Baseline Assessment to Evaluate Attitudes, Norms, Knowledge, and Behaviors around Violence Against Women and Girls and Evidence-based Practices for the Curricula of a Faith-based Youth Organization

By
Rachel Gayle Davidson

A Master's Paper submitted to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Master of Public Health in the Public Health Leadership Program.

Chapel Hill
Fall 2019

Adviser: Karine Dubé, DrPH

Date

Second Reader: Whitney Fry, DrPH

Date

ABSTRACT

Rachel Gayle Davidson: Baseline Assessment to Evaluate Attitudes, Norms, Knowledge, and Behaviors around Violence Against Women and Girls and Evidence-based Practices for the Curricula of a Faith-based Youth Organization
(Under the direction of Karine Dubé, DrPH)

Background: Violence against women and girls (VAWG) is a significant public health issue globally and in urban informal settlement communities, such as those in Nairobi, Kenya. A Nairobi faith-based organization, Ambassadors Football Kenya (AFK), recognizes this issue as one with significant, adverse impact in the communities where it serves and endeavors to implement activities to disrupt this cycle of violence, improving health outcomes of women.

Methods: A literature review was conducted to identify an evidence-based, community-led intervention program with documented results in preventing VAWG and a model leveraging activities already performed by AFK. The *SASA! Faith community mobilization intervention*, a four-phased program, fits these criteria. AFK began implementation of SASA! Faith's first phase, the START phase, during August 2019 by engaging a volunteer with previous experience working in the field of VAWG prevention. A baseline assessment was conducted using qualitative and quantitative exercises in the form of Assessment Dialogues and Rapid Assessment Surveys, respectively, to measure the starting point of community knowledge, attitudes, behaviors, and norms around VAWG.

Results: The baseline assessment indicated that VAWG is, indeed, a significant issue in the communities served by AFK. Men and women who participated have varying views on the power imbalance between them but agree that VAWG is a problem that needs to be addressed to improve safety and health in their communities.

Conclusion: AFK should continue to pursue implementation of SASA! Faith, engaging partners to aid in these activities and augment visibility in the community.

Table of Contents

SECTION I - INTRODUCTION

Background

Violence against women and girls (VAWG) is commonly acknowledged as a pervasive public health issue with wide-ranging acute and long-term adverse health effects. One in three women will experience intimate partner violence (IPV), the most prevalent type of VAWG, which includes physical, emotional, and/or sexual violence by a current or former spouse or partner, in her lifetime.[1] In Kenya, this burden is especially staggering, with 40% to 50% of women having experienced some form of violence in their life.[2] These figures correspond to the 2014 Kenya Demographic and Health Survey where more than 47% of women aged 15 to 49 years reported experiencing physical or sexual violence by their current age at time of response.[3] Similar to other contexts worldwide, the true prevalence of VAWG in Kenya may be much higher: many cases go unreported due to stigma, shame, self-blame, fear, and/or lack of confidence in the public, legal, or medical sector response(s) to a reported case.[2]

In addition to the acute physical injuries inflicted upon VAWG survivors, long-term physical and psychosocial consequences of such attacks can significantly and adversely impact survivors and their families. Apart from any permanent disability resulting from an attack, VAWG survivors are at higher risk for substance abuse, depression, suicidal thoughts, risky sexual behaviors, in turn escalating risks for acquiring sexually transmitted infections (STIs) and HIV infections.[2] These risks and behaviors affect families: children living in violent households may also experience fear, depression, withdrawal from social situations, distrust of adult figures, or misbehavior in school, as well as the intergenerational disposition to continue the cycle of violence.[4,9] Likewise, the burden of VAWG on communities is considerable. In concert with the previously indicated statistics, community-level health and wellbeing are adversely impacted by

VAWG. Violence reduces productivity: survivors miss school and work, and/or are unable to fulfill domestic duties. VAWG adds additional burden to already thinly-resourced health facilities and psychosocial service providers.[2]

Ambassadors Football Kenya

Part of a global network of partner organizations, Ambassadors Football Kenya (AFK or "Ambassadors Football") seeks to reach young men and boys through role model coaches, football, and Christian faith-based studies. AFK's mission is to nurture these children and youth to become responsible, productive citizens and competent leaders of integrity in their communities, also known as 'football ministry'.[5] Based on the premises of the International Christian Centre at Imara Daima ("ICC Imara") in Nairobi, Kenya, AFK has strong ties to the Christian community as well as to nearby communities. Many of the children and families served by ICC Imara and Ambassadors Football live in the nearby Kibera, Mukuru, and Utawala informal settlements.

Untapped Opportunities

According to the United Nations, the median age of Kenyans is 19.5 years.[5] In consideration of this statistic, and the mounting issue of VAWG in Kenyan communities, especially urban, informal settlements such as those served by Ambassadors Football, there exists a major opportunity for positive impact on this public health crisis and for quality of life for the beneficiaries of AFK's presence.

Ambassadors Football's primary activities involve football coaching in a variety of settings: clinics and camps hosted on its premises, school-based leagues, hosting and participating in tournaments, as well as classroom-based coaching. Coaches are identified through various vehicles, including former AFK players, volunteers from the community, or

former professional players. Coaches undergo extensive training programs, known as Training Resourcing and Equipping Churches/Coaches (TREC), to prepare for leadership of football ministry in their communities and effectively work with children and youth on and off the football pitch.[5] These activities and trainings avail many points of contact and outreach with communities including players, players' parents, church groups, and schools. While AFK does not currently have a girls' football league, this is a population it aims to reach in other ways such as through camps and tournaments. The organization intends to organize a girls' football league as part of its long-term goals.[5]

Objectives

Ambassadors Football is not a public health organization; it is a faith-based community outreach organization. However, its work affects and promotes health and wellness in the communities it serves; indirectly impacting public health issues due to the emphasis on teaching resilience and reducing public health burdens through coaching children and youth on physical activity, health, integrity, compassion, and respect. Its vision, mission, and the passion and commitment of its staff members and volunteers to reaching local communities is valuable in many contexts, including population-level health status. An area that its staff and volunteers have identified of grave concern is the volume of reports from players and coaches it receives surrounding VAWG. The organization is at a crossroads in terms of response: it aims to provide space for people to feel safe and protected, but it cannot control what happens to individuals once they leave the pitch or the classroom. The aim is to identify an evidence-based curriculum that leverages AFK's current activities and network, has been proven to be effective in reducing VAWG, and provides flexibility in implementation (low cost, minimal baseline technical expertise required).

SECTION II - LITERATURE REVIEW

Methods

Research Question

A literature review was conducted to ascertain which, if any, existing community-based intervention programs have been tested and/or implemented in a Kenyan or East African context to combat VAWG. Selection of an evidence-based intervention of violence prevention against women and girls, utilizing a community-based approach, is important to the effectiveness of any program implemented by Ambassadors Football Kenya.

Inclusion Criteria

- Published in an academic or medical journal from 2000 to present (2019) in English;
- Presents and analyzes interventions addressing domestic violence, IPV, or VAWG;
- Interventions are centered around community mobilization and ownership of the activities;
- Study population includes communities in Kenya or East Africa or developing, urban settings.

Exclusion Criteria

- Published in a medium other than an academic or medical journal, prior to 2000, and/or in a language other than English;
- Focused on a population targeting sex workers, individuals living with HIV, pregnant women, or solely on female students or youth;
- Examined types of abuse or violence outside of an intimate or domestic relationship;
- Study populations were located outside of East Africa and in a developed context;

- Examined interventions administered in a healthcare or governmental setting and/or not focused on violence prevention (e.g. promotion of medical care for survivors of violence post-incident);
- Article was not available for review through virtual libraries of the University of North Carolina at Chapel Hill.

The literature searches were conducted using the Global Health and PubMed databases using the search terms “GBV” OR “gender-based violence” OR “violence against women” OR “violence against girls” AND “Kenya” OR “Nairobi” OR “East Africa" AND “community-based program” OR “community-based intervention” in English from 2000 to present. Executing the searches yielded 199 results in the Global Health database and 25 results in the PubMed database. Duplicated results were removed from the results and the titles and abstracts of the remaining articles were screened for the above eligibility criteria or excluded accordingly.

Program Summaries

Communities Care: Transforming Lives and Preventing Violence (“Communities Care”)

Developed by UNICEF, the Communities Care program is designed with the assumption that although living in an environment with armed conflict can be detrimental and dangerous, an affected community may have an opportunity to reimagine social and gender roles, especially those of women, in changing norms to reduce VAWG. The Communities Cares program has two objectives: first, to “improve timely, coordinated, and compassionate care and support for survivors of sexual violence in conflict-affected settings by strengthening community-based response”, and to “reduce tolerance for VAWG within the community and catalyze community-led action to prevent it”. [6] The approach focuses on not only change in behavior, but also shared agreement on social change being in the best interest of the community leading to a collective

change in social norms and behavior. The Communities Care program first aims to strengthen community-based care for VAWG survivors, and then concentrates "on engaging community members in collective reflection and exploration on values, aspirations, and harmful norms that foster violence and discrimination, and then fosters exploration of alternatives to violence and discrimination" leading to new shared beliefs and acceptable behavior within the community. Objective 1 aims to validate the issue of VAWG and its survivors' physical and psychosocial harms, in addition to promoting healing, otherwise referred to as a 'survivor-centered approach' to service delivery. This requires such survivor-centered care and practices to be transferred to healthcare workers by way of training and capacity building. Achieving Objective 2 involves a structured and facilitated community dialogue over the course of 15 weeks to build awareness, safety, and trust among different groups. This dialogue program utilizes a phased approach whereby community members are trained to lead these discussions and carry out discussions of potentially increasing sensitivity each week along with participatory exercises.[6]

Challenges to measure the impact of the Communities Care program include the nascent stage of evaluations interventions surrounding VAWG prevention and changing social norms. UNICEF partnered with Johns Hopkins University to develop evaluation tools and methods once the pilot implementations are further along. Although preliminary findings from a randomized-controlled trial indicated positive results of the Communities Care program interventions, there is insufficient evidence to its efficacy. These preliminary, yet positive, results involved a measured improvement in community discussion participants' attitudes on different VAWG scenarios. Notably, in a theoretical scenario about a 14-year-old girl raped by a group of older boys, 66% of participants agreed that the rape victim should tell her parents and marry one of the boys at baseline. At follow-up at four months, only 7% agreed with the same statement.[6] As it relates to

the context in which AFK works, a significant limitation of the Communities Care program is the settings in which it has been piloted. The program was designed specifically for and piloted in conflict-affected areas where conditions are often more unstable—lacking basic infrastructure, resource-starved and/or violent—than those experienced by communities reached by AFK.[6]

The Stepping Stones and Creating Futures ("SSCF") intervention

The SSCF intervention program hypothesizes a strong association between joblessness or economic insecurity and use of violence against women. This program is based in informal settlements in Durban, South Africa and is characterized as a "participatory gender transformative and livelihood strengthening" intervention. Evaluation is performed through a two-arm cluster randomized control trial in a study population of women and men aged 18 to 30 years.[7] While the evidence base supporting gender transformative interventions coupled with economic strengthening to reduce VAWG is relatively small prior to the implementation of this intervention evaluation, early impact assessment results from such interventions are promising. The SSCF intervention was first piloted in informal settlements during 2012-13. Findings from the 12-month follow-up time point indicated an increase in mean earnings for both men and women participants and a significant reduction in IPV events from 30% to 19% in the prior three-month period.[7] The combination intervention of IPV reduction and economic empowerment for men and women is among the first of its kind and is expected to provide considerable information on the relationship between economic security and men's use of violence.

The program itself is a combination of two separate interventions. First, the *Stepping Stones* manual which is a program of ten, three-hour sessions conducted over the course of six to eight weeks for participants of the same sex. Its content is delivered using participatory learning

approaches and includes "how we act and what shapes it (gender and peer influences); sex and love; conception and contraception; STIs and HIV; safer sex and condoms; gender-based violence; motivations for sexual behavior (including alcohol and poverty); and communication skills".[7] Second, *Creating Futures* consists of eleven, three-hour sessions delivered subsequently to the *Stepping Stones* curriculum to the same participants. Content for these sessions is centered around setting livelihood goals, how to get and keep jobs, spending and saving skills, managing expectations, and small-income generating activities.[7] A limitation of the SSCF program appears to be the lack of community leadership in intervention implementation; both curricula were delivered by public health professionals during the pilot and evaluation phases.[7]

SASA! Community Mobilization (SASA!) model

The SASA! model aims to prevent violence against women and address the underlying drivers of violence in communities. It focuses on positive, non-shaming methods to change social norms and address the power imbalance between men and women that perpetuates violence. Fundamental to the SASA! method is the Ecological Model and Prochaska's Stages of Change theoretical frameworks. Namely, the idea that individuals must pass through various stages prior to adopting new behaviors; SASA! applies this to community-level change. The SASA! model was developed by Raising Voices, an NGO based in Kampala, Uganda, where it was also initially implemented.[8]

SASA! consists of four phases: (i) the START phase consists of learning about a community by mapping out its formal and informal resources and how it is structured and organized. This also includes identifying local activists within the community to engage in SASA! efforts; (ii) the AWARENESS phase catalyzes activists identified during the START phase to conduct informal activities within their communities and encourage community

members to critically think about power dynamics and imbalances between men and women in society and how these ideas may manifest in the local context; (iii) the SUPPORT phase is designed to strengthen community member networks and skills to encourage and support changes occurring within the community; (iv) the ACTION phase focuses on encouraging individuals to experiment with new, positive behaviors and celebrate behavioral 'successes' within the community.[8] The four SASA! phases are implemented utilizing multiple strategies which evolve with each phase:

> Staff-supported community activists are encouraged to conduct activities where people ordinarily congregate. The use of media and advocacy strategies, through small-scale media and street theatre, also encouraged reflection and debate. Many SASA! activities were supported by a variety of contextually relevant communication materials. Training activities were offered to community activists to improve their confidence, skills, and ability to act as change agents within their community.[8]

Results of a cluster randomized-controlled trial with a nested qualitative study assessed the impact of the SASA! model implemented in an informal settlement in Kampala, Uganda at the individual- and the community-levels of the Ecological Model. Observations reported at the individual-level included an increased level of sharing and communication about finances, sexual behavior, and household responsibilities between partners. At the community-level, perceptions around the norms of domestic violence as a shameful secret to be managed within the family began to change as women spoke out and understood that violence is not an act of love by a partner, a common perception in informal, urban settlement communities in East Africa. Moreover, some male participants who were actively engaged in the SASA! process were willing to use their own experience of perpetrating violence to educate other men in the community to

change social norms and behaviors.[8] In contrast, some of the limitations discussed by Kyegombe et al. (2014) included the evaluator focus on participants who were exposed to SASA! and reported positive change in relationship violence as well as the focus on only one partner of a couple for evaluation. Further, interviews were conducted only at follow-up rather than multiple interviews with the same participants over time, potentially exposing the study to recall bias or desirability bias of the participants 24 months into implementation.[8]

Responsible, Engaged, and Loving (REAL) Fathers initiative

The REAL Fathers initiative is a "twelve-session father mentoring program implemented by volunteers that is designed to reduce child exposure to violence at home, breaking the cycle of intergenerational violence" as well as engaging men to transform norms and attitudes around gender roles, expectations, and IPV. According to Ashburn et al. (2017), there is limited evidence of effectiveness of IPV interventions where women are the sole population of interest; men should be included to improve the effects of changing attitudes around gender and social norms and reducing IPV perpetration.[9]

Using a mentoring program and a community poster campaign, the REAL Fathers initiative is founded upon the Social Cognitive theory with respect to the development of gender differences and related social norms. Further, this theory argues that individuals adapt their behaviors and beliefs to gender roles and expectations based on a variety of social experiences. In consideration of this idea, the REAL Fathers initiative "uses modeling of alternative strategies for nonviolent discipline and conflict resolution to improve fathers' parenting and communication skills and confidence in adapting nonviolent strategies".[9] Not only does targeting these skills help to reduce IPV, critical self-reflection on gender roles in society and in the community by both men and women and at the community level through exposure to a poster

campaign leads to an increased degree of open-mindedness of an expanded (domestic) role of a father.[9]

Younger and newer fathers were targeted for this initiative, since the parental, and perhaps marital, roles are more ambiguous at the beginning stages of a family structure and may be more easily adapted. In addition, mentors were volunteers from the community and were selected by the young father participants. While the mentoring sessions primarily focused on teaching fathers new coping and relational skills, a few sessions involved the wives or partners of the participating father. The poster campaign depicted a collection of desirable father behaviors, such as reading to a child, and the images were rotated monthly. At the completion of the mentoring program, participants were invited to a community-wide celebration with their wives/partners and families to reinforce successes achieved during the program.

Overall positive improvements were recognized at end-line follow-up and long-term follow-up, with reports of increased positive parenting skills and couple's communication skills along with reports of physical violence against children and verbal, physical, and psychological IPV at a decreased prevalence. More specifically, the study indicated a decline in physical violence reported from baseline of 38% prevalence across the study population to 12% at long-term follow-up. However, there was limited change noted with respect to men's views on traditional gender roles. The authors surmised that more involvement of wives or other influential family members in the initiative could make a more significant impact on such views.

Community-Based Action Teams (COMBAT) initiative

The COMBAT initiative was developed as part of the rural response system (RRS) in Ghana during 2002 to address findings from a study conducted on VAW and children in 1998. These findings consisted of four main themes: (i) inadequate response to VAW and children

reports and cases from state and local agencies; (ii) overall high level of tolerance of VAW and children in Ghanaian society; (iii) lack of knowledge and education on what constitutes VAW and children, its causes, consequences, and societal norms and mechanisms that perpetuate this violence; and (iv) the physical isolation of rural women and dissatisfaction of VAW survivors to the response and reception received upon reporting cases.[10]

Stemming from these findings, the COMBATs were borne from the RRS against VAW. COMBAT members were selected by community members and trained to create awareness of gender-based violence (GBV) incidents and to provide support to women who report GBV cases. COMBATs are staffed equally with men and women and are trained in survivor-centered practices, where the GBV survivor can make the final decision regarding her care after being provided on available options. The COMBAT volunteers' chief responsibility is to provide compassionate support and referrals to resources to GBV survivors. State agency representatives are also trained in proper GBV response in their roles, as well as in much of the same content delivered to the COMBAT volunteers.[10]

In summary, the COMBAT initiative is seen to be an important tool in the healing and recovery of GBV survivors. However, the study acknowledges that intervening at the individual level, as RRS COMBAT is designed to do, may not be an optimal way to interrupt the cycle of violence against women.[10]

Analysis and Intervention Program Selection

All the intervention programs evaluated share a goal outcome of reducing VAWG. Although each program has valid features, ultimately what is of primary importance is which program best complements the ongoing activities of Ambassadors Football and the ways the organization already connects with the communities in which it is involved.

As it pertains to the design of intervention activities of each program reviewed, those of the Communities Care, SASA!, and REAL Fathers initiatives appear most aligned to those of AFK. In contrast, the SSCF initiative involves service delivery by healthcare or public health professionals; AFK does not require its staff to have this type of background or professional experience. The economic opportunity aspect of the SSCF program, while an important issue, is different from the aims of AFK's activities. Likewise, COMBAT focuses on the response to VAWG incidents—not the prevention—and is developed within the rural context—not in urban informal settlements where AFK's programs are delivered.

All the complementary programs mentioned (i.e. Communities Care, SASA!, and REAL Fathers) emphasize utilization of community members as volunteers to deliver interventions, thus highlighting the importance of a community-led program to reduce the burden of IPV. Although a survivor-centered response to VAWG is of the utmost importance in a survivor's healing process and reinstatement of her autonomy, objective (i) of the Communities Care program does not overlap with the work of AFK. AFK is not staffed by healthcare workers and does not routinely respond to or support VAWG survivors in the acute post-incident period. Further, Communities Care is designed for implementation in conflict-affected areas. The communities served by Ambassadors Football are indeed vulnerable, food insecure, and experience high levels of poverty; however, their structure is dissimilar to those served by Communities Care as they have not experienced a recent upheaval due to conflict like that experienced in Somalia or South Sudan.

Though the REAL Fathers initiative was effective in reducing IPV incidents at long-term follow-up in Uganda, the intervention population is restrictive when compared to that targeted by AFK. AFK's current strategy plans to expand its reach to girls and young women football

players. Limiting an intervention to fathers only, specifically fathers of small children who are too young to participate in AFK's programs, would limit its reach and success in light of AFK's strategy. Further, focusing only on partnered, young fathers would exclude unpartnered men who may not live in the same household as their children, as well as those who are not fathers and prone to use violence against women. The REAL Fathers initiative evaluators acknowledged the limited impact on changing men's views of gender and social roles, as earlier discussed.

Although one of its goals relates to the reduction of HIV acquisition risks in women, which does not directly correlate to AFK's mission, SASA! community mobilization program offers many avenues for members of the communities served by AFK to get involved and affect the issues that are most important to them. In addition to its activities being delivered by volunteers, SASA! materials and trainings do not require a background in public health or other expertise to be effectively delivered. Rather, it encourages activity leaders and participants to understand the concept of power imbalance as the key driver of VAW. Further, the SASA! program has been extensively studied and evaluated in similar contexts to that in which AFK operates: urban informal settlements. Finally, SASA! displays strong outcomes and measurable impact. For example, in a study performed by Abramsky et al. (2016), it was noted that women's past year experience of IPV in the SASA!-intervention group decreased from 25% to 9%, compared to 21% to 22% in the control group, respectively. Likewise, men's past year perpetration of IPV in the SASA!-intervention group was reported at 31% at baseline compared to 20% at follow-up, compared to 31% to 49% past-year perpetration in the control group, respectively.[1]

Given its strong evidence base, relative ease of implementation and extensive resources available, it appears that the SASA! community mobilization is the best fit for AFK's activities

and place in the communities in which it serves. Moreover, in recognition of the positive impact realized by the widespread implementation of the SASA! program, its developers, Raising Voices, went on to recognize the need of a specialized program for faith communities and develop a partner program: SASA! Faith.[11] Given AFK's partnership with and physical location within International Christian Centre at Imara Daima, the SASA! Faith program is best aligned with the goals and activities of AFK.

SECTION III - PROGRAM PLAN – SASA! FAITH

Overview

The premise of SASA! Faith states:

> Around the world, women are at increased risk of experiencing violence if they live in communities with norms that accept violence and value men over women. While factors such as alcohol use or poverty contribute to the perpetration of violence, the imbalance of power between women and men is a root cause of violence against women.[12]

It is by upending this power imbalance and interrupting the social norm that violence against women is an acceptable relationship tool that SASA! Faith differs from many other VAWG prevention programs. Through a series of networking events, trainings, convenings, informal discussions, and marketing campaigns originating within and led by the community, SASA! Faith aims to change these social norms and views on the value of women in society. A key difference between SASA! and other violence prevention programs is the lens through which this power imbalance is explored – emphasis is placed on the positive value women bring to their families, communities and society rather than blaming or shaming men – thus allowing for productive, candid discussions around these relationships and power dynamics.[12] SASA! Faith is an adaptation of the SASA! Activist Toolkit which was originally developed and implemented in

Kampala, Uganda from 2006 – 2008. The SASA! framework is currently being used in 60 institutions and organizations across more than 20 countries.[11]

Program Context

Political Environment and Consistency with National Priorities

The burden of violence against women is a public health crisis, globally and locally. Its prevention is aligned with Kenya's national priorities, as evidenced by the many laws and policies enacted by the Kenyan Government aiming to prevent and control the various forms of VAW, including the Constitution of Kenya (2010), the 2006 Sexual Offences Act, the Children's Act of 2001, the 2009 Penal Code, the Prohibition of Female Genital Mutilation Act (2011), and the National Gender and Equality Commission Act of 2011.[3] As it relates to the public health sector, a Domestic Violence section was included in the Kenya Demographic and Health Survey for the first time in 2014, in recognition of the magnitude of the public health burden.[3]

Globally, VAWG is viewed as an inhibitor to sustainable development and its prevention is expressly affirmed in the target 5.2 of Sustainable Development Goal Number 5: Achieve gender equality and empower all women and girls. Target 5.2 calls for countries to "eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation".[13]

While global and national priorities align with programs seeking to reduce VAWG, the current political environment in Kenya is one of distrust. Anecdotally, VAWG survivors have an extreme lack of confidence in local authorities and the judicial system that perpetrators will be arrested or brought to justice in what is viewed as a corrupt system. These views impede case reports or even acknowledgement of VAWG as a widespread issue. There are documented and observed instances of Kenyan law enforcement demanding bribes or illegally detaining innocent

people.[14] While changing social norms and opening dialogue is a significant component of the shift from violence to peace in the household and communities, there ought to be real consequences for those committing illegal and violent acts.

Healthcare Barriers

Many women do not seek medical care after a VAWG incident. This may be due to many reasons: the perpetrator may further threaten their safety or that of their children, anticipated victim-shaming of healthcare professionals, the prevalent view that violence in the home is the family's business alone, or the high cost of emergency care.[2] Many hospitals require sizeable deposits to be prepaid in cash and remaining balances paid upon discharge in order to be able to leave the hospital. Most people do not have private insurance to help cover these costs and therefore, access to emergency medical services for acute injuries is limited for many people living in informal settlements.[15] Another barrier to uptake of medical care is the potential for secondary traumatization of survivors by medical practitioners. While treatment of survivors of sexual violence should be guided by trauma-informed practices, empathy, and compassion, many healthcare practitioners are not properly trained in these techniques, exhibit victim-blaming attitudes, or accept many myths about rape and sexual violence as truth. This fear of shaming and stigmatization prevents many survivors from seeking healthcare.[2] Engaging survivors and their partners in SASA! community discussions may help alleviate these barriers and may also require additional efforts on the part of the implementers to build trust and open communication especially with women who have experienced violence.

Stakeholders

There are many parties that require engagement during AFK's implementation of SASA! Faith. Immediate stakeholders include institutions and organizations AFK already engages with

as part of its ongoing activities: ICC Imara, players and their parents, schools and neighboring football clubs. Stakeholder buy-in from these parties for SASA! Faith implementation is important since they will all be central to its effectiveness. ICC Imara is a key stakeholder, given the sensitive topics to be addressed by SASA! Faith, as buy-in from the pastors will encourage ICC Imara members to feel comfortable participating in implementation efforts. AFK also partners with like-minded corporate institutions for financial and publicity purposes; these stakeholders may not be directly involved with SASA! Faith's implementation but should be kept apprised of the process as they may be able to provide logistical or financial assistance.

AFK will need to cultivate specific stakeholder relationships in its endeavor to implement the SASA! Faith curriculum: local activists and those committed to VAWG prevention, referral resources such as victim advocates, legal and medical practitioners who are trained to work with VAWG survivors, local law enforcement and community elders. Building relationships with organizations that focus on VAWG prevention and/or response in the same communities will also help to extend the reach of AFK's SASA! Faith implementation. Finally, and arguably the most vital, AFK will need to reach community members residing in the areas where it operates; namely, informal settlement dwellers near to the Imara Daima district of Nairobi.

Financial and Technical Resources

The SASA! Faith program is designed for utilization by thinly-resourced organizations: all guides, training manuals, worksheets, and posters are available at no cost on the Raising Voices website.[11] While extensive technical expertise in VAWG prevention is not required to deliver the interventions, identifying someone in the community with related background and experience will be helpful and ethically responsible. AFK engaged a volunteer public health graduate student with this experience to perform the initial baseline assessment and preparation

for the START phase of implementation. While hiring and compensating qualified, dedicated staff is ideal, SASA! Faith can be implemented by a small team of unpaid, yet committed, individuals. Many of the other resources called for in SASA! Faith are encouraged to be sourced by donations; for example, community members can donate their living areas for a neighborhood convening, or ICC Imara can provide light refreshments for focus group discussion participants.

Apart from identifying individuals who are committed and passionate about VAWG prevention, there will be expenses associated with SASA! Faith implementation. Namely, reproduction and printing of materials, flyers, brochures, posters, surveys, and worksheets. Additionally, miscellaneous sundries such as office supplies, whiteboards, writing utensils, refreshments for meetings and perhaps, transportation reimbursement for participants.

Program Theories and Logic Model

As discussed earlier, the SASA! intervention program draws upon theories of the Ecological Model[8] and the individual-level behavior Stages of Change Theory of Prochaska et al. (1992).[16] SASA! utilizes the Ecological Model as it considers determinants of health and how VAWG affects and is affected by multiple levels: individual level, interpersonal (or relationship) level, community level, and society level.[8] Likewise, "it addresses individuals' risk of experiencing or using violence as well as the norms, beliefs, and social and economic contexts that create the conditions under which IPV occurs".[8] Kyegombe et al. (2014) describes how SASA! is formulated to address these conditions succinctly and at the multiple levels affecting an individual's risk for experiencing VAWG in the following Ecological Model representation:

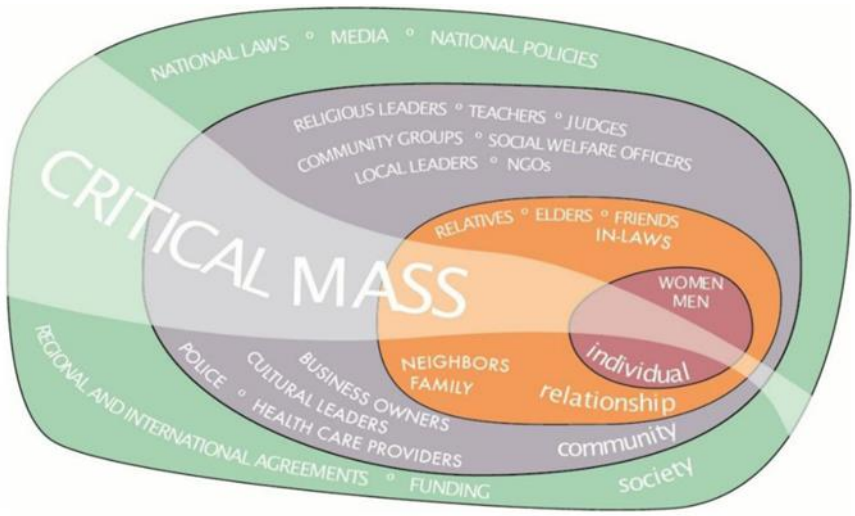

Figure 1: SASA! Ecological Model
Source: Kyegombe et al. (2014)

The premise behind the Stages of Change theory is that an individual's capacity to change is a process rather than a catalyzing event. According to this theory and, thus, SASA! Faith, an individual may pass through a five-stage process and various levels of motivation to truly adopt a new behavior and facilitate change: (i) Pre-contemplation; (ii) Contemplation; (iii) Preparation for Action (or Decision); (iv) Action; and (v) Maintenance.[16-17] SASA! Faith takes these individual change concepts and applies relevant activities at the community-level through each phase of implementation:

Stage of Change	Description	SASA! Faith Phase	SASA! Faith Activities
Pre-Contemplation	The person does not (yet) identify the issue or behavior as a problem	**START**	• Learn about community • Select Community Activists (CAs) & Foster "*Power Within*" staff & CAs
Contemplation	The person begins to identify the issue as a problem	**AWARENESS**	• Help CAs gain confidence • Encourage critical thinking about men's "*Power Over*" women
Preparation for Action	The person seeks information, support, and alternatives for making a change to behavior	**SUPPORT**	• Strengthening skills & connections between community members • Joining "*Power With"* others to support change
Action	The person begins to make a change in their life	**ACTION**	• Trying new behaviors, celebrating change • Fostering the "*Power To*" make positive change
Maintenance	The person sustains the changed behavior		

Table 1: Stages of Change and SASA! Faith Phases (adapted from Michau & Siebert, 2016)[17]

Goals and Objectives

The primary goal of the SASA! Faith community mobilization program is to reduce VAWG prevalence and prevent future incidence. SASA! Faith deconstructs its short-term and long-term objectives into implementation phases, as per Raising Voices (2016):

SASA! Faith START Phase Objective – 4 to 6 months

1. *Foster power within the team to address violence against women*
   a. Activities:
      i. "Create the SASA! Faith Team and Network, including the engagement of key religious leaders;
      ii. Identify community assets and services that could help with SASA! Faith;
      iii. Train and enable the SASA! Faith Team and Network to feel the *power within* themselves; and
      iv. Make initial community connections, spreading the word about SASA! Faith."[4]

SASA! Faith AWARENESS Phase Objective – 18 to 24 months

2. *"Engage the community to become aware of men's power over women, and the ways in which this power imbalance (manifested at both the relationship and societal level) perpetuates VAW."*[18]
   a. Activities:
      i. "Raise awareness in the faith community about the connection between VAW;
      ii. Introduce an analysis of men's power over women, and how this imbalance and the faith community's silence about it is the root cause of VAW…;

iii. Spark personal reflection, critical thinking and public dialogue about how the imbalance of power between women and men in relationships, families, and the faith community affects us all, and how change can benefit us all."[4]

SASA! Faith SUPPORT Phase Objective – 24 to 30 months

3. *"Engage the community to promote and facilitate individuals joining their power with others to confront the dual pandemic of VAW."*[18]

a. Activities:

i. "Provide religious leaders and faith community members with reasons and skills for joining *power with* others – specifically, with faith community members experiencing and confronting issues of power and violence…;

ii. Reach out to women directly affected by or living with violence…in the faith community;

iii. Foster formal and informal networking within and outside of religious institutions to build social support among women and men who are rethinking power imbalances in their relationships;

iv. Support individuals, groups, and religious leaders within the faith community with identifying positive alternatives to men's power over women and how they could act on these alternatives by joining their power with others".[4]

SASA! Faith ACTION Phase Objective – 30 to 36 months

4. *"Engage the community in using their power to take action, with the aim of normalizing shared power and non-violence, demonstrating its benefits, and as a result, preventing VAW."*[18]

a. Activities:

i. "Encourage personal and public choices and changes toward balancing power in relationships;

ii. Assist individuals, groups, religious leaders and religious institutions to sustain personal and institutional changes that promote nonviolence between women and men;

iii. Celebrate positive changes that contribute to an environment that promotes healthy and safe relationships, families and communities;

iv. Work closely with those within religious institutions to create policies and practices that sustain positive change."[4]

Figure 2 outlines these theoretical frameworks with links to summaries of activities, outcomes, and impact:

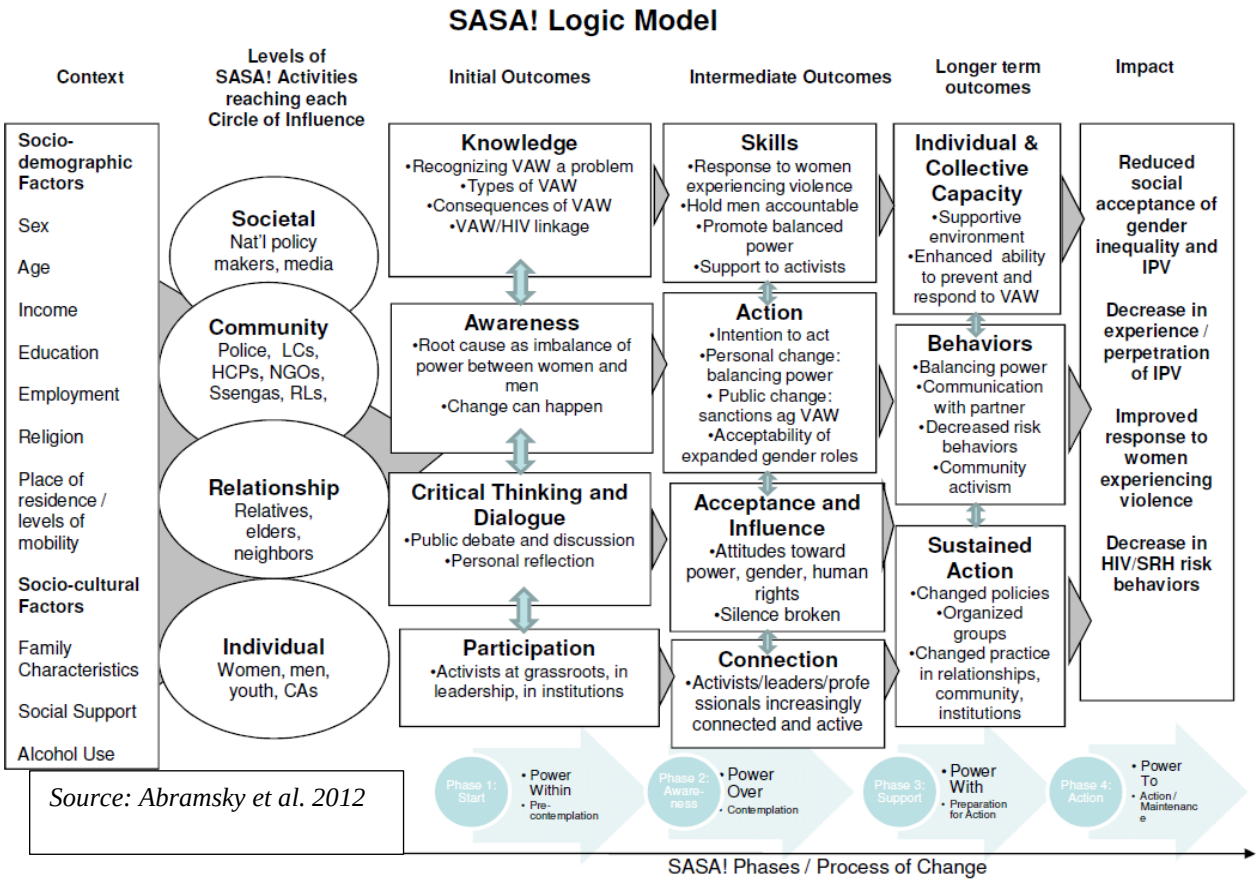

Figure 2 – SASA! Logic Model[19]

Implementation

SASA! Faith implementation with AFK began during August 2019, with the START phase. The START phase commences with a baseline assessment of community knowledge, attitude, behaviors, and norms. Subsequently, START phase activities primarily involve the identification and assembly of resources: SASA! Faith Team and Network members, mobilizing the broader faith community, connecting with media outlets, and self-evaluation for progression to the next phase of implementation. SASA! Faith cautions the implementation team that the START phase is largely program set-up, and that there is no formal activity monitoring to perform. Once activities conclude, the Team is to perform a critical self-review to determine whether the next phase of implementation should commence. Activity checklists are provided to facilitate this assessment.[4] Section IV includes further details of the implementation plan and outcomes associated with START phase implementation.

SASA! Faith AWARENESS phase implementation consists of preparing the SASA! Faith Team and Network and mobilizing the broader faith community. First, all materials, worksheets, and training modules must be reviewed for cultural relevance and consideration should be given to translation and adaptation, where necessary (since the program was developed in the Ugandan context). All members of the SASA! Faith Team and Community Activists (CAs, identified as part of START phase) are trained for AWARENESS phase content which focuses on raising awareness about men's *power over* women as the root cause of VAW. Following, the SASA! Faith Team organizes regular meetings internally, with CAs, Community Action Groups (CAGs), and key religious leaders to facilitate AWARENESS phase activities and community outreach. Finally, an end-of-phase assessment is conducted to measure change from commencement of the START phase. [4]

SASA! Faith SUPPORT phase implementation consists of preparing the SASA! Faith Team and Network to engage the faith community in building the skills for change. Like the AWARENESS phase, all materials, worksheets, and training modules must be reviewed for cultural relevance and consideration should be given to translation and adaptation, where necessary. All members of the SASA! Faith Team and CAs are trained for SUPPORT phase content which focuses on providing support by joining *power with* others. Following, the SASA! Faith Team organizes regular meetings internally, with CAs, CAGs, and key religious leaders to facilitate SUPPORT phase activities and community outreach. Finally, an end-of-phase assessment is conducted to measure change from commencement of the START and AWARENESS phases. [4]

Lastly, implementation of the final, ACTION phase, consists of preparing and supporting the SASA! Faith Team and Network to engage the faith community in making personal and institutional changes. Likewise, all materials, worksheets, and training modules must be reviewed for cultural relevance and any translation or adaptation needed should be performed to maximize reach. All members of the SASA! Faith Team and CAs are trained for ACTION phase content which focuses on using our *power to* take action. Following, the SASA! Faith Team organizes regular meetings internally, with CAs, CAGs, and key religious leaders to facilitate ACTION phase activities and community outreach. Finally, an end-of-phase assessment is conducted to measure change from commencement of the START, AWARENESS, and SUPPORT phases. [4]

SECTION IV - SASA! FAITH START PHASE IMPLEMENTATION

Ambassadors Football Kenya (AFK) has a distinct opportunity to contribute to the reduction of VAWG in the communities it serves. Although not a traditional public health

institution, AFK's mission and activities are valued by local communities and partners, thus providing a unique way to reach populations. AFK began implementation of SASA! Faith during August 2019, which consisted of a staff training and baseline assessment performed by a volunteer with experience in the field of VAWG prevention.

Staff Training – Violence Against Women and Power

AFK Leadership and Staff were trained on the SASA! Faith START phase content as the first implementation activity, with 12 participants. In consideration of the baseline assessment to be performed as part of the START phase, it was crucial that individuals trained on SASA! content did not later become participants in the baseline data collection (or follow-up assessment). This precaution served to preserve the integrity of baseline results. Ideally, the training should have been conducted once the SASA! Faith Team and Network were assembled; however, AFK Leadership and the volunteer trainer determined that training AFK staff was a valuable prerequisite to identifying interest and commitment to SASA! Faith, given their lack of formal training on VAWG prevention and power dynamics.

Training modules covered Understanding Power: types of power, experiences, and choices; Power and Activism: Stages of Change and SASA! Faith power; Violence Against Women: understanding VAW and how violence impacts us; and People, Processes, and Change: circles of influence, motivations and barriers to change, and ideas into action. Note that the START phase training included a module covering HIV and AIDS which was excluded from the above content delivery due to the singular focus on VAWG prevention by AFK in this effort. Training was delivered using lecture, worksheets, partner and group activities and discussions. Participants appeared engaged and several requested follow-up discussions and materials for reference later.

Baseline Assessment: Data Collection

The baseline assessment was performed to assess the starting point knowledge, attitudes, behaviors, and norms of selected community members, using two methods of data collection: Rapid Assessment Surveys (surveys) and Assessment Dialogues ("focus group discussions" or FGDs). Refer to **Appendix 1** and **Appendix 2** for data collection tools utilized. Follow-up assessments to be performed at the end of each following phase (Awareness, Support, and Action) will be measured against the baseline measurements to assess program impact.

The volunteer trainer conducted a training on data collection fundamentals for all staff and volunteers planning to participate in data collection. This session included the importance of informed consent, risks to the participant, voluntary participation, and confidentiality practices as part of data collection. Participants were also instructed on how to administer surveys and facilitate FGDs. Male survey enumerators would seek male respondents, and female survey enumerators were to seek out female respondents, in order to limit potential for discomfort on the part of respondents. Further, data collection sites and groups were identified for sampling purposes, discussed below. Because data collection was performed as part of program implementation by AFK staff, and not by the volunteer, the activities were exempt from UNC Institutional Review Board approval. At the time of data collection, respondents were provided with referral lists, directing them to additional resources. Respondents were also advised that participation was voluntary and could be ceased at any point without judgment or consequence.

Data Collection Design and Methods

Rapid Assessment Surveys

SASA! Faith recommends collection 100 surveys, from 50 men and 50 women, across five large sites and three small sites in the communities of interest. A large site is one where at least 100 people pass through daily; a small site is one where less than 100 people pass through

daily. Potential respondents should be systematically and randomly selected, and such sample selection method is to be applied at every site consistently. The age of potential respondents should be verified to be over eighteen years old as the population of interests consists of adults over eighteen years old.

AFK identified eight survey enumerators ("the enumerator team"), three large survey enumeration sites, and seven small survey enumeration sites. Both male and female survey enumerators selected every third man and woman to approach for survey participation, respectively. Ultimately, the enumerator team collected 87 surveys across six community sites: 57 surveys from men and 30 surveys from women. The enumeration sites visited were ICC Imara (after Sunday morning services), Mukuru, Utawala Church (after Sunday services), an ICC prayer meeting, Imara Daima, and Kobil.

Assessment Dialogues

SASA! Faith recommends conducting at least four assessment dialogues, or FGDs, where two are comprised of male participants of similar age, and two are comprised of female participants of similar age, until saturation is achieved. While not required, a more productive dialogue may result if participants share a common attribute or interest, such as living in the same area or having children who attend the same school. Participants should be probed to elaborate on responses and statements made, without causing harm. Ideal group size consists of six to eight people, though discussions with as few as three participants may be conducted. Group discussions are to be led by a main facilitator, with assistance of at least one note-taker. At least one of the facilitators should be comfortable speaking in a local language other than English, in the case that English is a second language for a FGD participant. A debrief discussion

must be conducted by the facilitators after each FGD to share perspectives and identify or ensure common understanding of the main discussion themes.

AFK identified six potential FGD opportunities for male participant groups, and four potential female participant groups. The volunteer trained two female staff from AFK and three male staff for facilitation and note-taking. Over the course of two weeks, AFK facilitators, with technical assistance of the volunteer trainer, conducted the following FGDs:

- Two male-participant FGDs, comprised of AFK coaches and players' fathers;
- Two female-participant FGDs, comprised of AFK coaches, as well as coaches who participated in an AFK-hosted Ladies Fellowship event.

FGD groups ranged in size from three to six participants each.

Baseline Assessment – Results and Follow-up

The following is a summary of the key results of the baseline assessment survey enumeration and implications for AFK's SASA! Faith implementation:

Survey Results at Baseline	Program Implications
• Most respondents were aged 23 to 34 years old and achieved at least a secondary education level. • Most participating men were married, most participating women were single.	• AFK should ensure participation in SASA! Faith Team, Network, and activities is representative of community demographics. • Women are more likely to experience violence as they age,[2] so reaching men and women in their 20s and 30s may help to disrupt this cycle.
• Regarding VAWG knowledge, 40% of men agreed with the statement about rape not existing in marriage (due to a wife's role of providing sex whenever her husband wants). It should be noted this proportion of men were married at the time of response.	• Educating all community member participants about power imbalance between men and women and how this imbalance may look in a relationship is an important component of SASA! Faith. • A key principle in SASA! Faith implementation is around the concept of a positive dialogue. Individuals are not to be singled out and groups (i.e. male participants) not to be shamed for perpetuating power imbalance, or even perpetrating violence, during SASA! Faith activities. Rather, community dialogues focus on mutual understanding about how these dynamics affect all community members, and the community at large.[4]
• Attitudes of survey respondents: 44% of total participants, including 49% of men, responded that it is not acceptable for a married woman to ask her husband to wear a condom during sex.	
• Skills and Behaviors: More than half of all respondents indicated they have not done any of the following during the past twelve months: - helped a woman experiencing violence at home;	

- told a local leader/elder about violence in a nearby home; - spoken out against VAWG to others in the community	• SASA! Faith raises the topic of sharing responsibilities across gender roles and norms and has been proven effective in shifting perceptions about gender roles and social norms.[8] • Positive indications of SASA! Faith principles reaching community members and making impact will include incrementally higher proportions of survey participants disagreeing with statements such as these and affirming a woman's autonomy and power to make decisions in future follow-up assessments (after AFK's implementation of SASA! Faith phases two through four).
• More than two thirds of survey participants have not heard of SASA! Faith nor seen any of its materials before the survey.	

The following figures further demonstrate these survey results across the 87 respondents at baseline:

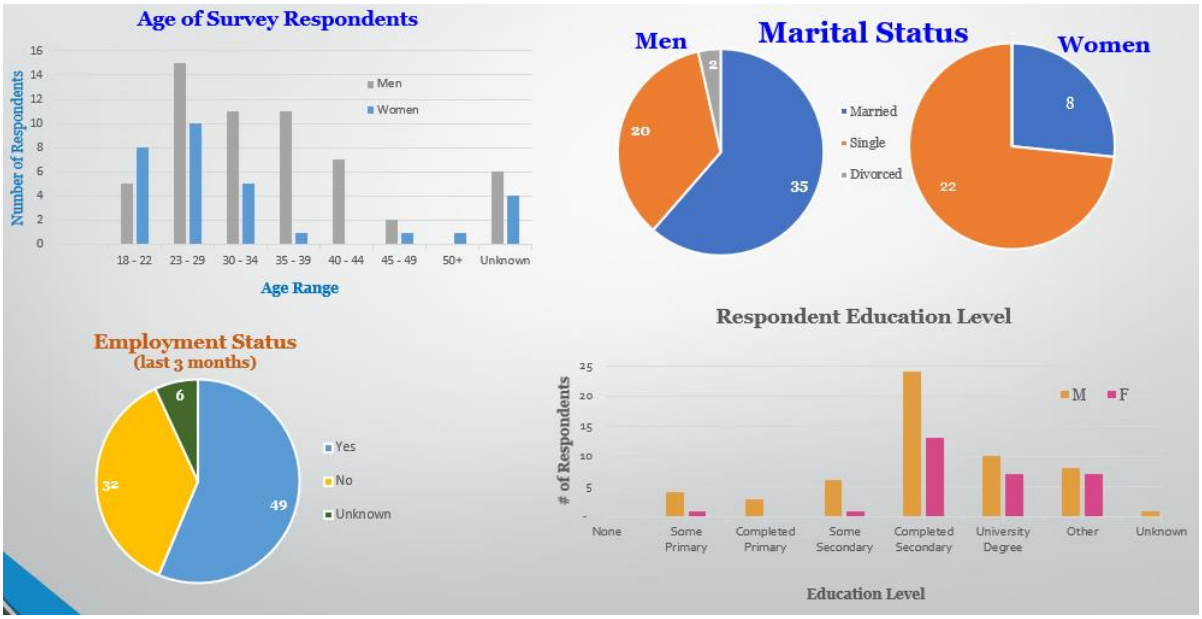

Figure 3 – Survey Respondent Demographics

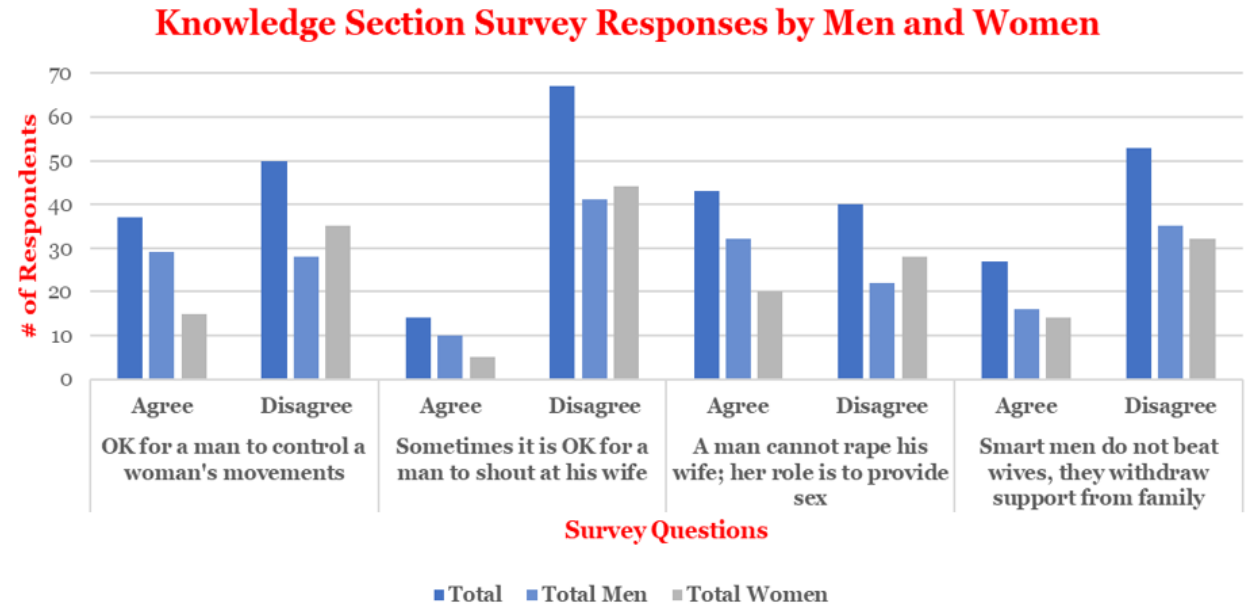

Figure 4 – Survey Section 1 Responses disaggregated by sex

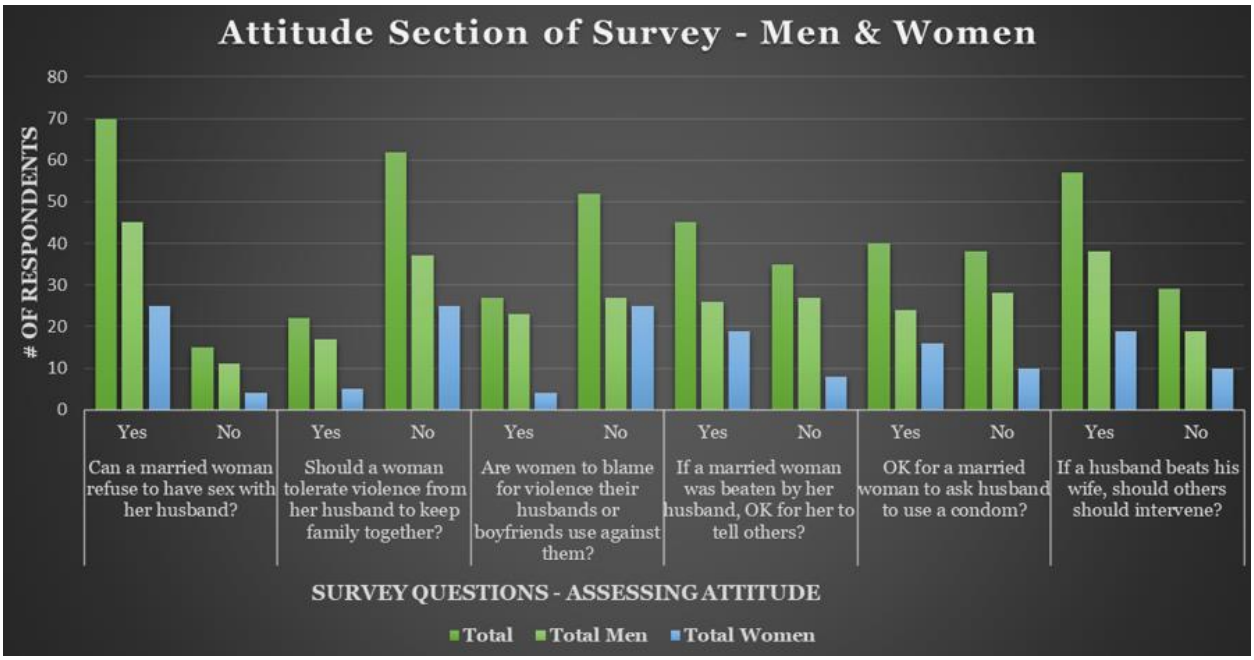

Figure 5 – Survey Section 2 Responses disaggregated by sex

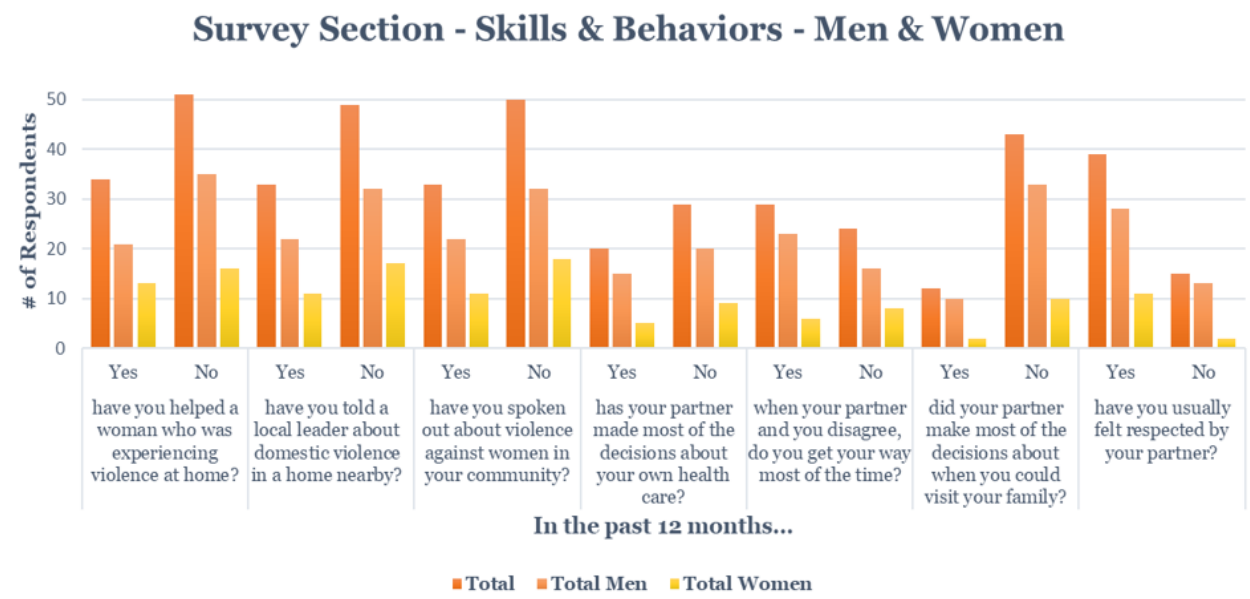

Figure 6 – Survey Section 3 Responses disaggregated by sex

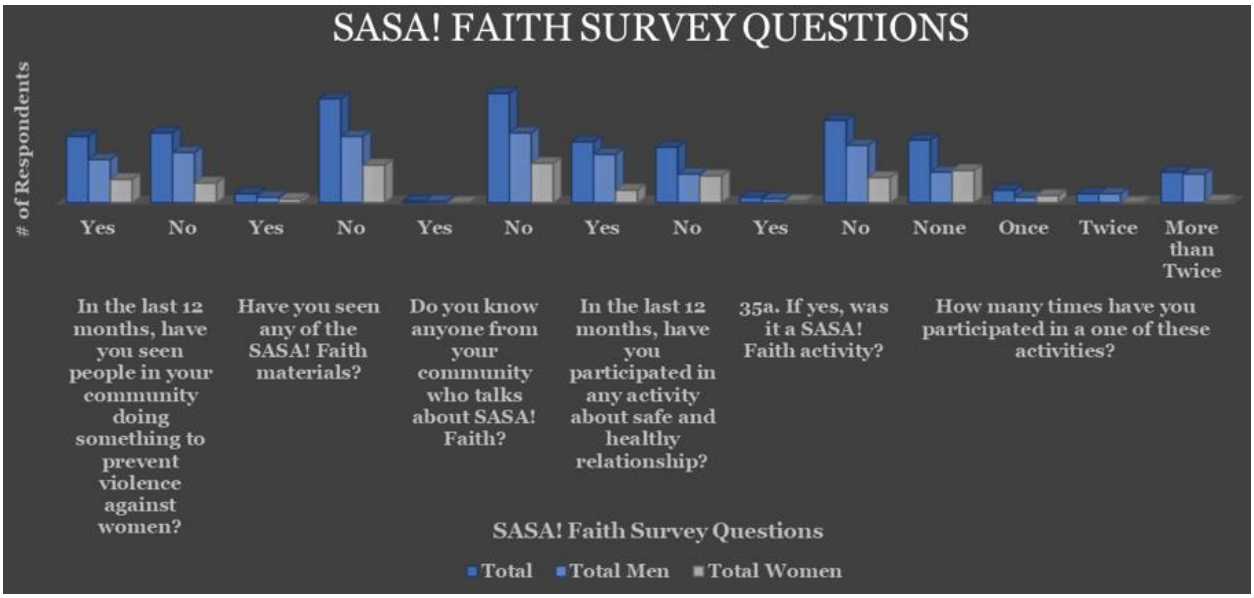

Figure 7 – Survey Section 4 Responses, disaggregated by sex

The preceding survey results were supported by themes noted during FGDs. Overall, participants valued the opportunity to voice concerns without judgment or retribution and AFK is viewed as a safe space for both men and women to gather and train. Each FGD group provided candid views and responses to the discussion questions.

Men who participated often reported much inner conflict, stress, and external pressure about the societal role of the man as the family provider and protector. These men felt the need to always show strength, within and outside the household, and felt they would be, or have been, stigmatized for showing any emotion. This strength was demonstrated often by exerting control, sometimes physically, over one's spouse. Some participants did not share the view that there was a power imbalance between men and women in Kenyan society nor that men had more privilege by virtue of their sex compared to women. Generally, male participants agreed that violence against women was wrong, but there was variability as to what constituted 'violence' or 'abuse'. For example, one participant stated that a man giving a woman "only one slap" was not considered violence. Some felt that much of household violence was instigated by a wife/partner's verbal abuse, which was compounded by coping mechanisms of substance use or gambling or by a man's unemployment status. Most male participants believed that what happened within a family should stay private, but bystanders should intervene if violence in the home was known in the community. Finally, few participants had participated in activities surrounding safe and healthy relationships, apart from pre-marital religious counseling, nor had any heard of the SASA! Faith curriculum prior to FGD participation.

Women who participated in the focus group discussions largely reported that violence against women, including transactional sex for survival, was a significant, yet unprioritized issue in Nairobi slum communities, where many of the participants resided. These participants believed there were none or few reliable options for recourse for VAWG survivors. Reporting to police or community elders (persons with elevated status in the community) was seen as futile, as most of these individuals were men and/or had social connections to the perpetrators. Further, there was insufficient coverage of these matters by the media. One woman gave the recent

example in her community (Mukuru) of five women who were murdered by their partners over the course of three months and "nothing was done" (i.e. perpetrators were not arrested, there was no media coverage, and no intervention by community members). There were mixed views on seeking support services through the church or religious institution, as couples were usually counseled to remain together despite known abuse in the relationship. However, in some cases, participants reported situations where church members rallied together to extricate female members from violent home situations. Mostly, bystanders feared retribution and would not intervene in these violent situations, though it was agreed that community action was needed.

In consideration of the continuation of START phase implementation, remaining activities consisted of identification and recruitment of staff and volunteers to comprise the various roles of the SASA! Faith Team and Network. Though there were no formal activities required for these groups during the START phase, the SASA! Faith Team and Network member engagement should commence, with regular meetings planned. A critical self-evaluation of the SASA! Faith Team should be performed prior to moving onto AWARENESS phase (2) implementation activities.

Data Limitations

Though the baseline assessment results will be used for comparison against future follow-up assessments to measure any impact of program activities, execution of data collection was limited by several factors.

Rapid Assessment Surveys

- *Surveys conducted were written only in English:* Though all enumerators spoke Swahili, some were more comfortable reading and speaking in English and, if surveying a respondent who preferred Swahili, would require real-time translation of the survey questionnaire. This

may have increased the risk of misinterpretation of the questions by the respondent or inaccurate real-time translation by the enumerator and, therefore, correspondingly the risk of inaccurate responses.

- *Lack of on-site enumeration supervision:* All enumerators were trained on the importance of remaining neutral in expression and language during survey administration, reading the questions as they were written, and preparing and debriefing after each survey collected. However, in order to limit desirability bias by respondents if the volunteer trainer and supervisor had been onsite, the supervisor debriefed with the team offsite at a later time. There was no mechanism to recognize and mitigate any interviewer bias that may have occurred due to enumerator behaviors or reactions to any survey responses.
- *Desirability or response bias due to males surveying females or females surveying males:* Enumerators were trained on the importance of performing same sex interviews (i.e. men surveying men and women surveying women). However, in several cases, men interviewed women and, more often, women interviewed men. The team was unable to determine whether or to what extent desirability or response bias occurred as a result of respondents' discomfort by an enumerator of a different sex.
- *Non-response bias that resulted from exclusion of planned survey sites:* Due to enumerators' scheduling conflicts or competing priorities, three planned survey sites were not completed, which resulted in a smaller sample size and potential non-response bias from potential respondents that were not included.
- *Incompleteness of several surveys:* Some survey questions and/or sections were left unanswered or blank. The team was unable to determine whether this was due to the unwillingness of the respondent to answer these questions or whether the enumerator

overlooked the question during administration. While these survey results were included within the data analysis, some sections, such as Section IV – Knowledge of SASA! Faith, had a low response rate relative to other sections of the survey.

Assessment Dialogues

- *Difficulty in recruitment of facilitators and participants:* Due to location of the FGD administration, relative to the targeted community, as well as lack of private transportation, it was logistically difficult for some people to attend an FGD at the agreed-upon time. In addition, some planned participants—such as football players who are parents whose children participated in Saturday morning football clinics—were unable or unwilling to take the time to stay for a discussion after dropping their children off.
- *Language barrier:* Though participants were encouraged to speak and respond in any language they felt most comfortable, there may have been information lost during the debrief sessions as the volunteer trainer did not speak Swahili; she was, therefore, unable to take notes for conversations in Swahili. This limitation will be mitigated in future phase implementations of SASA! since all facilitators and note-takers will be Kenyan and at least familiar with Swahili, if not fluent.

SECTION V – DISCUSSION

The results of the baseline assessment have important implications for Ambassadors Football's plans to intervene in the problem of VAW. The main objective of the baseline assessment was to determine (1) whether VAWG is a prevalent issue in the community and (2) whether community members recognize the issue as important to them. Though men and women viewed the issue of VAWG differently, both groups acknowledged that violence in the communities in which AFK operates was a significant problem that required action.

The SASA! Faith community mobilization program is supported by extensive, peer-reviewed evidence. The curriculum is comprehensive, accessible to non-public health practitioners, and relevant to the East African context, while allowing flexibility for different types of organizations to adapt the activities and practices to their operations and structure. Further, the community-driven aspect of the program ensures interested parties are part of the decisions that will affect them, increasing the likelihood of full-scale adoption and, ultimately, a change in social norms and behaviors around VAW and improving health status of these vulnerable populations.

Although the vehicle by which violence prevention interventions are delivered may be a program other than SASA! Faith, AFK has an ethical duty to its community to implement activities to reduce the public health burden of VAWG and its resulting adverse health effects.

REFERENCES

1. Abramsky, T., Devries, K. M., Michau, L., Nakuti, J., Musuya, T., Kiss, L., … Watts, C. (2016). Ecological pathways to prevention: How does the SASA! community mobilisation model work to prevent physical intimate partner violence against women? *BMC Public Health*, *16*(1), 15–17. https://doi.org/10.1186/s12889-016-3018-9
2. Munala, L., Welle, E., Hohenshell, E., & Okunna, N. (2018). "She Is NOT a Genuine Client": Exploring Health Practitioner's Mistrust of Rape Survivors in Nairobi, Kenya. *International Quarterly of Community Health Education*, *38*(4), 217–224. https://doi.org/10.1177/0272684X18781790
3. Kenya National Bureau of Statistics. Kenya demographic and health survey 2014, https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf 2014, accessed 10 November 2019.
4. Raising Voices. (2016). *SASA! Faith: A guide for faith communities to prevent violence against women and HIV*. Retrieved from http://raisingvoices.org/sasa-faith/
5. Ambassadors Football Kenya website: https://ke.ambassadorsfootball.org accessed 10-11 November 2019.
6. Read-Hamilton, S., & Marsh, M. (2016). The Communities Care programme: changing social norms to end violence against women and girls in conflict-affected communities. *Gender and Development*, *24*(2), 261–276. https://doi.org/10.1080/13552074.2016.1195579
7. Gibbs, A., Washington, L., Willan, S., Ntini, N., Khumalo, T., Mbatha, N., … Jewkes, R. (2017). The Stepping Stones and Creating Futures intervention to prevent intimate partner violence and HIV-risk behaviours in Durban, South Africa: study protocol for a cluster randomized control trial, and baseline characteristics. *BMC Public Health*, *17*(1), 1–15. https://doi.org/10.1186/s12889-017-4223-x
8. Kyegombe, N., Starmann, E., Devries, K. M., Michau, L., Nakuti, J., Musuya, T., … Heise, L. (2014). "SASA! is the medicine that treats violence". Qualitative findings on how a community mobilisation intervention to prevent violence against women created change in Kampala, Uganda. *Global Health Action*, *7*(1), 1–11. https://doi.org/10.3402/gha.v7.25082
9. Ashburn, K., Kerner, B., Ojamuge, D., & Lundgren, R. (2017). Evaluation of the Responsible, Engaged, and Loving (REAL) Fathers Initiative on Physical Child Punishment and Intimate Partner Violence in Northern Uganda. *Prevention Science*, *18*(7), 854–864. https://doi.org/10.1007/s11121-016-0713-9
10. Addo-Lartey, A. A., Ogum Alangea, D., Sikweyiya, Y., Chirwa, E. D., Coker-Appiah, D., Jewkes, R., & Adanu, R. M. K. (2019). Rural response system to prevent violence against women: methodology for a community randomised controlled trial in the central region of Ghana. *Global Health Action*, *12*(1). https://doi.org/10.1080/16549716.2019.1612604
11. Raising Voices website. http://raisingvoices.org/sasa/ accessed 10-11 November 2019.
12. Raising Voices. (2013). *SASA! Mobilizing Communities to Inspire Social Change*. 24. https://doi.org/10.1029/2011gl050226
13. UN SDG Knowledge Platform https://sustainabledevelopment.un.org/sdg5 accessed 11 November 2019.
14. Gilchrist, N., Eisen, N., Corruption and terrorism: The case of Kenya. Brookings blog. https://www.brookings.edu/blog/order-from-chaos/2019/08/22/corruption-and-terrorism-the-case-of-kenya/ 22 August 2019, accessed 11 November 2019.

15. Cheng, M. At many hospitals worldwide, you don't pay, you can't leave. Associated Press, AP News. 22 October 2018. Retrieved from https://apnews.com/4ea44fa54f6c4c0aaa510b3d183c3c23
16. Prochaska JO, Diclemente CC, Norcross JC: In search of how people change - applications to addictive behaviors. Am Psychol 1992, 47:1102–1114
17. Michau, L., & Siebert, S. (2016). A training manual to prepare everyone involved in SASA! Faith. Retrieved from https://www.trocaire.org/sites/default/files/resources/policy/sasa-faith-training-manual.pdf
18. Abramsky, T., Devries, K., Kiss, L., Nakuti, J., Kyegombe, N., Starmann, E., … Watts, C. (2014). Findings from the SASA! Study: A cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC Medicine*, *12*(1), 15–17. https://doi.org/10.1186/s12916-014-0122-5
19. Abramsky, T., Devries, K., Kiss, L. *et al.* A community mobilisation intervention to prevent violence against women and reduce HIV/AIDS risk in Kampala, Uganda (the SASA! Study): study protocol for a cluster randomised controlled trial. *Trials* 13, 96 (2012) doi:10.1186/1745-6215-13-96

Other references

Abramsky, T., Musuya, T., Namy, S., Watts, C., & Michau, L. (2018). Changing the norms that drive intimate partner violence: Findings from a cluster randomised trial on what predisposes bystanders to take action in Kampala, Uganda. *BMJ Global Health*, *3*(6), 1–15. https://doi.org/10.1136/bmjgh-2018-001109

Glass, N., Perrin, N., Marsh, M., Clough, A., Desgroppes, A., Kaburu, F., … Read-Hamilton, S. (2019). Effectiveness of the Communities Care programme on change in social norms associated with gender-based violence (GBV) with residents in intervention compared with control districts in Mogadishu, Somalia. *BMJ Open*, *9*(3), 1–10. https://doi.org/10.1136/bmjopen-2018-023819

Starmann, E., Collumbien, M., Kyegombe, N., Devries, K., Michau, L., Musuya, T., … Heise, L. (2017). Exploring Couples' Processes of Change in the Context of SASA!, a Violence Against Women and HIV Prevention Intervention in Uganda. *Prevention Science*, *18*(2), 233–244. https://doi.org/10.1007/s11121-016-0716-6

Starmann, E., Heise, L., Kyegombe, N., Devries, K., Abramsky, T., Michau, L., … Collumbien, M. (2018). Examining diffusion to understand the how of SASA!, a violence against women and HIV prevention intervention in Uganda. *BMC Public Health*, *18*(1), 1–20. https://doi.org/10.1186/s12889-018-5508-4

USAID Maternal and Child Survival Program. (2017). *Kenya—Selected Demographic and Health Indicators Indicator Data Indicator Data Indicator Data*. (March), 1–6. Retrieved from http://www.mcsprogram.org/wp-content/uploads/2017/04/Kenya-Country-Summary-March-2017-1.pdf

APPENDIX 1 – RAPID ASSESSMENT SURVEY TOOL

SASA! Faith Rapid Assessment Survey

Hello, my name is _____ and I am working with _____to help them learn about your faith community. If you don't mind, I would like to ask you a few questions about your thoughts about men and women's health, relationships and what happens in families in our community. This should not take much of your time, and you can choose to stop the interview at any time, or to skip any questions if you like. Your responses are confidential, and your name will not be written down. We will use the information that you provide to plan activities, and to see how well we are doing in our work.

Do you have any questions?

Are you happy to proceed with the interview? Yes ☐ No ☐
(IF NO, THANK AND SAMPLE SOMEONE ELSE)

SECTION 1: About the respondent

1	*Record the respondent's sex*	FEMALE ..... 1 MALE 0
2	*Record the date of the interview*	DAY [ ][ ]MONTH [ ][ ] YEAR [ ][ ][ ][ ]
3	*Record the location of the interview*	CHURCH/MOSQUE..... COMMUNITY/VILLAGE.....
5	Have you participated in this faith community for at least 1 year?	YES.....1 NO.....0 (IF NO, THANK AND SAMPLE SOMEONE ELSE)
6	How old are you?	[ ][ ] (IF LESS THAN 18, THANK AND SAMPLE SOMEONE ELSE)
7	What is your marital status?	MARRIED ..... 1 SINGLE..... 0 WIDOWED ..... 2 CO-HABITING ..... 3 DIVORCED ..... 4 REFUSE TO ANSWER..... 9
8	What is your level of education?	NO FORMAL EDUCATION..... 0 COMPLETED PRIMARY EDUCATION..... 1 COMPLETED 'O' LEVEL..... 2 COMPLETED 'A' LEVEL..... 3 DIPLOMA HOLDER ..... 4 UNIVERSITY DEGREE..... 5 OTHER..... 6 REFUSE TO ANSWER..... 9
9	Have you been employed in the last 3 months?	NO..... 0 YES..... 1

SECTION 2: Knowledge and Attitudes

In this community and elsewhere, people have different ideas about families and what is acceptable behavior for men and women in the home. In these questions, we'd like to learn from you what you think about some of these issues. I am going to read some statements, can you please tell me if you agree or disagree with them? There are no right or wrong answers, please answer honestly.

Knowledge		
10	It is okay, for a man to control movements and determine friends for his wife as way to prove his authority over her.	AGREE ..... 0 DISAGREE ..... 1 REFUSE TO ANSWER..... 9
11	Sometimes as head of the family it is okay for the man to shout at his wife to prove his status.	AGREE ..... 0 DISAGREE ..... 1 REFUSE TO ANSWER..... 9
12	If a husband is violent toward his wife, she is at higher risk for getting infected by HIV.	AGREE ..... 0 DISAGREE ..... 1 REFUSE TO ANSWER..... 9
13	Women often experience violence from their husband after sharing their HIV positive status.	AGREE ..... 0 DISAGREE ..... 1 REFUSE TO ANSWER..... 9
14	A man cannot rape his own wife, since her primary role in marriage is to provide sex whenever her husband wants.	AGREE ..... 0 DISAGREE ..... 1 REFUSE TO ANSWER..9
15	Smart men do not beat their wives, they simply withdraw support from the family.	AGREE ..... 0 DISAGREE ..... 1 REFUSE TO ANSWER..... 9

Thank you very much. This next section is about what you think about common issues that come up in relationships between women and men as we are interesting in learning your opinion. Please answer yes or no and remember, there are no right or wrong answers.

Attitudes		
16	In your opinion, can a married woman refuse to have sex with her husband if she doesn't feel like it?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
17	Do you think that a woman should tolerate violence from her husband to keep her family together?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
18	Do you think that women are to blame for the violence their husbands or boyfriends use against them?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
19	If a married woman has been beaten by her husband, is it okay for her to tell others?	YES..... 0 NO 1
20	Do you think women are mostly to blame for bringing HIV to the household?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
21	Is it acceptable for a married woman to ask her husband to use a condom?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
22	If a husband beats his wife, do you think others outside the couple should intervene?	YES..... 0 NO 1

SECTION 3: Skills and Behaviors

In the next few questions, I am going to ask you about some common situations that happen in communities. We would like to know what you think about them. Please answer yes or no, there are no wrong answers, please be honest.

Skills and Behaviors		
23	In the last 12 months, have you helped a woman who was experiencing violence at home?	YES ..... 0 NO ..... 1 DOESN'T APPLY..... 8
24	In the last 12 months, have you told a local leader about domestic violence in a home nearby?	YES ..... 0 NO ..... 1 DOESN'T APPLY..... 8
25	In the last 12 months, have you spoken out about violence against women to others in your community?	YES ..... 0 NO ..... 1 REFUSE OR N/A 9
26	**If talking to a woman ask:** Do you regularly do things that are typically thought of as men's role? **If talking to a man ask:** Do you regularly do things that are typically thought of as a woman's role?	YES ..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
27	**If talking to a woman ask:** Does your partner regularly help with washing dishes in the home? **If talking to a man ask:** Do you regularly help with washing dishes at your home?	YES ..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
28	During the last 12 months, has your partner made most of the decisions about your own health care?	YES ..... 0 NO ..... 1 DOESN'T APPLY..... 3 REFUSE TO ANSWER..... 9
29	During the last 12 months, when your partner and you disagree, do you get your way most of the time?	YES ..... 0 NO ..... 1 DOESN'T APPLY..... 3 REFUSE TO ANSWER..... 9
30	During the last 12 months, did your partner make most of the decisions about when you could visit your family/relatives?	YES ..... 0 NO ..... 1 DOESN'T APPLY..... 3 REFUSE TO ANSWER..... 9
31	During the last 12 months, have you usually felt respected by your partner?	YES ..... 0 NO ..... 1 DOESN'T APPLY..... 3

SECTION 4: Exposure to *SASA! Faith*

Thank you so much, we are almost finished. These last questions are about what you see in your community about violence prevention. Please answer yes or no.

Exposure to SASA! Faith		
32	In the last 12 months, have you seen people in your community doing something to prevent violence against women?	YES ..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
33	Have you seen any of the *SASA! Faith* materials?	YES .....0 NO 1
34	Do you know anyone from your community who talks about *SASA! Faith*?	YES ..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
35	In the last 12 months, have you participated in any activity about safe and healthy relationship?	YES ..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
	35a. **If yes,** was it a *SASA! Faith* activity?	YES ..... 0 NO ..... 1 REFUSE TO ANSWER..... 9
36	How many times have you participated in a one of these activities?	NONE..... 0 ONCE..... 1 TWICE..... 2 MORE THAN TWICE..... 3 REFUSE TO ANSWER..... 9

Thank you for your time. I really appreciate you talking with me and sharing your thoughts.

Would you like a list of organizations/people who you could talk confidentially with about any of these issues?

(If yes, give referral list. If no, thank again and remind them of the name of your organization in case they are interested in follow up.)

APPENDIX 2 – ASSESSMENT DIALOGUE TOOL

Introduction:

Welcome and thank you for participating in today's discussion. We would like to understand your opinions and perspectives on men's and women's health and relationships, and behaviors in families and within your community.

Please be assured we will keep your answers confidential: we are not collecting anyone's names or other identifying information. Rather, we are conducting these discussions to gather information about the communities in which Ambassadors operates to help improve its programs and activities. Please also know that we are looking for your opinions and perspectives on different hypothetical situations and what may happen within the community; and are not asking you to divulge any personal situations or circumstances. There are no right or wrong answers, and little risk to your participation in this discussion; we hope you will feel comfortable to answer honestly and without judgment. You may participate in as little or as much of the discussion as you'd like and may leave at any time without consequence.

Thank you very much for your time and participation today. Is everyone okay to get started?

---

1. **What are the gender roles of men in your community? Women? Boys? Girls?**
    - Who decides what the gender roles are?
    - Do you feel pressure to adhere to the gender role expected of you by the community or society? Why or why not?
    - What may happen to those community members who do not adhere to these expected gender roles?

2. **In general, who makes decisions within the family structure, in your community?**
    - What kind of decisions does this person make (for example, financial, childcare and child rearing, education, household chores)? Please explain.
    - What happens when someone in the family does not adhere to the decisions made for others in the family?
    - Do you agree with these social roles in the family?
    - Do you agree with the consequences if they are not met? Why or why not?

3. **What are some of the general views about power in your community?** ***[Power can include decision-making power, personal autonomy or choice, and voice]***
    - Who in the family unit has or should have power? In the church? Other parts of the community?
    - Are people treated differently if they are seen as having or lacking power?
    - Are there ever situations where you think this power is misused or abused? Please explain. Do you think this is ever or sometimes okay?

4. **Is violence considered acceptable in the home, school, workplace or church? When and why? *[remember: physical, sexual, emotional, economic]***
    - What kind of violence is acceptable?
    - What kind of violence is NOT acceptable?
    - Do people in the community talk about this kind of violence?
    - How do people in the community see or talk about those people who carry out violence?
    - What are the community member perceptions of those who experience violence?

5. **How do you think violence against women and girls in the community affects different groups, such as women?**
    - Think about violence in schools, the workplace, church, at home.
    - How do you think this violence affects others in the community, such as:
        i. men,
        ii. children,
        iii. families,
        iv. religious groups,
        v. the larger community?
    - Do people feel comfortable discussing these situations with others? If so, who? If no, why not?

6. **Are there consequences for those who perpetrate violence against women? What kind? If no, why not?**
    - Are there consequences for women or children who speak out about violence or abuse they've experienced? What kind?
    - How are perpetrators of violence treated in the community?
    - How are survivors of violence treated in the community?

7. **What would you do if someone told you about abuse or violence they are experiencing? For example, a woman or child in your social group, church, or the larger community**
    - Do you think *their* status in the community would be affected if people knew? Why?
    - Do you think *your* status in the community would be affected if you spoke out?
    - Thinking about the effects of violence against women on members of the community. Do you think it's an issue that needs to be addressed by everyone in the community? Why or why not?

Conclusion:
This concludes our discussion. Thank you again for your participation! We really appreciate your time and your thoughts.