The SASA! Study: a cluster randomized trial to assess the impact of a violence and HIV prevention program in Kampala

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Abstract

Background

Intimate partner violence against women is a violation of women’s human rights, a serious public health concern, and a common experience worldwide. HIV infection also disproportionately affects women, with 58% of those living with HIV in sub-Saharan Africa (the region most affected by HIV/AIDS) being women. Gender and power inequalities are at the root of both of these epidemics, increasing women’s vulnerability to both intimate partner violence and HIV acquisition. SASA! is a community mobilisation intervention that seeks to prevent violence against women and reduce HIV-risk behaviours. It was designed by Raising Voices, and is implemented in Kampala by the Centre for Domestic Violence Prevention, both of which are Ugandan-based NGOs.

The SASA! study

The SASA! study was conducted between 2008 and 2012 in two administrative divisions of Kampala (Makindye and Rubaga). It incorporates four elements: a cluster randomised controlled trial (CRT); a nested qualitative evaluation; operations research and an economic costing of the intervention. As detailed in the SASA! trial protocol, the trial has six primary outcomes: attitudes towards the acceptability of violence against women and the acceptability of a women refusing sex (among female and male community members); past year experience of physical intimate partner violence and past year experience of sexual partner violence (among women); appropriate community response to women experiencing violence (among women reporting past year physical or sexual partner violence); and past year concurrency of sexual partners (reported by men with a primary partner). Given the small size of the trial, in the final analysis we not only assessed the statistical significance of each outcome, but also considered the consistency of findings between outcomes. The qualitative research similarly aimed to assess the plausibility of the findings, and explore the pathways and processes through which SASA! is affecting change at the individual and community level.

Results

The findings are extremely positive. SASA! reduced the reported social acceptance of physical violence in relationships among both women (AOR 0.54 (0.37 – 0.80) and men (AOR 0.13 (1.01 – 1.14)), and also increased the social acceptance of the belief that there are circumstances when a women can refuse sex from her partner (AOR 1.31 (1.01 – 1.70) for women, 1.28 (1.06 – 1.54) for men). The levels of physical partner violence occurring in the past year reported by women were 52% lower in the SASA! intervention communities compared to the control (AOR 0.48 (0.16 – 1.39)). Women in intervention communities who had experienced violence were over twice as likely as women in control communities to report that they experienced a supportive community response, although this was not significant due to small numbers in each cluster. The findings also suggest that SASA! impacted significantly on the reported levels of sexual concurrency, with 27% of partnered men in intervention communities reporting having had other sexual partners in the past year, compared to 45% of men in the control communities (AOR 0.57 (0.36 – 0.89)).
These quantitative findings are strongly supported by the qualitative findings. In depth interviews with stakeholders and community members suggest that these results were achieved through SASA!’s influence on the dynamics of individual relationships, as well as its impact on broader community norms. At the relationship-level, SASA! helped couples explore the benefits of mutually supportive gender roles and encouraged improved communication, joint decision-making and problem solving between couples. This resulted in reduced relationship tensions and disharmony, the more deliberate effort by individuals to work together for the good of their relationship and family, and an increase in intimacy within the relationship.

At the community level, SASA! helped foster a climate of non-tolerance of violence against women by reducing the acceptability of violence against women and improving individuals’ skills, willingness and sense of responsibility to reduce violence against women in their communities. It also helped to develop and improve formal and informal community-based support mechanisms and services to support this.

**Policy recommendations**

A number of stakeholder-specific policy recommendations have arisen out of this study. *For the Government of Uganda* (GoU) the study highlights the importance of their continued support to the implementation of SASA! in Busoga in Eastern Uganda, as well as for a long-term, nationwide campaign to shift social norms linked to violence against women. This will require adequate funding of implementing Ministries and agencies and would be aided by mandatory training for all government service providers and the implementation and enforcement of relevant legislation that supports gender equality in Uganda. *For organizations that work to prevent violence against women* the study has highlighted the value of investing in social norm change interventions at the community level. While this has been shown to be achievable within project time frames, it requires high intensity programming through a combination of communication channels and must be preceded by a process of internal reflection by staff in order that they are able to support community activists to implement SASA!. *For development partners* community mobilisation interventions require longer-term funding and support for this type of intervention should only be provided with this understanding in mind. *For researchers* rigorous studies and evaluations should only be applied to strong well-articulated interventions which build on the synergies developed through meaningful partnerships between research and programme teams.
1.0 Introduction

1.1 Background and study rationale

Intimate partner violence (IPV) against women is recognised as a violation of women’s human rights. It is also a serious public health concern given its negative impact on women’s physical, mental and emotional health (Devries, Mak et al. 2013, Stöckl, Devries et al. 2013). Furthermore, IPV against women is a common experience worldwide. (Campbell 2002, Garcia-Moreno, Jansen et al. 2006, Heise 2011, Abramsky, Devries et al. 2012) Indeed recent global estimates of the prevalence and health effects of violence against women indicate that 30% of women will experience physical or sexual violence from an intimate partner during their lifetime. (Devries, Mak et al. 2013)

The gendered nature of HIV/AIDS epidemic is also increasingly recognised particularly in sub-Saharan Africa, the region most severely affected by HIV, where women and girls constitute 58% of those living with the virus. (Joint United Nations Programme on HIV/AIDS (UNAIDS) 2012)

Underlying women’s risk of both IPV and HIV is gender inequality, which is both a cause and consequence of women’s lower socioeconomic and political status, their unequal access to education and employment and their exposure to violence. (Joint United Nations Programme on HIV/AIDS (UNAIDS) 2012). Inequalities in power also reduce women’s ability to protect themselves from HIV infection, including their ability to negotiate sex or insist on condom use. Furthermore, gender and power inequalities may increase women’s risk of violence following a diagnosis of HIV, which in turn may reduce women’s willingness and ability to test for HIV, disclose their status or seek treatment. (Maman, Mbwambo et al. 2001, Dunkle, Jewkes et al. 2004, World Health Organization 2006, Jewkes, Dunkle et al. 2010, Joint United Nations Programme on HIV/AIDS (UNAIDS) 2012).

Norms and expectations around men’s and women’s behaviour within and outside of intimate partner relationships further increase women’s exposure to both IPV and HIV, particularly where notions of masculinity and femininity dictate men’s dominance and control of women whilst also requiring women’s subservience and obedience to men.

Relatively few violence and HIV prevention interventions, that seek to address gender inequality or directly empower women, have been subject to rigorous impact evaluation. (Abramsky, Devries et al. 2012). Examples include the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) Study conducted in the Limpopo province in rural South Africa; an evaluation of Stepping Stones, conducted in the Eastern Cape Province in South Africa; an evaluation of Program H in Rio de Janeiro, Brazil, and a Men and Women in Partnership intervention in Cote d’Ivoire. (Abramsky, Devries et al. 2012)

1.2 The SASA! study: objectives and design

The SASA! study was conducted in Kampala, Uganda and is an evaluation of SASA!, a community mobilisation intervention focused on addressing the gendered power imbalances and social norms which perpetuate both violence against women and HIV risk-related behaviours. The SASA! study is the first community randomised controlled trial (CRT) in sub-Saharan Africa to seek to assess the community-level impact of a violence against women and HIV prevention intervention programme, rather than solely assess the impact of interventions on direct intervention recipients. Because of this, the
findings are extremely important to the field of violence prevention and are highly anticipated, as they will provide important new evidence on the potential for community focused social change interventions to achieve the community-level primary prevention of IPV and HIV infection.

As detailed in the SASA! trial protocol, the primary objective of the SASA! study was to assess the impact of SASA! on six primary outcomes, chosen to reflect the broad scope and complex nature of the intervention:

- the acceptability of men’s use of physical violence against a partner (among female and male community members);
- the acceptability that a woman can refuse sex with her partner (among female and male community members);
- past year experience of physical intimate partner violence (among women);
- past year experience of sexual intimate partner violence (among women);
- appropriate community response to women experiencing violence (among women reporting past year physical or sexual partner violence); and
- past year concurrency of sexual partners (reported by non-polygamous men).

Other objectives of the SASA! study were to:

a) Conduct a qualitative evaluation of SASA! in order to investigate the process and causal pathways through which the intervention operated.

b) Conduct operations research in order to document the scale and nature of programme implementation over time.

c) Conduct a full economic costing of SASA!, to learn more about the costs and cost-effectiveness of SASA!.

1.2.1 Design of cluster randomised controlled trial

The trial involved a pair matched cluster randomised trial with randomisation conducted within matched community pairs. Four communities were randomly selected to receive the full intervention from baseline and four communities wait-listed to receive the intervention at the end of the trial. Two cross-sectional surveys were conducted, one at baseline before implementation of the survey (2008) and one four years later (2012). A total of 1583 respondents were interviewed at baseline (717 women, 866 men) and 2532 respondents were interviewed at follow-up (1130 women and 1402 men). A cluster level analysis was used to compare outcomes in intervention and control communities at follow-up. Given the small number of communities in the trial, in the final analysis we not only assessed the statistical significance of each outcome, but also considered the consistency of findings between outcomes (Habicht, Victora et al. 1999).

The study was conducted in accordance with WHO guidelines for the safe and ethical collection of data on violence against women (Watts, Heise et al. 1999). These guidelines seek to minimise reporting biases and risk of harm to both respondents and interviewers. Interviewers received at least three weeks of training on the ethical and methodological issues surrounding the conduct of a survey relating to IPV and HIV. Interviews were conducted in private settings, by interviewers of the same sex as the respondent and trained in what to do in the event of an interruption. Interviews were concluded by providing information on additional support services in the area.
1.2.2 The Qualitative evaluation

Complementary qualitative research was conducted, to provide a more in-depth understanding of the pathways and processes through which SASA! is operating as well as community members’ experiences and perceptions of it. At baseline 64 in-depth interviews and 12 focus group discussions were conducted with a variety of participants including community members, program implementers, religious leaders and the police. At follow-up a further 92 in-depth interviews were conducted and again reflected a cross-section of the community including community members, community activists, local leaders and traditional leaders.

As with the quantitative analysis, the qualitative research similarly aimed to assess the plausibility of the findings, and explore the pathways and processes through which SASA! is affecting change at the individual and community level.

1.2.3 Operations research

Over the course of the implementation of SASA! a large amount of data was collected. These included over 6000 process reports, over 750 impact monitoring reports and six rapid assessment surveys. These data were used to monitor the progress of SASA! implementation as well as inform key programming and research decisions.

1.2.4 Economic Costing

A full economic costing of SASA! was conducted, from a provider perspective. For this, an ingredients approach was used, where the total costs of the intervention was estimated using detailed data on the inputs needed to start up and deliver the intervention in Kampala. Cost elements included both the costs of developing the SASA! materials, as well as the programmatic costs of supporting key activists and stakeholders. An important element of this costing was assigning a value to the voluntary time given by community activities. As such, the full economic costs of the intervention reflect both the costs of developing and delivering the intervention, incurred by Raising Voices and the Centre for Domestic Violence Prevention, as well as the value of the time donated by community activists, that form a core part of the intervention delivery.

Analysis of the data arising from the operations research and the costing study, as well as secondary analysis of the trial data, is on-going and as such, the findings will not be included in this report.

1.3 Overview of the report

This report is divided into six sections. In the section that follows, the study context will be elaborated, highlighting key aspects of the context that are important for understanding the communities in which SASA! was implemented. In Section 3, the SASA! intervention is described in more detail and the logic model that underlies SASA! is explained. The implementation of the SASA! intervention is described in Section 4, including a discussion of the challenges that were encountered during the process of implementation. The findings of the primary analysis of the trial data are presented in Section 5, focusing in particular on the impact of the intervention on the primary outcomes. A summary of the main findings from the qualitative evaluation of SASA! is
also provided. Policy recommendations arising out of the study are provided in Section 6 of this report.
2.0 Study Context

The SASA! study was conducted in eight communities, comprising twelve parishes, in two administrative Divisions of Kampala District – Makindye Division and Rubaga Division - both of which had not had any prior exposure to SASA! These communities contained approximately 66,500 households and 251,500 inhabitants. The communities were relatively impoverished and characterised by concentrations of people who had migrated from other parts of Kampala and Uganda in search of employment. (Abramsky, Devries et al. 2012)

Mobility in many parts of the study area is high, with people moving in search of employment opportunities and improved living conditions.

2.1 Demographic characteristics

Based on the findings of the baseline data collection, the population of the study communities was relatively young (40% of respondents were 25 years of age or younger and dominated by the Baganda ethnic group. The dominant language was therefore Luganda although, as in the rest of Kampala, the study sites were culturally diverse with a number of different tribal groups and mother tongues represented in the area. (Abramsky, Devries et al. 2012). The most highly represented religion was Catholicism although Protestants, Muslims and born again Christians are also well represented (see Table 1)

2.2 Socio-economic characteristics

The findings of the baseline data collection also indicate that more than two thirds of study respondents lived in rented accommodation and that approximately a third of men and almost two-thirds of women had either not completed, or not progressed beyond primary education. The majority of households lived on low incomes with informal sector self-employment a dominant livelihood option for most residents.

Patriarchy - the concentration of both individual and institutional power in the hands of men – is a dominant aspect of the social-cultural context. Through this, men are considered the head of the household and women are expected to be subservient to them.

2.3 Prevalence of intimate partner violence and HIV

HIV prevalence in the study communities is high. The 2004-2005 HIV/AIDS Sero Behavioural Survey estimated HIV prevalence in Kampala to be 12% among women and 5% among men, higher than the national average. Findings from the baseline study also indicate that 27% of women have experienced physical or sexual violence from an intimate partner in the past year. Violence is commonly accepted, with the 2011 Uganda national Demographic and Health Survey suggesting that violence against women is
widely accepted in Uganda, with 73% of women and 57% of men believing, for example, that there are circumstances when beating a wife is acceptable. There is also emerging evidence of the links between exposures to violence against women and HIV – with recent evidence from cohorts in Rakai in Central Uganda, suggesting that women who had experienced physical and/or sexual violence had an adjusted incidence rate ratio of incident HIV infection of 1.55 (95% CI 1.25-1.94, p=0.000), compared with women who had never experienced IPV.

### 2.4 Comparability of intervention and control sites at baseline

Intervention and control sites were highly comparable at baseline in terms of demographics, socio-economic characteristics and the outcomes under study (see Table 1). Some minor differences were observed for household-level indicators (with neither intervention nor control communities consistently better or worse across indicators); tribe among women; and religion, education and childlessness among men.

#### Table 1: Characteristics of respondents to baseline survey, presented separately for men and women in intervention and control communities

<table>
<thead>
<tr>
<th>Household-level</th>
<th>Interventio n Men n(%)</th>
<th>Control Men n(%)</th>
<th>chi-squared p-value</th>
<th>Interventio n Women n(%)</th>
<th>Control Women n(%)</th>
<th>chi-squared p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household has electricity</td>
<td>328/419 (78%)</td>
<td>367/447 (82%)</td>
<td>0.158</td>
<td>259/374 (69%)</td>
<td>264/343 (77%)</td>
<td>0.020</td>
</tr>
<tr>
<td>Main drinking water source – public tap</td>
<td>267/419 (64%)</td>
<td>324/447 (72%)</td>
<td>0.006</td>
<td>228/374 (61%)</td>
<td>212/343 (62%)</td>
<td>0.816</td>
</tr>
<tr>
<td>Toilet facility – traditional pit toilet/latrine</td>
<td>281/419 (67%)</td>
<td>268/447 (60%)</td>
<td>0.030</td>
<td>225/374 (60%)</td>
<td>203/343 (59%)</td>
<td>0.790</td>
</tr>
<tr>
<td>House is rented</td>
<td>279/419 (67%)</td>
<td>310/447 (69%)</td>
<td>0.383</td>
<td>231/374 (62%)</td>
<td>246/343 (72%)</td>
<td>0.005</td>
</tr>
</tbody>
</table>

#### Individual-level

| Age (yrs) | 27.1 (6.8) | 27.6 (7.0) | 28.4 (7.7) | 28.2 (7.7) | 0.001 |
| Baganda Tribe | 304/417 (73%) | 308/447 (69%) | 0.225 | 263/373 (71%) | 203/343 (59%) | 0.001 |
| Religion | | | | | 0.635 |
| Catholic | 164/418 (39%) | 177/447 (40%) | 0.067 | 119/374 (32%) | 108/343 (31%) | 0.735 |
| Muslim | 103/418 (25%) | 114/447 (26%) | | 90/374 (24%) | 93/343 (27%) | 0.001 |
| Protestant | 79/418 (19%) | 107/447 (24%) | | 104/374 (28%) | 80/343 (23%) | 0.123 |
| Born Again | 52/418 (12%) | 34/447 (8%) | | 50/374 (13%) | 49/343 (14%) | 0.123 |
| Above primary education | 275/419 (66%) | 321/447 (72%) | 0.050 | 157/374 (42%) | 140/343 (41%) | 0.752 |
| Able to read | 399/419 (95%) | 429/445 (96%) | 0.387 | 345/373 (92%) | 313/342 (92%) | 0.631 |
| Does not earn money | 87/419 (21%) | 94/447 (21%) | | 180/374 (48%) | 166/343 (48%) | 0.001 |
| Ever had a regular partner | 326/418 (78%) | 352/447 (79%) | 0.787 | 350/374 (94%) | 316/342 (92%) | 0.534 |
| Had a regular partner in the past 12 months | 313/419 (75%) | 335/447 (75%) | 0.935 | 305/374 (82%) | 274/343 (80%) | 0.572 |
| Currently married/cohabiting | 165/419 (39%) | 191/447 (43%) | 0.317 | 228/374 (61%) | 205/343 (60%) | 0.744 |
| In polygamous marriage (among those married) | 37/165 (22%) | 45/191 (24%) | 0.800 | 49/201 (24%) | 57/187 (30%) | 0.178 |
| No children | 237/419 (57%) | 223/447 (50%) | 0.049 | 83/374 (22%) | 83/343 (24%) | 0.525 |

#### Outcome variables

<p>| Acceptability of physical violence by a man against | 112/419 (27%) | 107/445 (24%) | 0.364 | 214/373 (57%) | 203/343 (59%) | 0.624 |</p>
<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Non-Polygamous</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptability that a woman can refuse sex</td>
<td>223/419 (53%)</td>
<td>251/447 (56%)</td>
<td>0.387</td>
</tr>
<tr>
<td>Past year experience of physical IPV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past year experience of sexual IPV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosed violence and got helpful response (if experienced violence in past year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past year concurrent sexual partners among non-polygamous partnered men</td>
<td>109/270 (40%)</td>
<td>105/284 (37%)</td>
<td>0.412</td>
</tr>
</tbody>
</table>
3.0 Description of Intervention and Theory of Change

3.1 SASA! An Activist Kit for Preventing Violence Against Women and HIV

SASA! was designed by Raising Voices, and is implemented in Kampala by the Centre for Domestic Violence Prevention (CEDOVIP), both of which are Ugandan-based NGOs. Please see appendix 1 for a detailed description of SASA!. SASA! is a community mobilisation intervention that seeks to change community attitudes, norms and behaviours that result in men’s power over women. This power imbalance is conceptualised to be the root cause of violence against women and to support HIV risk-related behaviours. SASA! challenges individuals and communities to think about their power and how their use of power affects their intimate partner relationship as well as their interaction with their fellow community members. SASA! is currently being implemented in 15 countries in sub-Saharan Africa including amongst pastoralist communities and in post-conflict and refugee settings. As such, SASA! encourages implementers to adapt the materials to their own particular context in order to best overcome specific contextual challenges. In rural areas for example, community activists often target existing opportunities when community members congregate for example on market days or days of prayer.

Designed around The Ecological Model of violence, (Dahlberg and Krug 2002, Heise 2011) SASA! recognises that intimate partner violence results from an interplay of factors which operate at individual, relationship, community, and societal levels and thus takes a holistic approach which engages all members of a society in order to achieve change at each of these levels. (Abramsky, Devries et al. 2012) In so doing, SASA! 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. (World Health Organization and London School of Hygiene and Tropical Medicine 2010, Heise 2011)

The logic model that underlies SASA! is depicted in Figure 1. Figure 1 maps out the key contextual variables that may influence the intervention impact, the various activities that are conducted as part of the intervention and the levels of the ecological model that the activities target. It also identifies the short, medium and longer term impacts that the intervention is designed to catalyse. (Abramsky, Devries et al. 2012). As depicted in Figure 1, SASA! works with a broad range of stakeholders including individual women and men; other people who may have a role in preventing or responding to violence (eg relatives, elders and neighbours), community leaders and service providers who provide direct prevention and response services (eg health care workers and police), and institutional leaders (eg local and central government policy makers) who are responsible for designing and implementing policy changes within their respective institutions. (Abramsky, Devries et al. 2012)

Figure 1: The SASA! Logic Model
SASA! focuses on positive, non-punitive benefits-based programming that is designed to take individuals and communities through four evolutionary phases that are loosely structured on Proschaska and Velicer’s (1997) Stages of Change theory. The intervention seeks to support communities to go through a process of critical awareness and change, with 4 phases of intervention activity (Start, Awareness, Support, Action), being used to recruit and sensitise key community members and stakeholders (Start), conduct activities that foster a greater awareness and discussion of how power can be misused, and its implications, and also the potential for people to use their power in more positive ways (Awareness), support community members to start to make changes in their own lives, both to prevent violence and respond appropriately to cases of violence in their community (Support), and to institutionalise this change within their communities (Action).

Through these phases, individuals and communities are challenged to critically engage with the causes and consequences of violence and gender inequality. SASA! also helps people to develop appropriate skills to reduce gender inequities in their personal relationships, challenge and respond appropriately to violence in their communities and foster community-based networks that support this. These changes are expected to precede both reductions in IPV and improved community responses to women and men who are affected by violence, and are seen as important in their own right as well as vital for the long term sustainability of violence-related behavioural change.

3.2 The SASA! Study: primary outcomes

The SASA! study is a collaboration between Raising Voices, CEDOVIP, the London School of Hygiene and Tropical Medicine and Makerere University. The SASA! intervention was expected to have multiple community-level impacts and result in: reduced social
acceptance of gender inequality and IPV; decreased experience/perpetration of IPV; improved response to women experiencing violence and decreased sexual risk behaviours associated with HIV. (Abramsky, Devries et al. 2012)

The primary objective of the SASA! study was to assess the impact of the intervention on six primary outcomes which were chosen to reflect the broad scope and complex nature of the intervention:

**Reduced social acceptance of gender inequality and IPV**

1. Acceptability of intimate partner violence (among all women, all men)
2. Acceptability that a woman can refuse to have sex (among all women, all men)

**Decrease in experience/perpetration of IPV**

3. Past year experience of physical violence from a partner (among women who have had an intimate partner in the past year)
4. Past year experience of sexual violence from a partner (among women who have had an intimate partner in the past year)

**Improved response to women experiencing violence**

5. Appropriate community response to women experiencing physical and/or sexual IPV in past year (among women who experienced physical and/or sexual IPV in past year)

**Decrease in sexual risk behaviours**

6. Past year concurrent sexual partners (among non-polygamous partnered men)

Details of questionnaire items used to construct outcomes are presented in Appendix 2. Questions on IPV were the same as those used in the World Health Organisation Multi-country Study on Women’s Health and Domestic Violence (Garcia-Moreno 2005), and similar to those in the Uganda Demographic and Health Survey. These questions ask about experiences of specific acts, rather than more general questions that would elicit responses influenced by (1) a respondent’s subjective understanding of what constitutes violence or (2) perceived stigma attached to words such as ‘abuse’ or ‘violence’. Questions on attitudes were originally taken from the WHO Multi-country study and then adapted and added to in order to increase their validity and reliability within this setting.
4.0 Programme Implementation

4.1 Overview SASA! implementation in Kampala

SASA! was implemented in the study intervention communities between 2008 and 2011. Owing to a number of interruptions to programming, discussed below, in practise this equated to two years and eight months of actual programming in the intervention communities.

4.2 Implementation process

SASA! was implemented in Kampala by the Centre for Domestic Violence Prevention (CEDOVIP). This was done using a combination of four strategies. The first is Local Activism, through which CEDOVIP staff recruit and support male and female community-based activists, who mobilize and engage with their fellow community members around issues of power and violence. The second is Media and Advocacy. For this, Raising Voices and CEDOVIP use a variety of media and advocacy channels to raise awareness around issues related to violence against women, as well as how individuals and communities can act to prevent it. Owing to the requirements of the trial design, the media and advocacy activities were restricted to local media channels in order to avoid exposing control communities to SASA! ideas and materials. The third strategy is the use of Communication Materials, which are designed to be locally and contextually relevant and provide activists with a tool for guiding discussion around various themes and topics. For this they draw on a range of materials, developed by Raising Voices, designed to support different forms of activity, and to be relevant for different phases of the intervention (A sample of SASA! communication materials are provided in Figure 2). This requires intensive support, with CEDOVIP staff being present in the implementing communities on a daily basis, supporting and mentoring community level activists. The fourth strategy is Training, by which CEDOVIP staff and community activists are supported to continually strengthen their knowledge and skills to support community members to prevent violence against women.
Figure 2: Examples of SASA! communication materials

Over the duration of the SASA! study, CEDOVIP staff supported over 400 activists to implement SASA in their communities. These included ‘regular’ women and men in the community, local government and cultural leaders, police, health care providers, drama activists and youth. Each activist committed to conducting four activities a month, but in practice, they often conducted more than this. Indeed, it is estimated that over the intervention period, activists led over 11,000 activities, which took a variety of formats including community conversations, door-to-door discussions, quick chats, trainings, public events, poster discussions, community meetings, film shows and soap opera groups in order to engage a variety of community members through a number of different channels. Using the on-going process and monitoring data, CEDOVIP estimate that SASA! activities reached over 260,000 community members in the six parishes in the Makindye and Rubaga divisions in Kampala District, where SASA! was being implemented.

4.3 Implementation challenges

There were some disruptions to the implementation of SASA! in Kampala District, which are detailed below:

1. Presidential and parliamentary elections were held in February 2011. The campaigns that supported these elections took shape at the grassroots from as early as September 2010 with many politicians wanting to use the SASA! forums to promote their political ambitions. In addition, at least 15 CAs dropped out of SASA! because their desire to stand for political office at the local council level interfered with their role as a CA. As a result of these tensions, CEDOVIP had to suspend SASA! implementation for a period of almost 4 months due to the pre-
and post election circumstances that made it difficult to engage community members without being accused of being partisan.

2. The communities in the SASA! sites are transient, which raised the risk that community members that had been engaged through SASA! may have moved out of intervention sites, including the potential that they moved to the SASA! study control sites. There was no way to control for this, although respondents in the control sites were asked whether they had heard or participated in SASA! activities. Based upon this data, there does not appear to be substantial contamination, that would affect the study findings.

3. The CRT design is challenging when this is being used to evaluate an intervention model that is built on a social diffusion model. To try to minimise the risk of contamination, a number of somewhat unnatural restrictions were placed on the implementation of SASA!, to try to ensure that the control communities were not contaminated. In particular, when activists were encouraged to reach out through their social networks, CEDOVIP staff tried to encourage them not to go into control communities. The attempt to limit the diffusion elements to certain geographic boundaries is a false limitation, which did not always reflect natural community social and structural boundaries, and was, at times, frustrating for CEDOVIP staff and community activists.

4. Following the 2011 elections, a number of opposition campaigns including the ‘Walk to Work’ campaign against the results of the presidential election and the high fuel and commodity prices often led to violent clashes between security forces and members of the public. Furthermore, during this time, the police banned people from congregating in groups of more than 5 people, which meant that all SASA! programme activities had to be stopped for a period of over three months. This break in programming meant that some momentum was lost both in terms of the development of community activists’ skills and confidence, as well as community members’ progress in exploring power, and how it affects them in their relationships. In order to overcome this, once programming resumed, CEDOVIP intensified the number of activities and increased staff presence in the communities in order to better support activists to rebuild momentum. CEDOVIP also introduced a number of new activities such as the ludo game and held more public events whilst also encouraging community activists to reach out to community members in informal ways. During this period CEDOVIP also continued to publically recognise and celebrate individuals and groups that were standing up to prevent violence against women.

5. High levels of population mobility in some SASA! communities also meant that the awareness phase of SASA! was longer than had originally been planned, as community activists had to continually engage new community members.
5.0 Impact Results

The findings of the SASA! study break new ground. Whilst previous studies have shown that violence can be reduced amongst direct recipients of interventions, SASA! is the first trial in sub-Saharan Africa to assess the potential for a VAW prevention intervention implemented at the community-level to impact on community levels of violence.

Here we present the results of a cluster-level analysis, performed on an intention to treat basis, whereby data on all respondents were included according to the site they lived in regardless of whether or not they reported any contact with the intervention. The analysis compares outcomes in intervention and control communities at follow-up, controlling for age, marital status and baseline measure of the relevant outcome indicator(Abramsky, Devries et al. 2012).

5.1 Primary outcomes

The findings are extremely positive. For each of the 6 primary outcomes, the difference between intervention and control communities is in the hypothesised direction, with several of these differences being statistically significant (see Table 2). Given the small size of the trial, the consistency of results across outcomes helps add weight to the plausibility of an overall impact of the intervention.

5.1.1 Social acceptance of physical violence in relationships.

Specifically, SASA! was associated with reduced social acceptance of physical violence in relationships among both women (AOR 0.54 (0.38 – 0.79) and men (AOR 0.13 (0.01 – 1.15)), although the result was not statistically significant among men. Along with this reduced acceptance of violence against women came an increased willingness to act against violence as illustrated by findings from the qualitative data:

“I have to behave well [and intervene in violence] with the help of groups like SASA! and the police, government in general. However, I should be the first person to prevent the violence in the community.”

Male community member

In the past we would just ignore if a man beat his wife but now I think it is not okay to ignore ...”

Female community member

5.1.2 Social acceptance that women can refuse sex

SASA! was also associated with increased social acceptance of the belief that there are circumstances when a woman can refuse sex from her partner (AOR 1.31 (1.00 – 1.70) for women, 1.28 (1.07 – 1.52) for men). This was also supported by several quotes from the qualitative research:
Table 2: Estimates of effect on primary outcome indicators*, comparing prevalence of outcome in intervention versus control communities

<table>
<thead>
<tr>
<th>Reduced social acceptance of gender inequality and IPV</th>
<th>Baseline</th>
<th>Follow-up</th>
<th>Unadjusted RR* (95% CI)</th>
<th>Adjusted RR** (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention</td>
<td>Control</td>
<td>Intervention</td>
<td>Control</td>
</tr>
<tr>
<td>Acceptability of physical violence by a man against his partner*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Male attitudes</td>
<td>112/419 (27%)</td>
<td>107/445 (24%)</td>
<td>136/768 (18%)</td>
<td>544/634 (86%)</td>
</tr>
<tr>
<td>• Female attitudes</td>
<td>214/373 (57%)</td>
<td>203/343 (59%)</td>
<td>191/599 (32%)</td>
<td>311/528 (59%)</td>
</tr>
<tr>
<td>Acceptability that a woman can refuse sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Male attitudes</td>
<td>223/419 (53%)</td>
<td>251/447 (56%)</td>
<td>744/768 (97%)</td>
<td>474/634 (75%)</td>
</tr>
<tr>
<td>• Female attitudes</td>
<td>152/374 (41%)</td>
<td>123/342 (36%)</td>
<td>542/599 (90%)</td>
<td>385/529 (73%)</td>
</tr>
<tr>
<td>Decrease in women’s experience of IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past year physical IPV</td>
<td>75/302 (25%)</td>
<td>57/273 (21%)</td>
<td>46/504 (9%)</td>
<td>93/424 (22%)</td>
</tr>
<tr>
<td>Past year sexual IPV</td>
<td>38/303 (13%)</td>
<td>31/273 (11%)</td>
<td>70/504 (14%)</td>
<td>84/423 (20%)</td>
</tr>
<tr>
<td>Improved response to women experiencing IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate community response to women experiencing IPV in past year</td>
<td></td>
<td></td>
<td>28/102 (27%)</td>
<td>18/139 (13%)</td>
</tr>
<tr>
<td>Decrease in sexual risk behaviours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past year concurrent sexual partners among non-polygamous men partnered in past year</td>
<td>109/270 (40%)</td>
<td>105/284 (37%)</td>
<td>139/508 (27%)</td>
<td>177/397 (45%)</td>
</tr>
</tbody>
</table>

*Risk ratios calculated at the cluster-level, both crude and adjusted ratios adjusting for community-pair, and weighted according to the number of observations per village

**Adjusted risk ratios generated on the basis of expected number of events from a logistic regression model on individual data with independent variables including age, marital status and EA-level summary baseline measure of outcome indicator

Outcome not measured at baseline. aRR instead controls for baseline measure of ‘disclosed violence and found response helpful’

Translation of items changed between baseline and follow-up, so a before/after comparison is not possible for this outcome
“[from attending SASA! activities] I learned that some of the things I used to do were not right at all...for instance I thought that whenever I needed sex I had to have it without her denying me. I thought whenever I wanted sex, she would automatically want it. So whenever she would refuse, I would get so enraged and we would fight”

Male community member

5.1.3 Experience of physical acts of violence from partner in past year

The levels of physical partner violence occurring in the past year reported by women were 52% lower in the SASA! intervention communities compared to the control (AOR 0.48 (0.16 – 1.39)), although this difference was not statistically significant.

The qualitative findings suggest that this change was valued by both men and women as illustrated by the following quote from the qualitative data:

“I feel so proud of my marriage at this moment...now people admire us and our children... We do not quarrel neither do we use violence against our children”

Female community member

“When it comes to me I have changed a lot. I no longer beat her as I used to, I no longer use abusive language on her...”

Male community member

5.1.4 Appropriate community responses to violence experienced

Women experiencing violence who had been directly exposed to SASA! were also more than twice as likely to report that they experienced a supportive response than women in the control communities, although this was not significant due to small numbers in each cluster. This support was highly valued by women as illustrated in their own words:

“Personally I was going through violence but I did not know what to do and where to go but when SASA! came, I realized I had support”

Female community member

“Well this program is so good especially for us women. Before this program... a man could beat you up or use any form of violence against a woman...but now we have a voice and they [services, police] listen to us”

Female community member

5.1.5 Men’s reported sexual concurrency in the past year

SASA! also reduced men’s levels of sexual partner concurrency¹. In control communities, 45% of men reported that they had other sexual partners outside of their primary intimate partnership. The equivalent figure in SASA! communities was 27% (statistically significant at the 5% level). The shift in their partner’s behaviour was highly valued, especially by women:

¹ Additional sexual partners outside of their primary relationship
"I think he became more faithful and I think he is still faithful because he has attended so many SASA! activities. You know you might start a relationship very well but then it can fail after sometime but I think because my husband has been exposed to SASA! this has helped him to be a good man." **Female community member**

5.1.6 Intervention impact among subgroup reporting exposure to the intervention

Survey respondents were asked how often they had seen various SASA! materials and attended different types of SASA! activities. From their responses, they were categorised into low, medium, or high exposure groups. A per protocol analysis was performed to compare outcomes among those reporting at least a medium level of exposure to SASA! in intervention communities with outcomes among controls with similar demographic and neighbourhood characteristics. This analysis produced very similar effect estimates to the intention to treat analysis, attesting to the success of the community diffusion process at the heart of the intervention model.

5.1.7 Heterogeneity of intervention impact according to respondent characteristics

The cluster-level analysis was also performed separately for different subgroups of the population (18-29 years versus 30-49 years; married versus unmarried; those living in the community for 4 years or more versus those living in the community for less time). The results of this analysis are presented in Table 3. While low power to compare intervention effects between subgroups makes it difficult to draw definitive conclusions from this subgroup analysis, it appears that for some behavioural outcomes intervention effects might be slightly larger among older respondents. There is also some suggestion that married/cohabiting respondents may have experienced greater impacts than unmarried/non-cohabiting respondents with respect to the acceptability of a woman refusing sex and past year concurrency. Those living in the community for 4 or more years compared to those living there for a shorter time also experienced greater impacts in relation to some of the attitudinal and behavioural outcomes, as well as in relation to community response to women experiencing IPV. Results from individual-level logistic regression models, including interaction terms between intervention group and each of these characteristics, indicated similar patterns, with interaction terms being significant at the 10% level in the case of intervention effects on: past year sexual IPV by age-group (greater effect in older respondents, p=0.04); female attitudes on the acceptability of a woman refusing sex by marital status (greater effect among married/cohabiting women, p=0.05); concurrency by marital status (greater effect among married/cohabiting men, p=0.04); female attitudes on the acceptability of IPV by length of time in the community (greater effect among longer term residents, p=0.07).

5.1.8 Internal and external validity of results

The rigorous study methodology minimises several forms of selection bias that are often present in evaluations of complex interventions. Cluster randomisation prevents programme placement bias, and community matching was successful in ensuring that intervention and control communities were similar at baseline despite the low number of sites randomised. The intention to treat analysis assessed the community impact of the intervention rather than effects among self-selecting individuals choosing to participate in intervention activities. Furthermore, the adjusted analysis controlled for any baseline imbalances between intervention and control communities.
Table 3: Adjusted risk ratios (95% CI) of intervention effect on primary outcome indicators*, comparing prevalence of outcome in intervention versus control communities for different subgroups of the study population

<table>
<thead>
<tr>
<th>Reducing social acceptance of gender inequality and IPV</th>
<th>18-29yrs</th>
<th>30-49yrs</th>
<th>Not married/cohabiting</th>
<th>Married/cohabiting</th>
<th>Lived in community less than 4 years</th>
<th>Lived in community 4 or more years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptability of physical violence by a man against his partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Male attitudes</td>
<td>0.13 (0.02 - 0.97)</td>
<td>0.12 (0.01 - 1.20)</td>
<td>0.13 (0.02 - 1.03)</td>
<td>0.12 (0.01 - 1.51)</td>
<td>0.12 (0.01 - 1.06)</td>
<td>0.13 (0.02 - 1.01)</td>
</tr>
<tr>
<td>- Female attitudes</td>
<td>0.56 (0.42 - 0.75)</td>
<td>0.48 (0.30 - 0.77)</td>
<td>0.55 (0.45 - 0.68)</td>
<td>0.54 (0.32 - 0.89)</td>
<td>0.66 (0.34 - 1.30)</td>
<td>0.47 (0.41 - 0.54)</td>
</tr>
<tr>
<td>Acceptability that a woman can refuse sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Male attitudes</td>
<td>1.33 (1.05 - 1.67)</td>
<td>1.28 (0.97 - 1.69)</td>
<td>1.29 (1.05 - 1.57)</td>
<td>1.34 (0.95 - 1.88)</td>
<td>1.25 (0.88 - 1.80)</td>
<td>1.35 (0.96 - 1.89)</td>
</tr>
<tr>
<td>- Female attitudes</td>
<td>1.27 (1.04 - 1.54)</td>
<td>1.30 (1.03 - 1.62)</td>
<td>1.18 (1.14 - 1.23)</td>
<td>1.32 (0.95 - 1.84)</td>
<td>1.24 (1.16 - 1.33)</td>
<td>1.29 (0.98 - 1.71)</td>
</tr>
</tbody>
</table>

| Decrease in women’s experience of IPV |         |         |                        |                    |                                     |                                  |
| Past year physical IPV | 0.56 (0.15 - 2.09) | 0.39 (0.11 - 1.42) | 0.54 (0.22 - 1.31) | 0.50 (0.17 - 1.48) | 0.46 (0.06 - 3.32) | 0.54 (0.30 - 0.97) |
| Past year sexual IPV | 1.26 (0.22 - 7.20) | 0.51 (0.22 - 1.19) | 0.73 (0.33 - 1.59) | 0.77 (0.23 - 2.62) | 1.09 (0.28 - 4.20) | 0.62 (0.33 - 1.16) |

| Improved response to women experiencing IPV |         |         |                        |                    |                                     |                                  |
| Appropriate community response to women experiencing IPV in past year | 2.19 (0.67 - 7.14) | 2.02 (0.42 - 9.66) | 0.51 (0.05 - 5.17) | 1.97 (0.36 - 10.81) | 1.48 (0.71 - 3.10) | 1.99 (0.38 - 10.35) |

| Decrease in sexual risk behaviours |         |         |                        |                    |                                     |                                  |
| Past year concurrent sexual partners among non-polygamous men partnered in past year | 0.63 (0.52 - 0.75) | 0.46 (0.14 - 1.56) | 0.76 (0.44 - 1.29) | 0.51 (0.35 - 0.75) | 0.79 (0.48 - 1.31) | 0.51 (0.33 - 0.77) |

*Adjusted risk ratios calculated at the cluster-level by entering site-level ratios of observed to expected outcomes in to an analysis of variance model, weighted according to the number of observations per village, and adjusted for community pair. Expected number of events generated from a logistic regression model on individual data with independent variables including age, marital status and EA-level summary baseline measure of outcome indicator.
A number of factors may have caused us to underestimate intervention effects. Intervention engagement with police and healthcare providers by necessity took place across intervention and control sites - effect estimates should be therefore be interpreted as the added value of the intensive local components of the intervention when implemented against this backdrop of low-level involvement with these sectors. Interruptions to programming (described above) mean that levels of intervention exposure might not have been optimum among survey respondents. The above limitations would all lead to overly-conservative estimates of intervention effect, and despite this we were still able to observe sizeable effects on most of our outcomes.

As with many trials of community-based interventions, the number of communities included was small and the precision of some effect estimates is therefore low. Despite this, 95% CIs excluded 1 for most of the attitudinal outcomes, and the sexual concurrency outcome. It is also worth noting that, while levels of IPV declined in intervention communities over the course of the study, inter-cluster variation for these outcomes increased in control sites. This additional heterogeneity was unexpected - and as the statistical power of a CRT is strongly determined by the degree of inter-cluster variation, this substantially weakened the power of the study to detect statistically significant intervention impacts on the IPV outcomes. We had cautioned about the limited statistical power from the outset, and in the trial protocol we had pre-specified that in the trial analysis we would consider both the statistical plausibility, along with probability of the trial findings.

Reporting bias is a potential limitation in a study of attitudes and behaviours around IPV. While under-reporting of experiences of IPV by women is common, it is possible that increased sensitisation to issues surrounding IPV and its disclosure will have disproportionately increased reports of IPV experience among women in intervention communities. Again, this would result in our effect estimate being lower than the true intervention effect. For this reason, the lower levels of violence documented in the intervention communities is likely, if anything, to be an under-estimate of the intervention impact.

Conversely, among males, increased sensitisation to the issues may lead to the under-reporting of negative behaviours and over-reporting of progressive attitudes in intervention communities, thereby leading us to over-estimate intervention effects on male outcomes. We are not able to assess the degree to which this may have occurred. However, if social desirability bias has some role in influencing our observed results, this at least indicates a positive shift in perceived social norms, which is in accordance with SASA!’s objectives to achieve community level norm change.

Finally, the community response outcome only relates to women reporting IPV in the past year. Those cases of IPV persisting in intervention communities (despite the reduction in overall prevalence of IPV in these communities) are likely to differ from the larger pool of cases in control communities (where similar reductions in prevalence have not been seen). They may for instance be more hidden and less likely to elicit a community response. The observed effect estimate for the community response outcome should thus be interpreted as a conservative one – and it is encouraging that the size of the effect is nevertheless large.
Study results pertain to this model of SASA! implemented in these areas of Kampala. They offer proof in principle that this community mobilisation intervention model can achieve both attitudinal and behavioural change in communities. These findings are extremely promising, and support the intervention’s replication in other settings. Since by its nature SASA! would not comprise an identical package when implemented elsewhere, requiring considerable adaptation to different socio-cultural contexts, and since the characteristics of community members and baseline levels of outcomes will differ according to setting, it would not be valid to assume identical effect sizes would be achieved in other settings. It is the potential for the intervention to impact on IPV and HIV-risk related outcomes in the desired direction that is a transferable result, rather than the impact estimates themselves.

5.2 Qualitative evaluation

The qualitative evaluation of SASA! explored the dynamics through which shifts in the primary outcomes described above are operating. Via a number of important pathways, SASA! appears to be influencing both individual relationships and broader community norms. At the relationship level, SASA! is helping couples to explore the benefits of mutually supportive gender roles (resulting in reduced relationship tension and disharmony); improve communication on a variety of important issues (including women’s right to refuse sex, financial decision making and women’s work outside of the home); increase levels of joint decision-making and highlight non-violent ways to deal with anger or disagreement. This is resulting in improved intimacy between couples and a more deliberate effort work together for the good of their relationship and households. Not all couples experienced the same breadth and depth of change. Some individuals described how they and their partner experienced considerable or profound change in the way in which they interacted with their partners which resulted in a reduction in violence and more cooperation and intimacy between them and their partner as described above. Other participants described more limited change. Some women for example noted that though their partner used less physical violence, he continued to exercise controlling behaviours and prevented them from working outside of the home.

Levels of exposure to SASA! varied. Some individuals had attended a few activities or seen a few SASA! materials (for example posters) whilst others had regular contact with the intervention through attending several activities or through a strong personal interaction with community activists. Individual’s degree of exposure to SASA! appeared to influence the level of change that they experienced in their relationship with those with the greatest level of exposure experiencing most change. This change was however mediated by their partner’s willingness to change such that the relationships that experienced the most change were characterised by either one or both partners being exposed to SASA! and their partner also being open to try out the new ideas and behaviours that were encouraged through SASA!.

At the community level, the findings suggest that SASA! has helped to foster a climate of non-tolerance of violence, both by reducing the acceptability of VAW and also by increasing individuals’ skills, willingness and sense of responsibility to act to prevent it. The community focused response also seems to have helped develop and strengthen community-based structures that could be used to respond to violence. The research suggests that a focus on improving individuals’ personal relationships as well as their agency to take action against VAW, helped provide both individuals and communities with practical actions and meaningful ways to reduce conflict and violence within their
relationships, as well as respond in a more supportive way to violence in their communities.

5.3 Operational Research

The on-going monitoring and evaluation of programme implementation was an important aspect of learning. As part of this, 6 rapid assessment surveys were conducted in both intervention and control communities in order to be able to assess the programme implementation process including when communities were ready to move on to the next phase of SASA!. This improved programme implementation through helping CEDOVIP to tailor the support given to community activists. Monitoring and evaluation tools and practices developed during the course of this study are also being advocated by Raising Voices in the roll out of SASA!, both to aid in the assessment of its roll-out and to enhance programme implementation.

In this research the rapid assessments also provided an opportunity to test questions that were subsequently used in the follow-up survey to ensure that they were appropriately understood, and were able to adequately capture the issue of interest.

Although the analysis of the process data has not yet been completed, the operational research suggests that an effective approach to working at a community level is to systematically combine larger, public engagement activities (such as dramas or marches), with the ongoing engagement of key stakeholders (such as religious leaders, local leaders and the police), and the ongoing cultivation and support to local activists, who conduct small scale, one on one activities. What emerges also from the qualitative findings is that the model of intervention delivery of engaging people in their day-to-day environment via trusted community leaders and fellow community members is highly effective, achieving high coverage and promoting social diffusion of messages, and promoting local ownership of the problem and its solutions.

An important programmatic element is the positive, aspirational focus of the SASA!, and its entry point of discussing the use and misuse of power. The use of the language of power, rather than gender, seems to enable discussions about violence against women to avoid a dynamic of blaming and judgment. Instead, this approach appears to support a greater focus on how people can use the power that they have in more positive ways, to prevent and respond to violence. Important skills appear to be to support the development of a critical consciousness and analysis about the ways in which different people may use or abuse the power that they have; the unacceptability of violence; and to support couples to develop the skills communicate with each other more, and peacefully discuss and resolve any problems that they are facing.

Economic evaluation

The findings from the economic evaluation are summarised below. As can be seen, the average total costs of delivering SASA! are low, with the annual costs of supporting community level activists and stakeholders being US$385.48 – or just over US$1 per day per activist supported. This translates to between US$15.50 and $17.84 dollars per person in the intervention communities reached. Linking this cost data with the impact estimate on the reduction of intimate partner violence, the findings suggest an average cost of US$346.79 per case of intimate partner violence averted.
<table>
<thead>
<tr>
<th>Average Total Costs (US$2011)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per person in intervention communities (15yrs+)</td>
<td>$17.84</td>
</tr>
<tr>
<td>Per person in intervention communities (10yrs+)</td>
<td>$15.49</td>
</tr>
<tr>
<td>Per Community Activist Supported Per Year</td>
<td>$385.48</td>
</tr>
<tr>
<td>Per Case of Intimate Partner Violence Averted</td>
<td>$346.79</td>
</tr>
</tbody>
</table>

To date there is very limited data on the costs of violence prevention programming, and no established thresholds of what value represents a cost-effective investment. However, the unit cost of $385.48 per community activist supported compares very favourably with the unit costs of other community level interventions, such as the provision of support to community health workers. The estimate of $348.79 per case of intimate partner violence averted is also highly favourable in comparison to the only other published estimate of intervention cost-effectiveness using this measure (of between 2011US$710 and 2011US$213 per case of IPV averted).

6.0 Policy Recommendations

A number of key policy recommendations have been distilled from the findings of the SASA! study with clear implications for a number of different stakeholders.

6.1 For the Government of Uganda

The Government of Uganda (GoU) is already implementing SASA! in eight Districts in Busoga in Eastern Uganda. Through the GoU-Irish Aid Joint program to address gender-based violence in Busoga, the Ministry of Gender, Labour and Social Development, CEDOVIP and the Uganda Women’s Network collaborate closely to integrate and institutionalise violence against women prevention in local government structures, specifically, the Community-based Services Department. This is a pilot of how the SASA! methodology can be used by local government officials and integrated into their community development plans and activities.

The SASA! Study has shown the intervention to impact on community attitudes towards the acceptability of IPV and results are strongly suggestive of an impact on community levels of physical IPV. These intervention impacts, coupled with the more general conclusion we can draw from the results, that norm change and violence prevention is possible, lead to the recommendation that the Government of Uganda:

- Continue to support the implementation of SASA! by GoU-Irish Aid Joint Program in Busoga as a learning site for future GoU expansion and involvement in violence prevention.
- Support a long-term nationwide campaign to shift social norms linked to violence against women that uses aspirational messaging that promotes safe, healthy and happy relationships for women and men. Important norms to challenge include assumptions about the rigidity of gender roles and responsibilities, a lack of joint
decision-making or respect within relationships, and the acceptability of men’s use of violence against their partners.

The study also demonstrated that community mobilisation is an effective mechanism through which community level change can be achieved. This involves engaging actors at all levels of the ecological model (individuals, couples, community, society), including government services providers and legislators. We therefore recommend:

- SASA! Training modules for health service providers and the newly developed training modules for police are incorporated into national level government programmes.
- Given the central importance of the Ministry of Gender, Labor and Social Development in the co-ordination of violence against women prevention efforts, their role in overseeing such initiatives needs to be supported.
- More broadly, such initiatives should be seen as taking place as part of the implementation of the Domestic Violence Act across Uganda.

6.2 For activists, practitioners and implementing organisations

The findings of the SASA! study also offer important insights for activists and organisations that seek to prevent violence against women. The intervention impacted on attitudes towards violence against women. Results are also strongly suggestive of an impact on levels of physical IPV and a strengthening of community responses to women experiencing violence. Furthermore a reduction in sexual concurrency among men is also attributed to the intervention. The main lessons for programmes are:

- Investment in social norm change at the community level can lead to changes in gender relationships and the acceptability of violence. For many organisations, the focus on prevention at a community level, and the explicit focus on power, rather than gender, represents a departure from their current prevention programming. The findings illustrate that the focus on power is a useful intervention strategy, which supports the increased engagement by men, and can be used to initiate discussions about what people can do to prevent violence in their own lives, and in the community.
- Currently, much of the focus of violence programming is on the strengthening of services. The findings illustrate that it is possible to work at a community level, and impellent a violence intervention with strong prevention and response components, with the findings suggesting that different intervention components are highly synergistic.
- Community interventions that improve the quality and levels of intimacy in relationships can impact on sexual concurrency, as well as the social acceptance of and levels of violence. Given that both exposure to partner violence and multiple sexual partnerships are associated with an increased HIV risk, the findings illustrate the potential importance to HIV prevention of aspirational messaging about relationships, that go beyond communicating knowledge about the HIV risks of multiple partnerships, to improving levels of communication, trust and intimacy within relationships. HIV programmes should also develop programming on gender inequality and violence.
- The study demonstrated that community mobilisation can have important community-level impacts over relatively short periods of time. Monitoring and evaluation data and qualitative data suggest that a high intensity of programming
is needed to achieve the impacts documented in this study. This requires a sustained staff presence in the community. This ongoing activity appears to be important for helping individuals and communities to continually reflect on issues related to power and violence against women, and to try out and adopt new behaviours and norms. It is probably unrealistic to expect that similar levels of change would be achieved through less systematic or one-off activities.

- A combination of communication channels are important for engaging community members in ways that are most appealing to them. A strength of SASA! is that it supports activists to engage with community members during people’s daily routines. This means that SASA! is able to reach a broad range of the community, and engage with and ensure that they are able to interact with new ideas.

- Community-level programming to prevent violence against women and reduce HIV risk behaviours requires strong organisational capacity to provide sustained support to community-led activities. The operational research suggests that this must also be preceded by a process through which the organisation supports its own staff to personally reflect on violence, power and relationships in their own lives as a means for them to internalise these issues and thus offer better support to activists.

- A core element of the intervention is that it is not CEDOVIP staff that deliver the intervention to the community, but rather that CEDOVIP supports community members to engage with others within their own social networks. Community activists are selected from the community for their interest and willingness to work with CEDOVIP to engage with their community on these issues, but at the start of the intervention may find it difficult to discuss issues of power and gender. Despite this, it is very important that intervention staff respect and trust community activists and members to implement SASA!, and focus on supporting activists to deliver the intervention effectively. This mentorship model of intervention delivery takes time, but is very important for supporting local ownership of the discussions and analyses of the intervention. Indeed, qualitative data especially indicate that the success and sustainability of SASA! is dependent on community ownership of and trust towards intervention ideas.

6.3 Development partners

The study’s demonstration of the success of the SASA! model in achieving community level impacts relating to attitudes and behaviours around IPV and HIV risk, highlights a number of important recommendations for donors and development partners

- For donors and organisations that work to prevent violence against women, the study highlights that violence is preventable, and the value of investing in social norm change interventions at the community level. Effective programming goes beyond one off or infrequent activities, requiring a high intensity of programming, using a combination of communication channels.

- Effective community level programming can both prevent violence and support strengthened community responses to violence. Donor investments should be careful not to focus unduly on ‘service provision’ or ‘prevention’ alone, but rather seek to support a broader process of community dialogue and change, that has the potential to impact both on levels of violence and the strength of the community and local service response.
• **For donors and organisations focused on HIV prevention**, the study highlights that community interventions that improve the quality and levels of intimacy in relationships can impact on sexual concurrency, as well as the social acceptance of and levels of violence. Given that both exposure to partner violence and multiple sexual partnerships are associated with an increased HIV risk, the findings illustrate the potential importance to HIV prevention of aspirational messaging about relationships, that go beyond communicating knowledge about the HIV risks of multiple partnerships, to improving levels of communication, trust and intimacy within relationships.

### 6.4 For Researchers and research funders

The successful implementation of the SASA! study, along with positive research findings, has illustrated that although it can be challenging to do a cluster randomised controlled trial of a community mobilisation intervention, it is feasible. Indeed, it suggests that when research is meaningfully embedded into interventions to prevent violence against women and HIV, it can strengthen programming and inform policy.

Important lessons regarding the implementation of violence research, as confirmed by our experience of conducting this study, include:

- Because of the costs and logistical difficulties in implementing rigorous evaluation studies, coupled with the careful tailoring of the study design to fit the specific intervention model, such rigorous studies should only be undertaken for well articulated interventions. Research should examine the efficacy of established interventions that have gone through prior piloting and development, so as not to be undermined by internal uncertainties or lack of clarity within the intervention.

- Although it is important that researchers are independent of the programmes that they evaluate, they should not be distant from the programme. The SASA! study would not have been feasible without a strong partnership between the research and programme teams. This partnership meant that we were able to design the study around a clear understanding of the intervention and its aims, set up and maintain the CRT design in an ethically responsible way, feedback the research findings into the programme in an ongoing manner, ensure that the control community were able to receive the intervention following the completion of the study, and interpret and develop programmatically relevant conclusions from the research. Models of evaluation research need to move away from a focus on 'independent evaluators' to support strong research/intervention partnerships.

Recommendations for further research, based on our findings are as follows:

- The study demonstrated that community mobilisation appears to be an effective mechanism though which community level change can be achieved. Future evaluation research should seek to evaluate other community mobilisation approaches. As this is the first trial to assess the community level impact of a violence prevention programme in sub-Saharan Africa, it will be important to continue to support further evaluation of community level approaches to violence prevention, including SASA! as it is rolled out and implemented elsewhere, where possible conducting larger scale (and thus higher powered) studies.
• The intervention merits replication and further evaluation research. It is important to learn further about the process of replication and adaptation of the intervention to other settings and contexts.

• The statistical power of the trial to detect intervention effect on past year levels of physical violence was reduced by increases in the inter-cluster variability in prevalence of violence between baseline and follow-up. Studies with small numbers of clusters already have limited power and can be especially vulnerable to increases in inter-cluster variability. Alongside the support of larger trials, it is important that methodological debates engage more with the design and interpretation of small trials, moving from an analysis of statistical probability, to that of consistency and plausibility of findings. This is particularly important for evaluation studies of complex interventions - where large scale evaluations may be particularly difficulty, and where there there may be multiple outcomes.
References


Appendices

Appendix 1: SASA! An Activist Kit for Preventing Violence Against Women and

Raising Voices and the Centre for Domestic Violence Prevention (CEDOVIP) are NGOs in Uganda that have been working in the field of violence prevention for over a decade. SASA! was designed by Raising Voices, and was implemented in Kampala by CEDOVIP. SASA! is a community mobilisation intervention that seeks to change community attitudes, norms and behaviours that result in gender inequality, violence and an increased HIV vulnerability for women. Designed around the Ecological Model of violence, (Dahlberg & Krug, 2002; Heise, 2011) SASA! recognises that intimate partner violence results from the complex interplay of factors which operate at the individual, relationship, community, and societal levels, and that if effective change is to be achieved, it is important for interventions to systematically work with a broad range of stakeholders within the community. In the SASA! intervention CEDOVIP staff work with four groups of actors: community activists (CAs) selected from the more progressive men and women rooted in the community, who work voluntarily to facilitate and promote SASA! activities; community leaders including Ssengas (traditional marriage counselors) who, as religious, cultural, governmental and other types of local leaders, are encouraged to integrate a gender and power analysis into their leadership roles; professionals such as health care providers and police officers, who provide direct prevention and response services; and institutional leaders who have the power to implement policy changes within their institutions.² SASA! entails the selection, training, and ongoing mentoring and skill building of these individuals and groups, to help improve their knowledge and inspire their activism to engage their social networks and different spheres of influence to address gender inequality and violence.

Recognising that an initial, explicit focus on ‘gender’ is likely to be off putting to many, the central focus of the intervention is to promote a critical analysis and discussion of power and power inequalities. As all community members are likely to have been disempowered at some point in their lives, this focus supports the broader engagement of both women and men in intervention activities. The intervention aims to be aspirational, and support a critical analysis not only of the ways in which men and women may misuse power, and how this affects their intimate relationships and the community, but also on how people can use their power positively to affect and sustain change at an individual and community level. Ultimately the use of an entry point of power leads to discussions about gender inequality and violence, but these topics emerge from the analysis of who holds power in the community and how it may be misused, rather than being imposed on the community from the outset.

Using this operational model, SASA! aims to support a phased, community level process of change, analogous to the processes set out in the individual-level behavior Stages of Change Theory of Prochaska et al. (1992), with the four phases (Start, Awareness, Support, Action) (See Figure 1). Each phase builds on the other, with an increasing number of individuals and groups involved in

² Due to the trial, the media engagement and national advocacy piece was not done so as to limit contamination of control communities.
each phase strengthening a critical mass committed to and able to create social norm change. During the first phase (Start), CEDOVIP staff focus on strengthening the capacity and ‘power within’ of CAs and other key stakeholders to work on issues of violence and gender - engaging them in critical thinking and discussion about what constitutes violence; the causes and consequences of violence; the underlying links between violence, gender inequality and the misuse of power; and the implications for individuals, families and communities. Gender inequality and social norms about sexual behavior for men and women are also discussed and opened up to analysis. Time is also spent getting to know more about the community’s perceptions of violence against women, gender and HIV, and building relationships with leaders and key gatekeepers who will support and enable the community mobilization in the subsequent phases.

During the second phase (Awareness) and subsequently, CAs and leaders are supported by CEDOVIP staff to conduct a range of local activism activities, including door-to-door visits, interactive community dramas, film shows, poster discussions, public events and one-on-one ‘quick chats’. The process of engagement for this and subsequent phases is done in an informal manner, with CAs integrating the activities into their day-to-day lives in their communities with neighbors, friends, and other groups to which they belong. The intention of this awareness phase is to spark and actively diffuse critical thinking among community members about men’s use of ‘power over’ women and the community’s silence about this. The aim is for a range of different community members to engage in discussions about power, and the ways in which power imbalances between men and women help perpetuate violence against women and HIV/AIDS risk, and question the legitimacy of violence against women and gender inequality. Alongside this, local leaders, the police, health workers and other professionals receive training and support to improve their community-based prevention efforts and the provision of services. At an institutional level, leadership of police and health care sectors are engaged in a series of seminars introducing similar ideas and analysis of the role their sector could play in addressing violence against women.

In the third phase (Support), community members are encouraged to explore alternatives to the status quo that would create more gender equality, power balance and happiness in their families and communities. The concept of joining ‘power with’ others is explored through the local activism activities - power to create positive change, for community members to reach out and support women experiencing violence and couples trying to balance power, and to challenge men using violence. Activities focus upon helping people to develop appropriate skills to reduce inequities in their relationships, and to challenge and respond appropriately to violence in their communities. These activities seek to encourage recognition of the ways in which different individuals can address the misuse of power, gender inequality and violence, and the strength that can be generated when they join together with a common aim. Community leaders and professionals are supported to work more closely together to address violence and gain skills in preventing and responding to violence against women. At an institutional level, policies and practices are examined by leaders with the support of CEDOVIP staff to identify areas where changes could be made to increase the capacity of the police and health sector to meaningfully respond to violence against women.
The focus of the final phase (Action) aims to consolidate and normalize a greater sharing of power and non-violence, demonstrating the benefits of more equal relationships, and as a result, preventing violence against women and reducing HIV/AIDS risk. The thrust of this phase is to encourage community members, leaders, professionals and institutions to use their ‘power to’ take action to address gender inequality and violence. Special emphasis is placed on formalizing change within community groups, local leadership structures, service delivery points and institutions.

**Figure 3: 4 phases of SASA!**

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The SASA! Approach: How it works

- **Start**
  - Learning about the community
  - Selecting Community Activists
  - Fostering ‘power within’ staff and community activists

- **Awareness**
  - Helping activists gain confidence
  - Informal activities
  - Encouraging critical thinking about men’s ‘power over’ women

- **Support**
  - Strengthening skills and connections between community members
  - Joining ‘power with’ others to support change

- **Action**
  - Trying new behaviors, celebrating change
  - Fostering the ‘power to’ make positive change

Involving community members, leaders and institutions to build critical mass

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## Appendix 2: Outcome Measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Respondents (denominator)</th>
<th>Items in composite indices</th>
<th>Expected direction of change due to intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social acceptance of gender inequality and IPV</strong></td>
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</table>
| Acceptability of physical violence by a man against his partner | Men; Women | Answers ‘yes’, a man has good reason to hit his wife in at least one of the following scenarios:  
  - She disobeys him  
  - She answers back to him  
  - She disrespects his relatives  
  - He suspects that she is unfaithful  
  - He finds out she has been unfaithful  
  - She spends time gossiping with neighbours  
  - She neglects taking care of the children  
  - She doesn’t complete her household work to his satisfaction  
  - She refuses to have sex with him  
  - She accuses him of infidelity  
  - She tells his secrets to others in the community  
  - He is angry with her | Decrease |
| Acceptability of a woman refusing sex | Men; Women | Answers that ‘yes’ in their opinion it is acceptable if a married woman refuses to have sex with her husband if she doesn’t feel like it. | Increase |
| **Women’s past year experience of IPV** | | | |
| Past year experience of physical IPV | Women who have had a regular partners/casual partner in the past year | Reports that her partner/most recent partner has done at least one of the following things to her in the past year:  
  - Slapped her or thrown something at her that could hurt her  
  - Pushed her or | Decrease |
<table>
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<tr>
<th>Past year experience of sexual IPV</th>
<th>Women who have had a regular partners/casual partner in the past year</th>
<th>Reports that her partner/most recent partner has done at least one of the following things to her in the past year:</th>
<th>Decrease</th>
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<tr>
<td></td>
<td></td>
<td>• Forced her to have sexual intercourse by physically threatening her, holding her down or hurting her in some way</td>
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<td></td>
<td></td>
<td>• She had sexual intercourse because she was intimidated by him or afraid he would hurt her</td>
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<tr>
<th>Response to women experiencing violence</th>
<th>Appropriate community response to women experiencing IPV in past year</th>
<th>Women who report in the survey having experienced physical and/or sexual IPV in the past year</th>
<th>Increase</th>
</tr>
</thead>
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<td></td>
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<td>Reports that during or after the experience, ‘yes’ someone in their community tried to help them AND they did so with at least one of the following responses:</td>
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<td></td>
<td></td>
<td>• Gathered other people from the community to help</td>
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<td></td>
<td></td>
<td>• Knocked on their door to stop the fighting</td>
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<td></td>
<td></td>
<td>• Separated her and her partner during the fighting</td>
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<td></td>
<td></td>
<td>• Informed a community activist, ssenga,</td>
<td></td>
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<tr>
<td>Sexual risk behaviour</td>
<td>Past year concurrent sexual partners among men partnered in the past year</td>
<td>Non-polygamous men who report having had a regular partner in the past year</td>
<td>Answers ‘yes’ to having had a sexual relationship with any other women in the last 12 months, while being with his partner/most recent partner.</td>
</tr>
</tbody>
</table>

- LC or police or other authority
  - Talked to her afterwards and asked her how she wanted them to help her
  - Told her to talk to someone else such as a family member, friend, community activist, LC, ssenga or other authority figure

Sexual risk behaviour

Past year concurrent sexual partners among men partnered in the past year

Non-polygamous men who report having had a regular partner in the past year

Answers ‘yes’ to having had a sexual relationship with any other women in the last 12 months, while being with his partner/most recent partner.

Decrease