.

The SVRI GWI GBV Science Fair

The SVRI and Global Women’s Institute (GWI) launched a global research contest – the GBV Research Science Fair - at the SVRI Forum 2013. This innovative platform enables researchers to give their research global visibility and the opportunity to share their projects, tools and ideas through interactive means. WeShareScience.com, was developed for all interested to browse through and upload 5 minute videos presenting upcoming or completed research. Researchers were invited to enter the GBV Science Fair by posting their 5 minute videos on their GBV research on WeShareScience.com. For more information on the GBV Research Science Fair, visit: http://wesharescience.com/GBV-Science-Fair.
The SVRI would warmly like to thank our co-hosts Partners for Prevention for the assistance they provided with organizing this event. We would also like to express gratitude to our partners and co-sponsors: the Medical Research Council of South Africa, MenEngage, Global Women’s Institute, Oak Foundation, Population Council and WHO, and our conference organising and scientific committees for all their support. I also express my appreciation to all those who helped with reviewing abstracts.

The SVRI would like to specially thank the Royal Thai Government for their support of this event. Thank you.

The Forum continues to be a wonderful event. May we continue our strong unity of purpose.

Claudia García-Moreno  
SVRI Forum 2013: Chair  
Department of Reproductive Health and Research  
World Health Organization
Invited guest: Mr Trakul Winitnaiyapak, Deputy Attorney General, Thailand

The Deputy Attorney General of Thailand, Mr Trakul Winitnaiyapak, represented Her Royal Highness Princess Bajrakitiyabha at the SVRI Forum 2013. HRH Princess Bajrakitiyabha, a PhD graduate in law from Cornell University and an Assistant Public Prosecutor in Thailand was appointed UN Women Goodwill Ambassador in 2008. Her passionate energy, professionalism and ability to unite different sectors led her to collect over three million names for UN Women’s global “Say NO to Violence against Women campaign” in 2008. HRH Princess Bajrakitiyabha has since been involved in a number of activities to raise public awareness about UN Women’s Say NO campaign and to mobilise stakeholders across the country. These campaigns include mass media efforts through the production of a film, signboards and interviews on various media channels; a bicycle rally in Udon Thani Province for public awareness; a role model competition; and the Youth Say NO to Violence against Women project. Her unparalleled support to end violence against women also extends to the enforcement of the Thai Protection of Domestic Violence Victims Act B.E. 2550 (2007) through various meetings. The Princess has moved the spirit of the country forward through her leadership and belief in ending violence against women and children, inspiring millions of citizens to take action.

Thailand’s efforts to respond to the needs of survivors of intimate and non-partner violence saw the opening of one-stop crisis centres across the country in early 2013. The crisis centres were established as a result of multi-sector collaboration and include a hotline, a network of 22 000 crisis centres and 1 300 mobile units to access communities (UN Women 2012). The mobile units are intended to raise public awareness, and lead interventions in communities where few services are available to survivors. The establishment of these centres was a revolutionary moment in the Thai Government’s commitment to end violence against women and children. These outstanding efforts to respond effectively to survivors and the commitment to end violence through various prevention policies, laws and campaigns, made Thailand an appropriate home for the SVRI Forum 2013.

1 Information on the work and life of HRH Princess Bajarakitiyabha extracted from: The Kamlangjai Project under the Royal Initiative of HRH Princess Bajarakitiyabha. Available at: http://www.kamlangjai.or.th
Preventing sexual and intimate partner violence in low- and middle-income countries

Intersections and linkages

The prevention of child maltreatment and neglect is gaining momentum as an important priority for sexual and intimate partner primary prevention interventions. The opening keynote address of SVRI Forum 2013, by Alessandra Guedes from PAHO/WHO, discussed the intersections between violence against women and violence against children (Guedes 2013). The close relationship between these two types of violence, with their shared risk factors, co-occurrence, the intergenerational effects and similar outcomes were presented. Ms Guedes, argued that if prevention programmes are to ensure we live our lives free from violence, the links between these two forms of violence need to be considered and efforts made to strengthen the coherence and links across preventions activities, while ensuring that each of the areas receive the appropriate attention (Bott, Guedes et al. 2013).

Sharing of interventions

The Forum provided a unique opportunity to share different types of prevention programmes currently being developed. Some of these have been exposed to preliminary testing, whilst others have been evaluated more formally using intervention-type studies. The types of interventions shared at the Forum ranged from school-based programmes; economic interventions for women; programmes for engaging men and boys; community-based models; and prevention interventions in conflict (more details of the latter are provided in the conflict section of this report).

Schools-based interventions shared at the SVRI Forum 2013, included:

• Supporting Success (aka Skhokho), South Africa: A multi-faceted school-based intervention to prevent intimate partner violence (Gevers, Jewkes et al. 2013). A randomised control trial evaluation is in progress.
• **Shifting Boundaries, USA**: An evidence-based, multi-level prevention programme for middle school students aged 11-13 years, on sexual harassment and precursors to dating violence which includes both school-wide interventions and classroom lessons (Stein, Mennemeier et al. 2012, Taylor, Stein et al. 2012, Stein 2013). A RCT study was done to evaluate this programme.

• **Gender equity programme - “Respect is the way” and “Opening schools for gender equity”, Mexico**: School-based intervention developed by the Mexican Ministry of Education, National Institute of Public Health in Mexico and UN Women - Mexico (Contreras 2013). This study has not yet been evaluated.

Two economic interventions and one empowerment / livelihoods intervention were presented:

• **EA$E (Economic and Social Empowerment)**: EA$E is an empowerment intervention that includes both an economic (village savings and loan associations) and social (gender dialogue groups) empowerment component plus business skills training (Gupta and Falb 2013). A randomised control trial has been undertaken.

• **The effect of cash, vouchers and food transfers on intimate partner violence**: The study aims to provide evidence on the impact of transfers on intimate partner violence; investigate whether impact varies by modality (cash, vouchers, food); and if the impact varies by woman’s baseline bargaining power (Hidrobo, Peterman et al. 2013). A randomised control trial was conducted.

• **Stepping Stones and Creating Futures intervention, South Africa**: This programme combines a livelihoods (Creating Futures) intervention and HIV prevention (Stepping Stones) intervention. Creating Futures aims to enhance the ability of young people to think more critically in appraising opportunities and challenges related to their lives and livelihoods (Misselhorn, Jama Shai et al. 2013). The South Africa Stepping Stones intervention is a tested HIV prevention intervention, which works to build sexual health through building stronger, communication and more gender equitable relationships (Jewkes, Wood et al. 2010). By combining these two interventions, the pilot project aims to build women’s economic power and reduce men’s controlling behaviours in relationships in an effort to reduce sexual and intimate partner violence (Gibbs 2013). This intervention was evaluated using an interrupted time series study.

Papers on engaging men and boys for the prevention of sexual and intimate partner violence included:

• **Engaging Arab male youth advocates against intimate partner violence, Lebanon**: In this intervention, eight Lebanese men and eight Iraqi male refugees living in Lebanon were trained on gender equality, masculinities, and human rights as a foundation for an understanding of gender-based violence and film-making. Participants were paired (one Lebanese and one Iraqi) to create storyboards for 30-second television spots to address gender-based violence, using men in Lebanon as the target demographic. Their advertisements were aired on Lebanese national television during the 16 Days campaign (Abirafeh 2013). No evaluation has been undertaken.

• **Young Men’s Initiative, Kosovo**: The Young Men’s Initiative is an adaptation of Program H. It is a school-based intervention, which engages young men to reflect on gender, social norms and masculinity through workshops and retreats (Namy 2013). A quasi-experimental mixed methods evaluation was undertaken to assess the effectiveness of the Young Men’s Initiative.
Preventing violence with responsible engaged and loving (REAL) fathers initiative, post-conflict northern Uganda: The REAL Fathers Initiative aims to build positive partnerships and parenting practices among young fathers (aged 16-25) in post-conflict northern Uganda to reduce the incidence of intimate partner violence and physical punishment of children. It includes a mentoring program that aims to build positive parenting practices and relationship skills; and a community message board campaign to encourage community-led reflection on fatherhood norms, parenting practices, and intimate partner violence (Adams 2013). This intervention is being evaluated using a pre-test/post-test control experimental design, including randomisation and control groups.

The following community-based interventions were shared and discussed:

- **SASA!**: A community mobilisation intervention to prevent violence against women and reduce HIV risk in Kampala: SASA! aims to prevent violence against women and HIV by focusing on the root causes of women’s vulnerability. The intervention mobilises communities to reassess the acceptability of violence and gender inequality, to recognise the links between these issues and HIV/AIDS, to take effective action to change their own relationships, and to support women experiencing violence or HIV/AIDS (Kyegombe 2013, Michau 2013, Starmann 2013). The SASA! study in an evaluation of the impact of SASA! on gender norms, and past-year levels of physical and sexual violence against women, HIV risk behaviours and community responses to intimate partner violence (Michau 2013, Watts and Devries 2013).

- **Public Oath Taking Ceremonies (Zero Tolerance Village Alliance), South Africa**: Public oath taking for the prevention and response to all forms of gender-based violence is a core component of the Zero Tolerance Village Alliance (ZTVA) intervention model. ZTVA oath taking ceremonies call upon male participants to publicly vow to speak out against human rights abuses. In doing so, participants receive placement on a roll of honour, whilst survivors are awarded a badge of courage for sharing their sexual and gender-based violence experiences (Carty 2013). Pre- and post-intervention evaluation study was undertaken.

- **Tostan’s Community-Based Empowerment Programme (CEP), Senegal**: Tostan’s CEP uses knowledge as a tool for positive change within communities. Community Empowerment Programme participants share knowledge learnt through workshops within their networks and communities. An evaluation of CEPs potential to impact levels of gender-based violence among its participants was presented. The study found that few participants received information on gender and violence in the past 6 months; that very few women spoke out on controlling behaviours of their husbands; and that key household decision-making were in the hands of their husbands. This programme shows promise to influence levels of gender-based violence if it considers differences in self-efficacy between men and women, and addresses inequitable gender norms in the implementing communities (Rowley 2013).

- **“We believe….partners to end violence against women” campaign, Lebanon**: ABAAD, a non-governmental organisation (NGO) based in the Lebanon, brought together four religious leaders from the Muslim and Christian faiths and had them speak out against violence against women in Lebanon using different social media and advertising platforms (Abirafeh 2013). Highlights of this campaign are available online at: http://www.youtube.com/watch?v=PAS4t0fYKyo. No evaluation was presented on this campaign.
• Awareness campaigns – Getting our messaging right. Findings from a review of messaging in anti-sexual and gender-based violence campaigns, Liberia: In field research over a period of five years, donor-led anti-gender-based violence awareness campaigns were documented, as well as informal discourses in conversations with urban Liberians in post-war Liberia. Findings demonstrate the importance of colonial history in understanding today’s conceptions of gender and violence. Many of the campaigns reviewed, advocated for male paternalism with messaging that promote ‘protection’ of women. A more egalitarian approach, and treating current campaigns with caution, especially if we view sexual violence as an expression of patriarchal norms is recommended (Thornhill 2013). This was a qualitative study.

• Growing up safe and healthy (SAFE): SAFE is an intervention to address violence against women and girls living in Dhaka slums. Intervention components include: 1) awareness-raising regarding rights, legal provisions and available services; 2) developing life skills and 3) providing health and legal services. A multi-site cluster randomised control trial design is underway to test effectiveness of the intervention (Naved 2013).

So what does the evidence presented at the SVRI Forum tell us about what works in primary prevention of sexual and intimate partner violence?

Firstly, the marked increase in rigorous evaluations presented at the Forum is a key achievement of the field. The findings of these evaluations show us that preventing/reducing sexual and intimate partner violence is possible. The study on Shifting Boundaries for example, found that both the combination of the classroom and school-wide interventions, and the school-wide intervention alone, reduced sexual harassment (victimisation and perpetration) by 26-34% six months post follow-up. This study involved random assignment of the school-based intervention to 30 public middle schools in New York City, and 117 sixth- and seventh-grade classes (over 2,500 students) to randomly receive the intervention. As described in the report on the Shifting Boundaries evaluation, “The classroom intervention was delivered through a six-session curriculum that emphasized the consequences for perpetrators of dating violence and sexual harassment (DV/H), state laws and penalties for DV/H, the construction of gender roles, and healthy relationships”. The school-based intervention included the use of temporary school-based restraining orders, higher levels of staff and security presence in areas identified through student mapping of safe/unsafe “hot spots,” and the use of posters to increase awareness and reporting of DV/H to school personnel” (Taylor, Stein et al. 2012). Of note, is the finding that this intervention was found to reduce victimisation and perpetration of physical and sexual dating violence by approximately 50% up to six months after the intervention. This has important implications for us when thinking about where best to focus our limited school-based prevention intervention resources. However, it needs to be kept in mind that this study is from a high-income setting, which may limit the transferability of both the model and the study findings to less well-resourced settings.

Research presented on economic empowerment programmes highlight the potential of economic interventions with women for reducing intimate partner violence. The study from northern Ecuador on cash transfers found that transfers decreased the probability of women experiencing intimate partner violence and that the modality of the transfers did not influence the outcome (Hidrobo, Peterman et al. 2013). The
combined economic and social empowerment programme – EA$E – demonstrated the potential of combining microfinance efforts with a gender dialogue group in improving gender norms and mental health among participants (Gupta and Falb 2013). Both these programmes were implemented among vulnerable populations in conflict settings (Northern Ecuador – Colombia border conflict and Cote d’Ivoire). The impact of building the economic power of women for reducing levels of intimate partner violence is further supported by the South African intervention, where combining gender equity and livelihoods positively influenced men’s controlling behaviours and increased women’s earnings (Gibbs 2013).

The review of reviews undertaken by George Washington University provides us with some insight into what aspects are shared across successful interventions (Morton, Arango et al. 2013). The review found that interventions which successfully shifted gender norms had the following characteristics - they focused on people younger than 24 years; targeted both women, men, and/or boys and girls; looked to influence community norms; and included a training component. The authors recommend an increase in the number and rigour of evaluations, particularly in low- and middle-income countries. Also, studies need to allow for a longer follow-up period to test the effects of an intervention.

Understanding the drivers of sexual and intimate partner violence

Interventions that are based on a theory of change are more likely to be effective, particularly when the theory of change builds on evidence of risk and protective factors. The WHO has undertaken significant work on documenting these risk and protective factors for sexual and intimate partner violence, highlighting the importance of integrating evidence and theories of change into our models (WHO/LSHTM 2010). Forum presentations help to further build and refine existing evidence on drivers of sexual and intimate partner violence.

A panel presentation on findings from the UN Multi-Country Study on Men and Violence in Asia and the Pacific provided insights into what drives men’s perpetration of violence against women (Fulu, Warner et al. 2013). Key drivers of violence found in this study include social norms related to the acceptability of violence; violent masculinities and men’s control over women; experiences of childhood abuse and neglect; a strong sense of sexual entitlement among men; and high levels of impunity for rape. This study found that for many men first perpetration starts in adolescence. Variations within and across countries on the prevalence, patterns and factors associated with rape perpetration were found. These findings highlight the need for multi-component prevention interventions that are informed by these drivers, based on local research on violence against women. It is recommended that locally informed interventions are complemented by comprehensive response systems for survivors, including justice, health and welfare systems (Fulu, Warner et al. 2013).

A presentation on an innovative cross-country data analysis linked women’s status, gender inequality, and overall level of socio-economic development to levels of partner violence across 40 countries (Heise 2013). Building on this, a number of country level presentations confirmed the link between childhood exposure to intimate partner violence, child sexual abuse, and sexual victimisation as an adolescent as key risk factors for perpetration and victimisation of sexual and intimate partner violence. For example, a study with adolescents from South Africa found a strong association
between being a perpetrator and being a victim, and that both perpetrators and survivors are more likely to engage in sexual risk taking (De Koker, Effers et al. 2013). In further support of Heise’s findings, a study from Bangladesh found a positive association between high levels of acceptance of violence and violence against adolescent girls (Vander Ende, Naved et al. 2013).

In an environment of seemingly increasing levels of marital violence against women in India, Shireen Jejeebhoy and colleagues’ presented findings of a study that attempted to understand better the factors associated with positive deviance. They did this by comparing violent and non-violent husbands, and assessing influences at multiple levels—individual, family, peer and community - that set non-violent men apart from their violent counterparts (Jejeebhoy and Santhya 2013). Again, belief in equal rights between men and women was a common theme among non-violent men. Challenging traditional gender norms must be an essential component of any primary prevention intervention.

Other research on risk factors for sexual and intimate partner violence among marginalised populations was also shared at the Forum. Sex work, for example, is highly stigmatised and this stigma may manifest in physical and sexual violence (WHO 2005). A study with sex workers in India found over a third of participants reported experiencing physical (11.6%) and sexual violence (19.3%), and that violence was strongly associated with reproductive health risks and age, with younger sex workers being at greater risk (Swain 2013). A study conducted in Siem Reap, Cambodia, found high levels of sexual violence (47%) among young men working in massage parlours, referred to as “Lingha Boys” (Davis and Miles 2013).

In Colombia, a country with six decades of internal conflict, a mixed-method study looked at experiences of, and risk factors for, sexual violence among transgender persons and men who have sex with men (MSM) (Bianchi, Zoa et al. 2013). High levels of violence were reported among both groups, with transgender persons who reported being a target of sexual violence and other forms of violence more frequently than the MSM participants. Both groups, however, face high levels of violence and
discrimination. An association between risky sexual behaviour and violence was also found in a study from Central America with MSM and Transgender Women (Gregowski 2013). A study with MSM in South Africa also found high levels of violence among the MSM population (22.9% reported ever experiencing intimate partner violence). In terms of risk factors for violence, they found the following were correlated with violence: drug and alcohol use; transactional sex and other high risk sexual behaviour; self-identification as feminine; discrimination and internalised negative thoughts about homosexuality (Dunkle, Murdock et al. 2013).

A study on disability and violence against women from Cambodia (“Triple Jeopardy”) showed women with disabilities are at increased risk of household violence as compared to their non-disabled counterparts (Astbury and Walji 2013). The authors noted that although, women with disabilities represent almost a fifth of the world population, they are largely absent from research on violence against women (Astbury, Walji et al. 2013).

Particularly vulnerable populations, such as the ones covered in Forum presentations are often underserved and under-researched. Current research highlights the need for more targeted research with such groups to enable us to developed tailored interventions based on their unique needs.

This overall body of work emphasises how sexual and intimate partner violence is firmly entrenched in patriarchy, toxic childhoods and lack of efficacy among adolescent and adult women.

### Responding to sexual and intimate partner violence

### Size of the problem

A global systematic review presented at the Forum, for the first time, provides aggregated global and regional prevalence estimates for both non-partner sexual and physical and /or sexual intimate partner violence using population data from across the globe (Abrahams, Shamu et al. 2013, Devries 2013, Garcia-Moreno 2013, Pallitto 2013, Watts 2013). The study found over one third (35.6%) of women have ever experienced intimate partner physical and/or sexual or non-partner sexual violence (WHO, LSHTM et al. 2013).

Findings from the new study by WHO, LSHTM and MRC (2013) which involved data from over 300 studies in more than 80 countries was presented at the Forum. It provides new insights into the global burden and distribution of poor health among survivors of intimate partner and / or sexual violence to assist our thinking in how to respond effectively to sexual and intimate partner violence. Key findings include:

- Women who have been abused by partners report higher rates of poor health which include 16% greater odds of having a low-birth weight baby, being twice as likely to have an abortion, and 1.5 times more likely to acquire HIV (Pallitto 2013).
- Focusing on longitudinal studies, evidence shows a positive association between experience of intimate partner violence and alcohol use. This finding is bi-directional as alcohol use also increases the risk of experiencing intimate partner violence (Devries 2013).
- Women experiencing partner violence are twice as likely to suffer from depression (Devries 2013).
Globally, 7.2% of women reported experiencing non-partner sexual violence. Women who have been sexually abused are 2.3 times more likely to abuse alcohol, and are 2.6 times more likely to suffer depression when compared to women who have not experienced this kind of violence (Abrahams, Shamu et al. 2013).

“The study [WHO, LSHTM, MRC study] is a landmark in its scale and rigour and offers a unique evidence base that confirms the need to address this public health challenge and violation of human rights worldwide,” (Yount 2014).

The study found surprisingly little longitudinal research and highlighted the need for more such studies to enable us to make the case for causality (Devries 2013, Garcia-Moreno 2013, Watts 2013). The study reported great variation in prevalence between countries, and urges the research community to look more carefully at socio-cultural and economic factors driving violence against women (WHO, LSHTM et al. 2013).

Findings from a multi-country study on prevalence of sexual and intimate partner violence in six of the Pacific Islands - Samoa, Kiribati, Solomon Islands, Vanuatu, Tonga, and Fiji - found high levels of violence against women, with more than 60% of women aged 15-49 reporting ever experiencing physical and/or sexual violence in their lifetime. As with the burden of disease research, this study also reveals great regional and cultural diversity –“pointing to distinct sub-regional patterns of violence even when risk factors are consistent across countries” (Jansen, Ilolahia et al. 2013). Findings support the need for each country to develop context specific and targeted policies and interventions based on analyses of their own data.

Essential services

Intimate partner and non-partner violence are important determinants for poor physical, sexual, reproductive, and mental health which may impact women’s morbidity and mortality (WHO, LSHTM et al. 2013). Comprehensive, gender-sensitive services for survivors of violence can greatly aid recovery. In many low- and middle-income countries, services for survivors are often not included in health care policies, and the challenges of providing comprehensive services are immense. A qualitative study from Tanzania highlighted the multiple socio-cultural barriers to post-rape care, support and justice, such as high levels of acceptance of intimate partner violence within communities, circuitous pathways for help-seeking that are not designed to meet women’s needs, and gendered norms that stigmatise and shame survivors who seek help (McCleary-Sills 2013). Research can help us to understand better how to deliver appropriate services for survivors, what types of services are needed, what services survivors want or use, and what services are currently in place.

A presentation on WHO’s clinical and policy recommendations for responding to sexual and intimate partner violence against women was delivered at the Forum (Garcia-Moreno 2013). This guide provides health care practitioners and policy makers with 36 evidence-based recommendations for the provision of sexual and intimate partner violence services, across six categories: 1) first line women centred care; 2) identification and care of survivors of intimate partner violence; 3) clinical care of sexual assault survivors; 4) training of health care providers; 5) health care policy and provision; and, 6) mandatory reporting (WHO 2013). Some notable recommendations are:
• Universal screening (i.e. asking all women who seek health care) is not recommended, but identification on the basis of clinical suspicion is. Routine enquiry may be appropriate in some settings if certain service requirements are met. This means that a protocol or standard operating procedure should be in place, the first line providers must be trained on how to ask and respond, and this should be done in a private setting, confidentiality is ensured and a system for referral is in place;
• Emergency contraception should be offered to survivors presenting within five days of sexual assault;
• Care for survivors of intimate partner violence and sexual violence should be integrated into existing health care rather than as a stand-alone service;
• All health care providers should be trained in first line response and acute post-rape care, and training should be integrated into undergraduate curricula for health care providers;
• Recommendations and approaches to service delivery need to be tailored to the local context and availability of human, financial and other responses.

These recommendations should be essential reading for all health care practitioners.

In support of the WHO recommendations on screening, a presentation on a randomised control trial done in Australia on the extent to which screening of women - and inviting women self-identified as fearful of a partner - for brief counselling by trained General Practitioners (GP) impacted on their quality of life and mental health outcomes, found that the intervention did not improve women’s quality of life at year one follow-up. The study recommends however that GPs should be trained to ask about women’s safety and in counselling, as the intervention was found to reduce depressive symptoms and increase safety discussions (Hegarty, O’Doherty et al. 2013). This is an important finding for countries in which GPs are a first point of contact. For example, one study found that child sexual abuse survivors currently experiencing violence are more likely to be high service users of general practice, and these survivors reported dissatisfaction with the services they received from their GP (Coles, Lee et al. 2013). A further study from Kenya found that routine screening was feasible only in carefully selected facilities where providers are trained and monitored, and where there is a referral system in place (Undie, Mak’Anyengo et al. 2013).
Unlike screening, emergency contraception is an agreed core component of the essential post-rape care package. Colleagues from Population Council presented a review of the extent to which countries in sub-Saharan Africa are adhering to the WHO’s guidance on emergency contraception (EC) provision in post-rape care. Their review of 16 countries in sub-Saharan Africa, found that ten of the 16 countries had policies on post-rape care, all of which included emergency contraception to varying degrees. Authors noted however, that more effort is needed to ensure access to emergency contraception in these settings (Thompson, Undie et al. 2013).

A study from Asia Pacific presented similar findings. This investigation identified that although emergency contraception is listed as an essential drug in the three countries studied (Kiribati, Solomon Islands and Vanuatu); emergency contraception kits were inaccessible in many of the services visited. The study concluded: “Identifying and eliminating barriers to women’s access to EC and contraceptive supplies is one mechanism to ensure essential comprehensive health services for survivors of sexual assault and promote women’s sexual and reproductive health rights” (Koziol-McLain, Muna et al. 2013).


A briefing paper entitled Emergency Contraception for Rape Survivors: A human rights and public health imperative developed by the International Consortium for Emergency Contraception (ICEC) in partnership with the SVRI was launched at the Forum (ICEC and SVRI 2013). This briefing paper highlights how emergency contraception is a neglected aspect of post-rape care. It reminds us that failure to ensure rape survivors receive emergency contraception may harm women’s physical and psychological health, especially in areas where safe abortion is illegal or unavailable, and is also a violation of women’s human rights. The briefing paper is a useful advocacy document for strengthening provision of emergency contraception in post-rape care. Access the briefing paper at: http://www.cecinfo.org/custom-content/uploads/2014/03/ICEC_EC-For-Rape-Survivors_March-2014.pdf

Multi-sectoral, comprehensive care models for sexual violence survivors was also a focus at the SVRI Forum. A review of models being implemented in five Central American countries documented advances, results and lessons learned about access to, and strengthening legal protection systems and health services. The review found that comprehensive care models that integrate health, justice, security and civil society - among others - improve care for survivors. Specifically, the review found that women had to provide fewer interviews, their applications for protection measures were processed faster, and they reported better access to services.

A number of important lessons emerged as a result of this work – the authors note that when defining responsibilities of each sector, a definition of financial mechanisms for service delivery, including human resources, training, supplies and infrastructure must also be included, similarly, formal inter-institutional mechanisms such as formal agreements can help guarantee the continuity and expansion of coverage for comprehensive services. The authors also highlighted the importance of involving the education sector when establishing a comprehensive model of care (Luciano and Taylor 2013).
Forum participants also saw a presentation of an assessment of a multi-sectoral response programme from the Ukraine for marginalised women and girls. This programme aims to bridge the gap between legislation on violence against women, and its implementation by developing, implementing, documenting and disseminating practical models addressing the needs of excluded and neglected groups of women survivors. An essential component identified as key to success was working across agencies and having people trained to identify and refer survivors. The authors highlighted the need to address violence against children along with staff mental health in future models (Hodgdon, Skipalska et al. 2013).

A study from Malaysia looked at how a national level policy on one-stop crisis centres was implemented in two states in Malaysia; and analysed barriers and opportunities to implementation (Colombini and Hawa Ali 2013). The study found no single model works for all levels of hospital care; scaling-up of pilot interventions need constant adaptation of service models at local level; and a systems approach to address challenges at all levels of care could greatly help to strengthen health sector responses.

During pregnancy, experiences of violence endanger both the mother and her unborn child. A study with pregnant women in Pakistan, found that 51% of the women in the study reported physical, verbal or sexual abuse six months prior to and/or during their pregnancies. Recommendations from this study include screening, support and referral, and integrating mental health care into primary healthcare during the antenatal and postnatal period (Karmaliani, Irfan et al. 2013).

Mental health consequences are often overlooked when developing responses for survivors of sexual and intimate partner violence. An exploration of the mental health consequences of sexual violence, and of intimate partner violence among survivors in Japan, revealed that women who experience sexual violence are at higher risk of poor mental health outcomes such as sleep disturbances, depression and suicide ideation (Kamo, Honda et al. 2013). The study from Cambodia on disability and violence against women found that household violence is linked to very high levels of psychological distress among women with disabilities (Astbury 2013). Violence against women can have severe and long term mental health consequences and services need to ensure that mental health care is integrated with models of care addressing physical, reproductive and sexual health.

Justice services for sexual violence survivors are an essential part of post-rape responses. Unfortunately in many settings justice is not within reach for many survivors. For example, interviews with police in India found that most police were not gender-sensitive and had not received any training on responding to individuals who had been raped, including evidence collection. None of the police stations visited had guidelines for responding to rape cases available (Khan and Bhatnagar 2013). Poor quality evidence collection is a barrier faced by many survivors in their efforts to obtain justice. A presentation from Kenya tested the feasibility of using a locally assembled rape kit for improving evidence collection. The study found an increase in the quality of evidence collection and a potential reduction in secondary traumatisation was suggested as survivors only had to report their rape once, at the point of first contact with services (Ajema, Mukoma et al. 2013).
Not all perpetrators are adults. A review of sexual and domestic violence cases in one province of South Africa found that, of all cases reviewed, 6% were perpetrated by adolescents under 18, and a third of these cases were never prosecuted. Qualitative data from this study found that alternative community-based justice responses were employed in the case of young perpetrators (Carty 2013). Justice systems could play an important intervention role with child perpetrators.

The findings from the presentations made at the SVRI Forum on post-rape care and support for survivors of gender-based violence show us that even though many gains have been made through legal reform, service standards and best practice, and our understanding of what survivors want and what needs to be provided, there is still much more to be done. Multi-sectoral and integrated models work well in providing quality care and support, and reducing secondary trauma. The challenge now is to work out how to scale-up promising service response models into workable sustainable models at a national level, and to ensure that these services are responsive to the needs of all survivors including children.

**Child abuse and neglect**

Childhood violence and abuse is a global problem. Meta-analyses of data on child abuse victimisation found lifetime prevalence rates ranging from 7-36% for women and 3 – 29% for men (Andrews, Corry et al. 2004, Finkelhor, Hammer et al. 2008, Stoltenborgh, van IJzendoorn et al. 2011). Country level studies often report levels of abuse and neglect at the higher end of these scales. For example, a study from Tanzania presented at the Forum found that 29% of children reported some form of sexual violence with attempted sexual intercourse (20%) as the most common form (Mallya, Mbwambo et al. 2013).

Children exposed to violence in the home are particularly susceptible to lifelong social, emotional, and cognitive impairments, and often are prone to health risk behaviours (Pinheiro 2006), both in the short and the longer term (Anda N.D.). Further, children and adolescents living in homes with intimate partner violence are also at greater risk
for other types of interpersonal trauma. One study found that children living in such circumstances are 2.5 times more likely to be physically abused and 5 times more likely to be sexually abused than children not exposed to IPV in the home (Graham-Bermann et al, 2012 in (Woollett 2013). Child abuse and neglect and the important intersections between violence in childhood and violence in adulthood was a key theme for SVRI Forum 2013. A study from Uganda found that women witnessing violence as children are at increased risk of experiencing all forms of violence within their intimate partnerships as adults (Wood 2013). Whilst a study with female college students in Brazil showed that sexual victimisation starts early (around age 14), and also found that child sexual abuse predicts sexual victimisation later in life (Winzer and Krahe 2013).

### Responsible reporting

Responsible reporting of child sexual abuse cases in the media is also critical in shaping public perceptions around the issue (Jayasuriya and Nazeer 2013). In Sri Lanka, an exploratory review of print-media revealed sensationalism in reporting through misrepresentation of events and using language in ways that contribute to a victim-blaming discourse. Placing sensationalist reports within traditional gender ideologies of female virtue resulted in missed opportunities to educate the public and promote prevention. The authors recommended that journalists and editors recognise their responsibility in shaping world views, and become aware of their own gender perceptions and attitudes.

A number of presentations at the Forum explored socio-cultural meanings of child sexual abuse. For example, a Kenyan paper explored the different ways in which members of a community understand transactional sex and how these understandings may influence a child’s access to protection and services. Study participants differentiated between survival sex and transactional sex for treats, with the latter being viewed negatively, and there was little consensus over what is a basic need or a treat. As one participant notes, “[members of the community] don’t take any action [if they see a child offered money for sex]...because they don’t know whether this child slept without food....it’s not that it is good, but the people won’t be against it”. The author concludes, “Adequate exploration of how participants construct these concepts and understand key terms.....is essential when delivering child protection awareness programmes.” (Shipman 2013).

“The Break the Silence” project implemented in Trinidad and Tobago found little public discourse on child sexual abuse impact and prevention, and identified this as a barrier to addressing child sexual abuse within communities. In response, a community-based intervention to address child sexual abuse was developed. A preliminary evaluation of the intervention showed increased knowledge of how to prevent and respond to child sexual abuse and teachers involved reported greater capacity to talk about sexual issues and identify possible cases of sexual abuse (Reid 2013).

A review of what is being done and what works for the prevention and response to sexual abuse and sexual exploitation of children was shared at the Forum. In terms of primary prevention, the main focus of primary prevention interventions identified in the literature was on: attitude and behaviour change (i.e. interventions targeting men and boys, and school-based programmes); reducing risk and vulnerabilities among children and their families (e.g. home-visiting and targeted parenting support); and,
promising practices emerging in humanitarian crisis contexts (e.g. safe spaces for children.) For most of these programmes the evidence found in the literature was generally weak. Strong evidence available is mostly from high-income settings, and of questionable relevance to low- and middle-income contexts. Authors recommend, among other things: greater collaboration between GBV and child protection fields; more research on the issue and current responses; and building capacity of the child protection systems to prevent, intervene early, protect and undo harm (Radford and Sommarin 2013).

An evaluation of a parenting intervention was presented at the Forum. The intervention, with mothers in domestic violence shelters in Johannesburg, South Africa and New York, USA, aimed to assist primary caregivers to manage mental health problems experienced by their children. The study found high levels of depression among the children (70%). After the intervention, caregivers adopted different parenting styles, specifically in terms of discipline and attachment styles and reported being better able to manage themselves and their children (Woollett 2013). Such programmes have enormous potential for helping parents to be the best parents they can be, and hopefully in the long term curbing the intergenerational continuation of trauma.

Little information is available on the global economic cost of violence against children, but this is estimated to be a significant burden (Pinheiro 2006). Investing in strong child protection systems may benefit countries in preventing abuse and responding adequately to the needs of survivors. A study from Zimbabwe on the costs and benefits of various types of violence, violence prevention and victim services to justify implementing such a system found that benefits of implementing a child protection system far exceed the costs — a finding which may benefit many low-resource settings (Fletcher 2013).

Prevention of child abuse and neglect is a strategic response to sexual and intimate partner violence as well as being important in its own right to improve child health and development. Research on child abuse and neglect shared at the Forum confirms the need to ensure that our primary prevention efforts begin with parents, prospective parents and continue across the lifespan. Cross-collaboration between colleagues working on these areas of violence must be encouraged.

HIV and sexual and intimate partner violence

Most research on HIV to date has focused on biological co-factors that may affect transmission, or on prevention efforts to reduce transmission of HIV (Heise and Watts 2013). New research is placing more emphasis on the economic and social forces that might be driving the epidemic. Gender-based violence has been established as one of the social forces which impacts on HIV prevention efforts. Although this link is well established, little data is available on this association and studies vary greatly in quality (LVCT, WHO et al. 2012). A few presentations at the SVRI Forum addressed this gap. These include:

- **Exploring masculinities, marital violence and HIV risk in India:** This study assessed the linkages between HIV and violence from men’s perspectives. Men from similar socio-economic backgrounds were surveyed about marital violence, perceptions of masculinity and safe sex practices. Separate in-depth interviews captured beliefs and norms related to gender, violence and marriage. The findings showed that men who conform to hegemonic masculinity (dominant masculinity) were more likely to perpetrate violence, engage in transactional sex, and use condoms inconsistently.
Working with men and changing notions of masculinity is key in reducing violence and lowering risky sexual behaviours to prevent HIV infection (Swain 2013).

- **Youth and HIV risk in Botswana**: A study from Botswana looked at HIV risk factors for youth to inform the design of effective interventions to prevent HIV. The survey was administered in 145 schools and collected data on risk behaviour, physical violence and contexts in which sexual violence occur. Twenty one percent (21%) of the sample reported ever having had sex. Of this percentage, 13% reported forced sex in the last 12 months. These figures indicate a need to increase awareness and education around sexual health in schools (Botshelo Rankoa 2013).

- **HIV disclosure and intimate partner violence, Zimbabwe**: A study from Zimbabwe investigated intimate partner violence following disclosure of HIV test results among pregnant women. Intimate partner violence was high after disclosure (32.8%) and factors associated with this were gender inequity, past experiences of violence and risky sexual behaviours. This research indicates that disclosure might be a risky process for women and that health care workers could play a valuable role in guiding clients through the process (Shamu, Zarowsky et al. 2013).

Presentations on HIV and violence against women at the Forum identified some key structural drivers including: poverty, gender inequality, alcohol use and stigma. They highlighted the need to strengthen efforts to meaningfully involve all sectors to address comprehensively the driving forces behind HIV through evidence-based interventions. Moving forward it is important that we invest in research on HIV and gender-based violence, identify evidence-based evaluated interventions, and adapt these to local settings.

**Trafficking for sexual exploitation**

Trafficking for sexual exploitation is a global phenomenon with far reaching physical, reproductive and mental health consequences. An entire parallel session was dedicated to this issue at the SVRI Forum.

Most health services for survivors of trafficking across the globe are poorly coordinated and mental health care remains inadequate (Macias Konstantopoulos, Ahn et al. 2013). The health needs of trafficked women are multiple. Migrant women accessing a service provided by MSF-OCBA, in Morocco were asked about their sexual, reproductive and mental health. Most women accessing this service are migrants from sub-Saharan Africa, often victims of human trafficking attempting to reach Europe. Of the group of women identified as trafficked, many had experienced sexual violence, coerced pregnancies and abortions, and presented with various mental health problems such as depression, anxiety and psychosomatic symptoms (Minne 2013). It is important that comprehensive, coordinated responses be developed for survivors to ensure holistic care and that sensitivity in care is built around the different experiences of each survivor.
Similarly, assisted return and reintegration programmes for survivors of trafficking and sexual exploitation can be extremely complex. Various factors may influence successful reintegration including quality of aftercare facilities, family relationships, economic and social support, and physical/mental health complications (Brunovskis and Surtees 2012). The Butterfly Longitudinal Research Project is one of the first to follow prospectively a cohort of sexually exploited people in Cambodia over a period of 10 years. This project is focused around child and adult survivors’ experiences of reintegration, starting from their time at shelters (Lim 2013). Researchers met with participants three times a year and data revealed the complex and diverse experiences of each participant. Validating the voices of survivors, researchers hope to learn about the effects and impacts of reintegration programmes to strengthen services and support survivors.

The complex nature of trafficking and sexual exploitation calls on researchers and those who provide services to listen to the voices of survivors. A study from Cambodia on competing conceptions of success found different definitions of successful reintegration, which relate to underlying discourses and the position of players in the field, and recommended that success should be defined by those who have been exploited (Bearup 2013).

Many policies, laws and protocols have been developed to address trafficking across and within country borders. Many prevention initiatives have also been identified but lack a viable theoretical framework to guide research development, practice and social policy (Rafferty 2013). A presentation on child trafficking for commercial sexual exploitation, recommended that we adopt a systems approach to prevention which incorporates both multi-sectoral and cross-sectoral strategies (Rafferty 2013). Prevention of child trafficking for commercial exploitation, must be grounded in a theoretical framework to inform our work and research in this field – a notion which should apply to all prevention initiatives.
Sexual violence in conflict, post-conflict and emergency settings

Sexual violence is a recognised tactic of war, and is highly prevalent in conflict, post-conflict and emergency settings. Sexual violence in conflict, post-conflict and emergency settings has been a central theme of SVRI Forums since the first conference. The past 6 years have seen a significant growth in research on this complex and evolving field, with an emergence of a deeper understanding of levels of violence, effective responses, drivers and risk factors for sexual violence. As a result of discussions held at the Forum 2011, the WHO, in collaboration with the SVRI, commissioned the development of a research agenda to help guide research on sexual violence in humanitarian, conflict and post-conflict settings. Through a multi-stage, consultative process, the research agenda identified key themes which needed more attention in research (SVRI and WHO 2012). These themes were reflected in presentations at the Forum.

Levels of sexual violence in humanitarian settings

The International Men and Gender Equality Survey (IMAGES) was revised to include questions on conflict. The survey from DRC reported 48% of men ever perpetrating physical violence against a female partner, and 34% reporting perpetrating rape in either conflict or their homes or other settings. Sixteen percent (16%) of men and 26% of women were forced to witness rape. This study concluded that high rates of sexual and domestic violence are prevalent in the eastern DRC and that infrastructure is imperative to support survivors and to prevent violence in schools and communities (Slegh, Barker et al. 2013).

Prevention of sexual and intimate partner violence in conflict, post-conflict and emergencies

Primary prevention of sexual violence in conflict settings is a new and emerging priority in the conflict field, and was a key theme at SVRI Forum 2013. A systematic review of evidence for interventions that reduced the risk and incidence of sexual violence in conflict, post-conflict and disaster settings in low- and middle-income countries was presented (Spangaro and Adogu 2013). The review identified 40 studies reporting programmes across 7 different strategy types: i) survivor care; ii) livelihood initiatives; iii) community mobilisation; iv) personnel initiatives; v) systems and security responses; vi) legal interventions and vii) multiple component interventions. Most interventions were delivered in Africa in post-conflict settings. Only one study was based in an emergency setting. The quality of the evidence found was generally weak, and actual implementation of programmes appeared limited. In terms of efficacy, distribution of firewood to reduce women’s exposure to risk appeared to reduce levels of sexual violence as did a program that aimed to prevent sexual exploitation and abuse by peacekeeping forces. Positive findings were also associated with multiple-component interventions and sensitive community engagement. The review highlighted the need to implement programmes. These programmes must “build on local capacity, while avoiding increased risk and re-traumatisation to survivors of sexual violence” (Spangaro, Adogu et al. 2013).

This review found few programmes which engage directly with men. An intervention study from Côte d’Ivoire which evaluated a male-focused intimate partner violence
prevention intervention addresses this gap (Hossain 2013). This study found a decline in sexual and/or intimate partner violence in the intervention community, and highlighted the importance of including men’s programming as part of intimate partner violence prevention activities. Finally, a study on early warning systems highlighted the potential of such systems for the prevention of conflict related mass sexual and gender-based violence (Davies and True 2013). Collecting routine data that includes gender related indicators and monitoring shifts and changes can provide crucial information on possible eruptions of violence against women in conflict settings.

Little is known about factors impacting relationships, marriage and co-habitation among adolescents affected by conflict and displacement. Early marriage, for example, is a risk factor for sexual violence (Hong Le, Tran et al. 2014). Findings from a study undertaken in Uganda show that conflict and insecurity were cited as motivation for early marriages, along with poverty, and that these were risk factors for intimate partner violence. This study recommended that humanitarian programmes consider addressing early marriage, empower parents and young people to access viable livelihoods, increase safe access to secondary education and involve communities in developing protection strategies in order to reduce intimate partner violence in conflict settings (Schlecht, Rowley et al. 2013).

A study on sexual violence, female employment and social isolation aimed to answer whether labour market participation by women decreased their likelihood of experiencing sexual violence, and if social isolation influenced the likelihood of sexual violence occurring. Findings across six sub-Saharan African countries found that in households where the female is the only breadwinner, women are more likely to experience violence from their husbands. It appears that economic models of intra-household bargaining failed to take into account periods of social upheaval where male power has been destabilised. Social isolation was found to increase the likelihood of experiencing sexual violence (Finnoff 2013). Potential for interventions to do harm must be assessed during intervention development, particularly in settings where access to services is limited and levels of stigma are high.

Responses to sexual and intimate partner violence in conflict

Responding to sexual and intimate partner violence in conflict remains a challenge. Despite global efforts to address the needs of populations displaced and affected by conflict, evidence shows that much still needs to be done. As with prevention interventions, implementation of programmes to respond to survivors are problematic. The Minimum Initial Services Package (MISP) has been established by the humanitarian health sector as a minimum standard for reproductive health, including the clinical management of sexual violence (Reis 2013). An inquiry into the utilisation of this package, however, has shown that these services are rarely available to survivors at health facilities. There is a growing concern that current approaches are targeted toward pursuing justice for survivors at the cost of services. There is a need to regain a balance between seeking justice and responses to meet the needs of survivors.

Although essential services may be inadequate at health facility level, a number of presentations at the Forum on service utilisation in conflict settings found where services do exist, they are underutilised by survivors (Myint 2013, Wirtz, Glass et al. 2013). In such settings, the burden of responsibility to report the crime committed against them lies solely with the survivor. A study on post-rape care from Myanmar attempted to answer the questions: Can community-based medical care be a safe
and feasible option of care for survivors where insecurity and other challenges act as barriers to facility-based care?; and, what are the challenges to providing care in this manner and how can they be addressed? (Myint 2013). The study found that although community-based post-rape care is feasible, the lack of survivor reporting is a major barrier. The researchers recommended greater attention to awareness-raising to inform communities about the potential benefits of accessing care. In an effort to increase survivor access to service, the ASSIST-GBV screening tool was developed to identify and refer survivors of gender-based violence and at risk of HIV in conflict and post-conflict settings. Of the people screened in the Ethiopia site, 50% screened positive for GBV in the past 12 months. Evidence from Colombia, Uganda and Ethiopia with male and female refugees/internally displaced suggested that the tool can confidentially identify those who have experienced gender-based violence, and refer them to available services. The next step for this work is to test the feasibility of this tool in other humanitarian services (Glass, Wirtz et al. 2013, Wirtz, Glass et al. 2013, Wirtz, Pham et al. 2013).

Ensuring that such services are available and delivered by trained service providers remains a challenge in humanitarian settings. A multi-country study on responses to gender-based violence undertaken in countries with limited capacity, including Pakistan, Myanmar, Central African Republic, Papua New Guinea and Libya found limited capacity among service providers to care for gender-based violence survivors (Martin, de la Puente et al. 2013). The study recommended that responses need to be informed by what is currently available on the ground, encourage the implementation of minimum standards, recognise that improving responses requires a long term vision, and that a project approach and short-term emergency responses are not sufficient to build capacity for sustained responses in fragile settings.
Mental health in conflict and post-conflict settings

Sexual violence in conflict and post-conflict has a significant impact on the well-being and health of individuals and undermines the long term psychosocial well-being of such populations (IASC 2007). Three presentations at the Forum focused on mental health impact and interventions in humanitarian settings, two on sexual violence related pregnancies and mental health outcomes, and one on what works to improve mental health outcomes for survivors of sexual violence.

The two studies on mental health outcomes for women with children born of rape were from the Democratic Republic of Congo (DRC). One study reported high levels of PTSD, depression and suicidal ideation, especially among those women who experienced stigma from their communities (Scott 2013). The second study looked at parental stress and sexual violence related pregnancies. It found that women with children born of rape experienced high levels of parenting stress (78.4%), although the majority reported positive regard towards their children (Rouhani 2013). Community interventions to address stigma towards survivors with children from rape is an important way forward in assisting women and their children to reclaim their lives within their communities.

A study from DRC on a mental health intervention addressed the lack of evidence of what works to improve the mental health of survivors of sexual violence in conflict settings, and what would be needed to support broader aspects of healing beyond mental health. This study evaluated Cognitive Processing Therapy (CPT). Sixteen villages were randomly assigned to CPT (1 individual and 11 group sessions) or individual support to survivors with high levels of PTSD symptoms and combined depression and anxiety. The study found that group psychotherapy, delivered by trained community members reduced PTSD, depression and anxiety and improved functioning significantly more than the individual support (i.e. six months after treatment, 9% of participants in the group therapy as compared with 42% of participants in the individual-support group met criteria for probable depression or anxiety (P<0.001), with similar results for PTSD). As the authors note, “The results indicate that with appropriate training and supervision, psychotherapeutic treatments such as cognitive processing therapy can be successfully implemented and can have an effect in settings with few mental health professionals” (Bass, Annan et al. 2013). They also acknowledged that intensive training and support was required and that this made the intervention difficult to scale up in many settings.

Youth, families and communities

Conflict impacts on different aspects of the lives of those involved; it changes family, social and economic structures. The following presentations highlighted various impacts of conflict on levels of violence among different populations:

- Perspectives of husbands on the rape of their partners in eastern DRC: Stigma towards rape survivors was a recurring theme throughout conflict presentations at the Forum. This study forms part of an ongoing project to develop community responses to reduce stigma towards rape survivors, specifically focusing on how men construct rejection or stigma toward their female partners. Men in the study described the rape of their partners as a loss of honour and pride, seeing no solution but to reject her from the family. Men who decide to stay with their partners were likely to use violence, and re-victimise the survivor (Slegh, Barker et al. 2013).
• Abducted children and youth in Lord’s Resistance Army (LRA) in north eastern DRC: This study reports on the LRA’s practices related to the abduction and conscription of boys and girls. Thirty three semi-structured interviews with girls and boys described highly systematised ways in which children are indoctrinated and controlled. Practices include strict social isolation, compelling children to act out rigidly defined gender roles and promoting de-identification with their own village and civilian life – taking on the new language and identity of the group. This study is the first to provide insights on the mechanisms of control once children are abducted. It is valuable in guiding the development of psycho-social interventions with survivors (Kelly, Branham et al. 2013).

Economic empowerment in conflict and post-conflict

Empowering women can contribute significantly to peacebuilding, and is an important mechanism for achieving women’s equal rights and improving their health and well-being (Pusic 2013). Two evaluations of economic interventions undertaken in humanitarian settings featured in the SVRI Forum conference programme, with interesting and exciting evaluation results.

The Pigs for Peace livestock micro-finance programme provides livestock assets (a pig) to rural villagers in the DRC through a loan system (Glass 2013). The presentation described an intervention study on the impact of livestock assets on health and family/community relationships in 10 conflict affected villages. The study found that a livestock micro-finance intervention reduced the health and social effects of multiple forms of trauma, and economically empowered women.

Similarly, the Village Savings Loan Associations (VSLA) allows groups of 15 – 25 members to save and contribute to a common pool of money. In addition to contributing to a solidarity fund, members apply for loans from the pool and pay back with interest. At the end of the cycle, group members cash out and receive their savings with the interest generated. A study looked at whether or not being part of a VSLA improved the overall well-being of sexual violence survivors (Robinette 2013). The VSLA was
tested using a randomised control trial. Preliminary findings showed that a small but significantly greater reduction of overall mental health symptoms (anxiety related symptoms) was evident compared to the wait-control groups. No significant difference was seen in improvements of ability to perform daily tasks.

Both these studies are based on sound, rigorous research design and evaluation, showing economic empowerment interventions positively impacted on the overall healing and recovery of survivors of sexual violence in conflict. These studies provide exciting results which could improve individual, family and community resilience through economic empowerment and improving well-being.

Presentations made at the Forum on sexual violence in conflict, post-conflict and humanitarian settings address key knowledge gaps in this field. Even still, further research, documentation and analysis is required in order to try build on these learnings, particularly in terms of the magnitude of sexual violence in conflict and emergency settings, what prevention looks like in such settings, and what works and why, and to respond effectively to the needs of survivors/victims of sexual violence. Guidelines and / or resources are needed to inform the development of interventions, and research to assist in refining a theoretical framework for these interventions should be encouraged. Finally, a major challenge for the field that, for the most part, is always working on short time frames to avert or respond to disaster, is the need for a long term vision for the prevention and response to sexual violence.

Social Media at SVRI Forum 2013

SVRI Forum 2013 presentation findings and conversations on the event were shared via social media platforms such as Twitter, Facebook and various blogs. During the Forum, 17 contributors actively tweeted and retweeted their day-to-day experiences at the conference with the hashtags #SVRIForum and #SVRI.

A number of bloggers expressed their experiences and thoughts on the Forum. “...I'm feeling privileged to have been able to spend time with such a diverse, animated group of researchers and people passionate about ending sexualised violence. It was a singular experience, to be sure, and I can't wait for the next one.”

Social media also provided a virtual platform for involving people who could not attend. A Twitter user commented: “Loving the #SVRI coverage. Please keep it up for those of us who can't be there.”

We hope to build on the dynamic online interaction the Forum generated at future Forums and for sharing SVRI activities and outputs. Please join us online:

SVRI on Facebook: Sexual Violence Research Initiative
SVRI on Twitter: @TheSVRI
Prize-giving

The SVRI awards certificates to presentations and posters at each Forum to recognise innovative and ground-breaking research. The following researchers received prizes at the SVRI Forum 2013 and have been added to the SVRI Hall of Fame (http://www.svri.org/halloffame.htm):

<table>
<thead>
<tr>
<th>Presenter</th>
<th>Presentation title</th>
<th>Award</th>
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<tbody>
<tr>
<td>Judith Bass</td>
<td>Group cognitive processing therapy: A specialized mental health intervention that supports improvements in well-being for sexual violence survivors</td>
<td>Best research presentation</td>
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<tr>
<td>Kelsey Hegarty</td>
<td>Women’s evaluation of abuse and violence care in general practice</td>
<td>Best research presentation</td>
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<tr>
<td>Luke Bearup</td>
<td>Competing conceptions of “successful reintegration” for the sex-trafficked and abused</td>
<td>Runner-up Research Presentation</td>
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<tr>
<td>Kathryn Falb</td>
<td>Addressing gender norms within economic programming in conflict-affected Cote d’Ivoire: Results from a randomized controlled trial on intimate partner violence, gender attitudes, and post-traumatic stress disorder</td>
<td>Best Young Researcher Presentation</td>
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<tr>
<td>Kerrie Thornhill</td>
<td>Transforming masculinities or consolidating patriarchy in Liberia? Messages about men in post-war campaigns against sexual violence</td>
<td>Runner-up Young Researcher Presentation</td>
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<td>Muganyizi Mutta</td>
<td>Violence is everyone’s problem: An evaluation of a mass media campaign to reduce community acceptance around intimate partner violence in Tanzania</td>
<td>Best Poster Presentation</td>
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<tr>
<td>Chi-Chi Undie</td>
<td>Feasibility of routine screening for intimate partner violence (IPV) in public health care settings in Kenya</td>
<td>Runner-up Poster Presentation</td>
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Closing remarks

The SVRI Forum is a unique event in the field of sexual violence. It combines heart with good science. We have cause to celebrate with the closing of this wonderful event as the programme reflects the tremendous leap forward made in the field since the last Forum. Similarly we should commend the quality of the research and presentations given during the event.

This Forum was particularly unique in its effort to expand in scope, to reach out to other fields and key players in the field, and to consider the intersections between sexual violence and other forms of violence. Moreover, the programme reflected more geographical diversity and also the beginnings of inclusion of issues related to sexual orientation, gender identity and also disability.
The level of passion and commitment that characterises the work of so many people at the Forum is reflected in the many excellent presentations. Of the many wonderful presentations heard at this event, there were some that stood out as catalytic and significant. For example, the UN Multi-Country Study on Men and Violence in Asia and the Pacific which provided insights into what drives men’s perpetration of violence against women, the intervention study done in Uganda on SASA! and the randomised control trial on cognitive behavior therapy from the Congo. Demonstrating that you can train lay people in two weeks to deliver a CPT intervention, opens the door for important and effective programming in the mental health arena.

The progress being made in the field raises many new and interesting questions. Questions on methodology, including for example: how to best evaluate complex multi-faceted community-based interventions; how we measure success; how to work across and within sectors effectively; how to roll-out promising and efficacious interventions in a sustainable and cost-effective way; and how to ensure research partnerships between researchers, practitioners and policy-makers are effective and mutually respectful. The SVRI needs to create a space to continue some of these discussions.

There is still more we can do to ensure that the SVRI Forum remains a key and relevant event for researchers and practitioners in the field. The presentations made at the Forum confirm that evidence from rigorous evaluations of interventions addressing violence against women and girls still comes largely from high-income countries or by high-income country researchers. We need to encourage more research presentations and representation from low-and middle-income country researchers, in the Forum programme, across all global regions. We need to encourage greater interaction between practitioners, policy-makers and researchers and we need to strengthen efforts to turn research into policy and practice.

That being considered, the SVRI Forum continues to be an important and respected professional space for people working on issues and matters related to sexual and intimate partner violence. This is still a lonely field for many. Providing this safe space to acknowledge what we don’t know, the challenges we face in advancing the science and reflecting on what the next stage will be is essential. As one participant noted, “the SVRI Forum is exciting, stimulating, and encourages me to do more. The Forums just keep getting better and better.”

In summary, we have much to celebrate and celebrate we should. I reiterate the thanks I made at the beginning to the government of the Kingdom of Thailand, our partners and co-hosts: Partners for Prevention, South African Medical Research Council, MenEngage, Global Women’s Institute, Oak Foundation, Population Council and WHO, our conference organising and scientific committees and the volunteers who gave their time to ensure the success of this event. I want to end with a particularly big thanks to the SVRI Secretariat, and in particular Elizabeth Dartnall (Liz) and Lizle Loots who make the SVRI what it is and make my task of chairing this event so enjoyable. With thanks,

Claudia García-Moreno
Chair: SVRI Forum 2013
## Annex A: Posters

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<thead>
<tr>
<th>No</th>
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<tr>
<td>SVF19</td>
<td>Tip of the iceberg: Reporting and gender based violence in developing countries</td>
<td>Amber Peterman</td>
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<tr>
<td>SVF26</td>
<td>Health and justice responses for women and girls bearing children from rape: A case study of Goma, eastern Congo</td>
<td>Helen Liebling</td>
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<td>SVF27</td>
<td>Experience of trauma services in Uganda and Rwanda: Implications for mental health policy and legislation</td>
<td>Helen Liebling</td>
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<td>SVF40</td>
<td>Implementing a gender transformative intervention in urban informal settlements in South Africa: Complexities and challenges</td>
<td>Andrew Gibbs</td>
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<td>SVF42</td>
<td>Prevalence of domestic and sexual violence among females in Haryana, India</td>
<td>Jagbir Malik</td>
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<td>SVF43</td>
<td>Community perceptions of rape and child sexual abuse in rural Tanzania</td>
<td>Muzdalifat Abeid</td>
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<td>SVF46</td>
<td>Sexual violence work and stress: Results from the SVRI e-survey in 2011</td>
<td>Jan Coles</td>
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<td>SVF55</td>
<td>An international study of working in and researching sexual violence: A qualitative study</td>
<td>Sathya Manoharan</td>
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<td>SVF69</td>
<td>Collaborating to become stronger: How can we use the lessons learnt from eradicating Chinese footbinding to end FGM across East Africa?</td>
<td>Ann-Marie Wilson</td>
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<td>SVF71</td>
<td>Strengthening medico-legal services for sexual violence cases in conflict-affected settings</td>
<td>Claudia Garcia-Moreno and Chen Reis</td>
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<td>SVF76</td>
<td>Getting it right for girls: Strategic shifts in gender based violence programming in Zimbabwe</td>
<td>Anthony Nolan</td>
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<td>SVF104</td>
<td>Respondent driven sampling to recruit survivors of sexual violence in eastern Democratic Republic of Congo: A methodological assessment</td>
<td>Ashley Greiner</td>
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<td>SVF108</td>
<td>Don’t stand by, stand up: A GBV bystander intervention in Iringa, Tanzania</td>
<td>Esther Majani</td>
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<tr>
<td>SVF109</td>
<td>Violence is everyone’s problem: An evaluation of a mass media campaign to reduce community acceptance around intimate partner violence in Tanzania</td>
<td>Muganyizi Mutta</td>
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<tr>
<td>SVF110</td>
<td>Haba na haba: Shifting Iringa community leaders’ knowledge and attitudes to improve their efforts to respond to violence against women</td>
<td>Esther Majani</td>
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<td>SVF118</td>
<td>Capacity strengthening for gender-based violence research in Senegal</td>
<td>Elizabeth Rowley</td>
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<td>SVF120</td>
<td>How can medical students be better prepared to deal with the health consequences of sexual violence in clinical practice?</td>
<td>Elizabeth Prime</td>
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<td>SVF123</td>
<td>Culturally sanctioned SGBV as a driver for child perpetration of assault in regions of traditional leadership in Limpopo, South Africa</td>
<td>Craig Carty</td>
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<td>SVF145</td>
<td>Child sexual abuse and its health impact among secondary school students in Kinondoni Municipality, Dar es Salaam, Tanzania, 2010</td>
<td>Grace Mallya</td>
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<td>SVF147</td>
<td>Uptake of post exposure prophylaxis by rape survivors: A situation analysis from Kenya</td>
<td>Lina Akinyi</td>
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<td>SVF149</td>
<td>Witnessing partner violence and experiences of violence from parents in Ugandan primary school children: A cross-sectional survey</td>
<td>Karen Devries</td>
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<tr>
<td>SVF151</td>
<td>Correlates of spousal violence against women in Bangladesh: A multilevel analysis of demographic and health survey data</td>
<td>Sajeda Amin and Ruchira Naved</td>
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<td>SVF155</td>
<td>Characteristics associated with follow-up attendance at a rape care centre in South Africa</td>
<td>Nozwelo Ncube</td>
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<td>SVF160</td>
<td>The relationship between hegemonic norms of masculinity and women’s conceptualization of sexual coercion in South Africa</td>
<td>Erin Stern</td>
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<tr>
<td>SVF166</td>
<td>Linking policy to practice: Work with men and boys towards a conducive policy environment for GBV and HIV laws and policies in Kenya, Rwanda and Sierra Leone</td>
<td>Tim Shand</td>
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<tr>
<td>SVF169</td>
<td>“Willing but not able”: High acceptability of addressing intimate partner violence in antenatal care is hindered by persistent gaps in policy and resources</td>
<td>Abigail Hatcher</td>
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<tr>
<td>SVF177</td>
<td>Feasibility of routine screening for intimate partner violence (IPV) in public health care setting in Kenya</td>
<td>Chi-Chi Undie</td>
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<td>SVF186</td>
<td>A study of child-on-child sexual abuse of children under 12 years</td>
<td>Shaheda Omar</td>
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<td>SVF187</td>
<td>The Teddy Bear Clinic model of child abuse services</td>
<td>Shaheda Omar</td>
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<td>SVF204</td>
<td>“Beating in a good way”: Gender norms and domestic violence in northern Uganda</td>
<td>Melissa Adams</td>
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<td>SVF205</td>
<td>Implementation science for gender-based violence: Tathmini GBV study in Tanzania</td>
<td>Susan Settergren</td>
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<td>SVF236</td>
<td>Effectiveness of reproductive health camp model for documentation and provision of comprehensive services to survivors of sexual violence</td>
<td>Upama Malla</td>
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<td>SVF244</td>
<td>The UK government’s prevention of sexual violence initiative (PSVI): Findings from scoping Mission to Libya</td>
<td>Sarah Martin</td>
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<td>SVF249</td>
<td>Physical and emotional victimization among primary school-going children in Malaysia</td>
<td>Wan Yuen Choo</td>
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<tr>
<td>SVF280</td>
<td>Interventions to prevent violence against women and girls: a systematic review of reviews</td>
<td>Diana Arango</td>
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Annex B: Preconference workshops

The Forum hosted seven interactive workshops on a variety of topics before the conference. The workshops provided participants with the opportunity to broaden their knowledge-base and improve skills.

**Workshop 1: Designing and analysing research for sexual and intimate partner violence.**

Presenter: Dr Henriette Jansen (Senior Consultant)

This workshop, designed for researchers, service providers and educators with a specific interest in GBV research methodology and ethics, was hosted for the second time at an SVRI Forum. The workshop explored essential principles and challenges when researching violence against women and provided participants with access to tools and resources to measure violence against women. It built on the experiences of the multi-country study undertaken by the WHO, and other VAW studies around the world. The workshop provided valuable insight into the newly established UN VAW indicators, the interpretation of survey data as well as service based data in particular in the monitoring of GBV prevention efforts, and important ethical and methodological challenges raised by research on violence against women.

**Workshop 2: Breaking the cycle: Understanding and addressing the intersections of violence against women and violence against children.**

Presenters: Ms Alessandra Guedes (PAHO/WHO), Dr Catherine Maternowska (UNICEF), Dr Claudia Garcia-Moreno (WHO), Michele Moloney-Kitts (Together for Girls).

Violence against women violence against women and child maltreatment have been traditionally addressed in isolation by researchers, policy makers and programs. In recent years, a growing body of research suggests that VAW and child maltreatment often can occur within the same household and that exposure to violence in childhood may increase the risk of experiencing or perpetrating different forms of violence later in life. This workshop examined the evidence regarding the different ways in which violence against women and child maltreatment intersect as well as where they do not intersect, assessing what contributes to perpetuating violence. It further explored the policy and programmatic implications of the evidence for prevention efforts and services, analysing the drivers of violence, the implication of this from the perspectives of the two fields and how this affects policy and practice.

A number of additional colleagues contributed the development of this workshop, but were not able to be at the SVRI Forum. They include: Dr. Daniela Ligiero (PEPFAR), Ms Diana Prieto (Bureau for Global Health, USAID), Dr Janet Saul (CDC) and Ms Neetu Abad (CDC).
Workshop 3: Monitoring and evaluation of sexual and reproductive health services.

Presenters: Dr. M.E. Khan and Dr. Ian Askew (Population Council)

This workshop described the fundamental principles and practices of monitoring and evaluation to ensure a service programme or intervention reached its goal. The facilitators provided participants with knowledge and skills that they can use in managing interventions within sexual and reproductive health services; developing a logic model for programme implementation and learning to monitor programme processes; and identified and applied appropriate goals, objectives and indicators for monitoring and evaluating outcomes and results services, programmes or interventions.

Workshop 4: Researching violence against women with disabilities by intimate partners and other household members.

Presenter: Professor Jill Astbury (Victoria University)

Using the Triple Jeopardy project on ‘Gender based violence, disability, other rights violations and access to related services among Cambodian women’, this workshop explored why so little research on violence among women with disabilities has been carried out and why large scale surveys on violence typically leave this group out. The facilitator described the current state of the evidence base and considered how to ensure the participation of women with disabilities in determining research priorities and conducting research.
**Workshop 5: Trauma and safety while researching sexual violence research.**

Presenter: Associate Professor Jan Coles (Monash University), Ms Sathya Manoharan (Monash University) and Ms Elizabeth Dartnall (Sexual Violence Research Initiative)

Working with victims of sexual violence can be difficult. The most effective way to support such research is to develop and retain a skilled research workforce but there is an international literature gap on how best to support sexual violence researchers in different countries and contexts. This workshop provided researchers with a much needed opportunity to discuss the personal impact of undertaking sexual violence research while providing them with strategies to prevent and respond to the potential for researcher trauma while undertaking sexual violence research. For more information on researcher trauma and materials, visit: http://www.svri.org/trauma.htm.

**Workshop 6: Using the UN Multi Country Study on Men and Violence.**

Presenters: Dr Emma Fulu and Mr James Lang (Partners for Prevention)

This workshop provided an overview on how to conduct rigorous and ethical research with men in order to better understand men’s perpetration and to design more effective primary prevention approaches. Participants were introduced to the UN Multi-Country Study on Men and Violence and the accompanying “Guide to Replicating the UN Multi-Country Study on Men and Violence”. The regional findings of the study from 6 countries in Asia and the Pacific were discussed along with the implications for enhanced prevention programmes and policies.

**Workshop 7: Developing youth-focused interventions for the primary prevention of gender-based violence in low and middle-income countries.**

Presenters: Dr Anik Gevers (Medical Research Council) and Ms Melissa Adams (Georgetown University)

Through the use of programmatic examples from low and middle-income settings and evidence-based recommendations, this workshop provided participants with a framework for the development and evaluation process for multi-level primary prevention interventions. The facilitators explored conducting formative research in local settings to inform intervention strategies, approaches, and content; adapting existing models/interventions or creating a new programme; and integrating feasible and rigorous monitoring and evaluation tools during development and testing of intervention materials.
Annex C: Launches and side events

Book launch, Tuesday, 15th October:
Emma Fulu (Partners for Prevention), launched her book: Domestic violence in Asia. Globalization, gender and Islam in the Maldives at the SVRI Forum. Using the Maldives as a case example, the book argues that forces of globalisation, consumerism, Islamism and democratisation are changing the nature of domestic relations, with shifting ideas surrounding gender and Islam being particularly significant.

MenEngage reception, Tuesday, 15th October:
The MenEngage global alliance hosted a reception event at the SVRI Forum 2013 to present their call for action to engage men and boys in preventing violence against women. The event included various media and short presentations by this international network. The network is made up of a number of country networks spread across many regions of the world. MenEngage members work collectively and individually toward advancing gender justice, human rights and social justice to achieve a world in which all can enjoy healthy, fulfilling and equitable relationships and their full potential. Through country-level and regional networks, MenEngage provides a collective voice on the need to engage men and boys in gender equality, to build and improve the field of practice around engaging men in achieving gender justice, and advocating before policymakers at the local, national, regional and international levels. (Information extracted from: http://menengage.org)
Tearfund satellite meeting: An integrated approach to addressing sexual violence in conflicts and humanitarian emergencies, Thursday, 17th October:

Tearfund (UK), in an effort to bring key actors in the sexual violence sector together with key actors in the humanitarian and development sector, hosted a scoping meeting during the SVRI Forum 2013 to discuss the importance of an integrated approach to addressing sexual violence in conflict and humanitarian emergencies, and also discussing the role of faith-based organisations in the same. The meeting brought together diverse stakeholders from the humanitarian, development and academic sectors to focus on exploring an integrated approach to addressing the prevention of sexual violence in emergencies and conflicts. More information on Tearfund can be accessed at: http://www.tearfund.org/.
Annex D: Committees

SVRI Coordinating Group

M.E. Khan (Co-chair)  Senior Associate, Population Council, India
Jill Astbury (Co-chair)  Research Professor, School of Psychology, Victoria University, Australia
Rachel Jewkes (Secretary)  Director, Gender and Health Research Unit, Medical Research Council, South Africa
Gary Barker  International Director, Promundo, USA/LAC
Claudia Garcia-Moreno  Team Leader, Department of Reproductive Health and Research, World Health Organization, Switzerland
Alessandra Guedes  Regional Advisor, Family Violence
Pan-American Health Organization / World Health Organization, USA
Nduku Kilonzo  Executive Director, LVCT, Kenya
Tandiar Samir  Freelance Consultant and General Manager, Josaab Foundation, Egypt
Linda Williams  Professor, Criminal Justice and Criminology
University of Massachusetts Lowell, USA

SVRI Secretariat

Rachel Jewkes (Secretary)  Director, Gender and Health Research Unit, Medical Research Council, South Africa
Elizabeth Dartnall (SVRI Programme Officer / Srn Research Manager)  SVRI / Gender and Health Research Unit, Medical Research Council, South Africa
Lizle Loots (SrN Scientist)  SVRI / Gender and Health Research Unit, Medical Research Council, South Africa

SVRI Forum 2013 Organising Committee

Claudia Garcia-Moreno (SVRI Forum Chair)  Department of Reproductive Health and Research, World Health Organization, Switzerland
M.E. Khan (SVRI Chair)  Senior Associate, Population Council, India
Jill Astbury (SVRI Co-chair)  Research Professor, School of Psychology, Victoria University, Australia
Rachel Jewkes (Secretary)  SVRI / Director, Gender and Health Research Unit, Medical Research Council, South Africa
Elizabeth Dartnall (SVRI Programme Office / Srn Research Manager)  SVRI / Gender and Health Research Unit, Medical Research Council, South Africa
Lizle Loots (SrN Scientist)  SVRI / Gender and Health Research Unit, Medical Research Council, South Africa
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<td>Abbie Fields</td>
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<td>Kate Graham</td>
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... Abstract review committee (cont.)

Kristin Dunkle  Emory University
Laura McCloskey  University of Illinois
Leslie Davidson  University of Columbia
Linda Williams  University of Massachusetts Lowell
Lizle Loots  Sexual Violence Research Initiative
Lori Michau  Raising Voices
Manuel Contreras  UN Women
Mary Ellsberg  The Global Women’s Institute, The George Washington University
Mary Koss  University of Arizona
Melissa Adams  IRH Georgetown University
M.E. Khan  Population Council
Mihoko Tanabe  Women’s Refugee Commission
Mzikazi Nduna  University of Witwatersrand
Naemah Abrahams  Medical Research Council of South Africa
Nancy Glass  The Johns Hopkins School of Public Health
Nicola Christofides  University of Witwatersrand
Nduku Kilonzo  LVCT Care and Treatment
Nwabisa Jama Shai  Medical Research Council of South Africa
Peter Cooper  University of Reading
Pablo Castillo-Diaz  UN Women
Rachel Jewkes  Medical Research Council of South Africa
Ravi Verma  International Center for Research on Women
Rikke Holm-Bramsen  Aarhus University
Ruxana Jina  University of Witwatersrand
Ruchira Naved  International Centre for Diarrhoeal Disease Research
Sarah Martin  Consultant
Shanaaz Mathews  Children’s Institute South Africa
Sarah Rich  International Consortium for Emergency Contraception
Shelley Lees  London School of Hygiene and Tropical Medicine
Simukai Shamu  Medical Research Council of South Africa
Sophie Read-Hamilton  Consultant
Tandiar Samir  Jossaab Foundation
Veena O’Sullivan  Tearfund
Yandisa Sikweyiya  Medical Research Council of South Africa
References


UN Women (2012). Factsheet: UN Women Thailand. UN Women Thailand Country Programme


SVRI Forum presentations


