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## The SASA! study

A cluster randomised trial to assess the impact of a violence and HIV prevention programme in Kampala, Uganda

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Impact Evaluation

# **The SASA! study: a cluster randomised trial to assess the impact of a violence and HIV prevention programme in Kampala, Uganda**

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## About this report

3ie accepted the final version of this report, *The SASA! study: a cluster randomised trial to assess the impact of a violence and HIV prevention programme in Kampala, Uganda*, as partial fulfilment of requirements under OW3.1059 under Open Window 3. The content has been copyedited and formatted for publication by 3ie. Due to unavoidable constraints at the time of publication, a few of the tables and figures are less than optimal. All of the content is the sole responsibility of the authors and does not represent the opinions of 3ie, its donors or its Board of Commissioners. Any errors and omissions are also the sole responsibility of the authors. All affiliations of the authors listed in the title page are those that were in effect at the time the report was accepted. Any comments or queries should be directed to the corresponding author, Charlotte Watts, [charlotte.watts@lshtm.ac.uk](mailto:charlotte.watts@lshtm.ac.uk).

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## Executive summary

### 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 per cent of those living with HIV in Sub-Saharan Africa (the region most affected by HIV and 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 Uganda-based non-governmental organisations.

### 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; 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 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 woman can refuse sex from her partner (AOR 1.31 [1.01–1.70] for women and AOR 1.28 [1.06–1.54] for men). The levels of physical partner violence occurring in the past year reported by women were 52 per cent 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 more than 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 per cent of partnered men in intervention communities reporting having had other sexual partners in the past year, compared to 45 per cent 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, a 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 change.

### **Policy recommendations**

A number of stakeholder-specific policy recommendations have arisen out of this study.

*For the Government of Uganda*, 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 organisations 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, so they are able to support community activists in implementing SASA!.

*For development partners*, community mobilisation interventions require longer-term funding and support for this type of intervention, and should only be provided with this understanding in mind.

*For researchers*, rigorous studies and evaluations should only be applied to strong, well-articulated interventions that build on the synergies developed through meaningful partnerships between research and programme teams.

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## **Abbreviations and acronyms**

AIDS	acquired immunodeficiency syndrome
AOR	average odds ratio
CA	community activist
CEDOVIP	Centre for Domestic Violence Prevention
CI	confidence interval
CRCT	cluster randomised controlled trial
GoU	Government of Uganda
HIV	human immunodeficiency virus
IPV	intimate partner violence
VAW	violence against women
WHO	World Health Organization

# 1. 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, Bacchus *et al.* 2013; Stöckl *et al.* 2013). Furthermore, IPV against women is a common experience worldwide (Campbell 2002; Garcia-Moreno *et al.* 2006; Heise 2011; Abramsky *et al.* 2012). Indeed, recent global estimates of the prevalence and health effects of violence against women (VAW) indicate that 30 per cent of women will experience physical or sexual violence from an intimate partner during their lifetime (Devries, Mak *et al.* 2013). The gendered nature of the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) epidemic is also increasingly recognised, particularly in Sub-Saharan Africa, the region most severely affected by HIV, where women and girls constitute 58 per cent of those living with the virus (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 (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 *et al.* 2001; Dunkle *et al.* 2004; WHO 2006; Jewkes *et al.* 2010, 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, while 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 *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 the Men and Women in Partnership intervention in Côte d'Ivoire (Abramsky *et al.* 2012).

## 1.2 The SASA! study: objectives and design

The SASA! study was conducted in Kampala, Uganda. It is an evaluation of SASA!, a community mobilisation intervention focused on addressing the gendered power imbalances and social norms that perpetuate both VAW and HIV risk-related behaviours. The SASA! study is the first cluster randomised controlled trial (CRCT) in Sub-Saharan Africa to seek to assess the community-level impact of a VAW and HIV prevention intervention programme, rather than solely assessing 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 (see Section 3.2 for a detailed discussion of these outcomes):

- 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 IPV* (among women);
- past year *experience of sexual IPV* (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).

The SASA! study had other objectives:

- Conduct a qualitative evaluation of SASA! in order to investigate the process and causal pathways through which the intervention operated.
- Conduct operations research in order to document the scale and nature of programme implementation over time.
- Conduct a full economic costing of SASA! to learn more about the costs and cost-effectiveness of SASA!.

### 1.2.1 Design of the CRCT

The trial involved a pair of matched cluster randomised trials with randomisation conducted within matched community pairs. Four communities were randomly selected to receive the full intervention from baseline and four communities were waitlisted 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 1,583 respondents were interviewed at baseline (717 women, 866 men) and 2,532 respondents were interviewed at follow-up (1,130 women and 1,402 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 and Vaughan 1999).

The study was conducted in accordance with World Health Organization (WHO) guidelines for the safe and ethical collection of data on VAW (Watts *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 were 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, programme implementers, religious leaders and the police. At follow-up, a further 92 in-depth interviews were conducted that again reflected a cross-section of the community, including community members, community activists (CAs), 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 levels.

### *1.2.3 Operations research*

Over the course of the implementation of SASA!, a large amount of data was collected. These included over 6,000 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 were 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 CAs. 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 (CEDOVIP), as well as the value of the time donated by CAs, 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 ongoing and as such, the findings will not be included in this report.

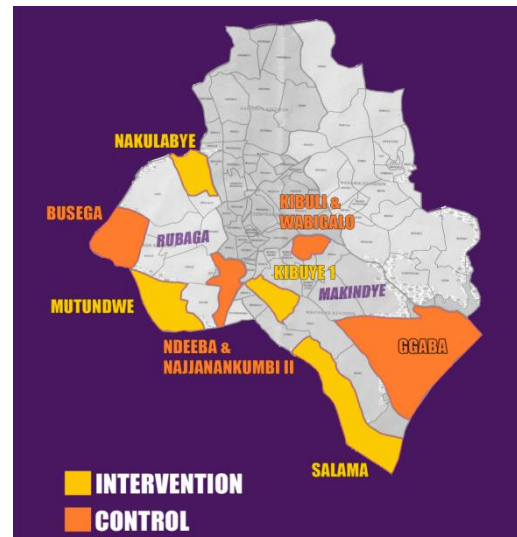
## **1.3 Overview of the report**

This report is divided into six sections. In Section 2, the study context will be elaborated, highlighting key contextual aspects 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. Study context

The SASA! study was conducted in eight communities, comprising 12 parishes, in two administrative divisions of Kampala District – Makindye and Rubaga, neither of which had had any prior exposure to SASA!. These communities contained approximately 66,500 households and 251,500 inhabitants. The communities were relatively impoverished and were characterised by concentrations of people who had migrated from other parts of Kampala and Uganda in search of employment. Mobility in many parts of the study area is high, with people moving in search of employment opportunities and improved living conditions.

Map 1: The SASA! study site



### 2.1 Demographic characteristics

Based on the findings of the baseline data collection, the population of the study communities was relatively young (40 per cent 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 *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 Socioeconomic 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 heads of the household and women are expected to be subservient to them.

### 2.3 Prevalence of IPV and HIV

The prevalence of HIV in the study communities is high. The 2004–2005 HIV and AIDS Sero Behavioural Survey estimated HIV prevalence in Kampala to be 12 per cent among women and 5 per cent among men, higher than the national average. Findings from the baseline study also indicate that 27 per cent of women have experienced physical or sexual violence from an intimate partner in the past year. The 2011 Uganda national Demographic and Health Survey suggests that VAW is widely accepted in Uganda, with 73 per cent of women and 57 per cent of men believing, for example, that there are circumstances when beating a wife is acceptable. There is also emerging evidence of the links between exposure to VAW

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 per cent confidence interval [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.

## **3. Description of the intervention and theory of change**

### **3.1 SASA!: an activist kit for preventing VAW and HIV**

SASA! is a community mobilisation intervention that seeks to change community attitudes, norms and behaviours that result in men's power over women. It was designed by Raising Voices and is implemented by CEDOVIP (see Appendix A for a detailed description of SASA!). This power imbalance is conceptualised as the root cause of VAW, which supports HIV risk related behaviours. SASA! challenges individuals and communities to think about their power and how their use of power affects their intimate partners, as well as their interactions with community members. SASA! is currently being implemented in 15 countries in Sub-Saharan Africa, including 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.

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

	Men n (%)			Women n (%)		
	Intervention	Control	chi-squared p-value	Intervention	Control	chi-squared p-value
<b>Household level</b>						
Household has electricity	328/419 (78%)	367/447 (82%)	0.158	259/374 (69%)	264/343 (77%)	0.020
Main drinking water source: public tap	267/419 (64%)	324/447 (72%)	0.006	228/374 (61%)	212/343 (62%)	0.816
Toilet facility: traditional pit toilet or latrine	281/419 (67%)	268/447 (60%)	0.030	225/374 (60%)	203/343 (59%)	0.790
House is rented	279/419 (67%)	310/447 (69%)	0.383	231/374 (62%)	246/343 (72%)	0.005
<b>Individual level</b>						
Age (yrs)	27.1 (6.8)	27.6 (7.0)		28.4 (7.7)	28.2 (7.7)	
Baganda Tribe	304/417 (73%)	308/447 (69%)	0.225	263/373 (71%)	203/343 (59%)	0.001
Religion			0.067			0.635
Catholic	164/418 (39%)	177/447 (40%)		119/374 (32%)	108/343 (31%)	
Muslim	103/418 (25%)	114/447 (26%)		90/374 (24%)	93/343 (27%)	
Protestant	79/418 (19%)	107/447 (24%)		104/374 (28%)	80/343 (23%)	
Born Again	52/418 (12%)	34/447 (8%)		50/374 (13%)	49/343 (14%)	
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%)	
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
<b>Outcome variables</b>						
Acceptability of physical violence by a man against his partner	112/419 (27%)	107/445 (24%)	0.364	214/373 (57%)	203/343 (59%)	0.624
Acceptability that a woman can refuse sex	223/419 (53%)	251/447 (56%)	0.387	152/374 (41%)	123/342 (36%)	0.199
Past year experience of physical IPV				75/302 (25%)	57/273 (21%)	0.260
Past year experience of sexual IPV				38/303 (13%)	31/273 (11%)	0.662
Disclosed violence and got helpful response (if experienced violence in past year)				67/114 (59%)	43/89 (48%)	0.138
Past year concurrent sexual partners among non-polygamous partnered men	109/270 (40%)	105/284 (37%)	0.412			

Designed around the ecological model of violence (Dahlberg and Krug 2002; Heise 2011), SASA! recognises that IPV results from an interplay of factors that operate at individual, relationship, community and societal levels, and thus takes a holistic approach that engages all members of a society in order to achieve change at each of these levels (Abramsky *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 (WHO and London School of Hygiene & Tropical Medicine 2010; Heise 2011).

The logic model that underlies SASA! (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 long-term impacts that the intervention is designed to catalyse (Abramsky *et al.* 2012).

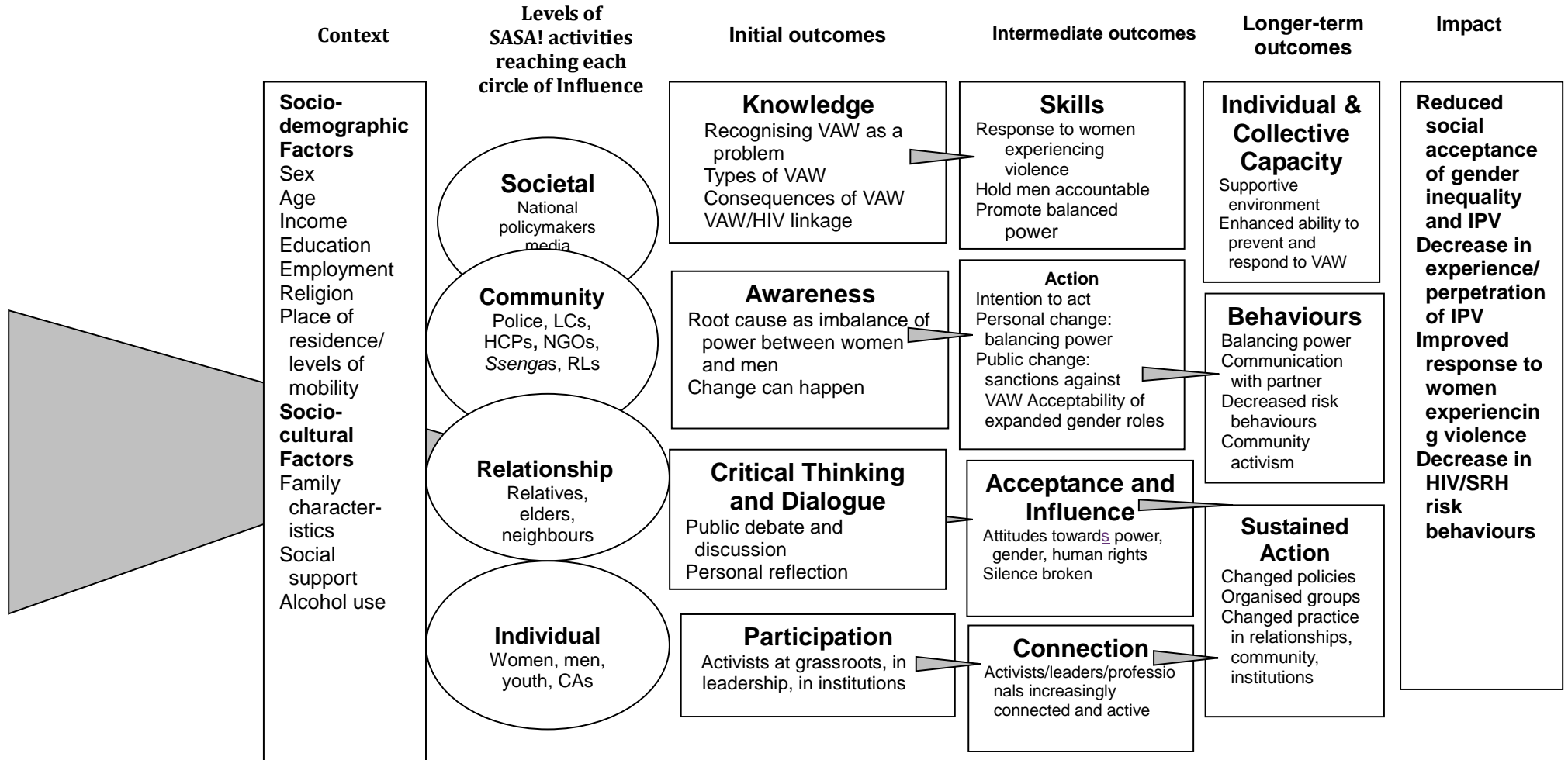
As depicted in Figure 1, SASA! works with a broad range of stakeholders, including individual women and men; other people who may have a role in preventing or responding to violence (e.g. relatives, elders and neighbours); community leaders and service providers who provide direct prevention and response services (e.g. healthcare workers and police); and institutional leaders (e.g. local and central government policymakers) who are responsible for designing and implementing policy changes within their respective institutions (Abramsky *et al.* 2012).

SASA! focuses on positive, non-punitive, benefits-based programming designed to take individuals and communities through four evolutionary phases that are loosely structured on Prochaska and Velicer's (1997) stages of change theory. The intervention seeks to support communities in going through a process of critical awareness and change, with four 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, its implications, and also the potential for people to use their power in more positive ways (Awareness); support community members who make changes in their own lives, both to prevent violence and to respond appropriately to cases of violence in their community (Support); and 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 supportive community-based networks (Abramsky *et al.* 2012). 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 (Abramsky *et al.* 2012).



**Figure 1: SASA! logic model**



### **3.2 The SASA! study primary outcomes**

The SASA! study is a collaboration between Raising Voices, CEDOVIP, the London School of Hygiene & 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 *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 IPV (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 the past year (among women who experienced physical and/or sexual IPV in the 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 B. Questions on IPV were the same as those used in the WHO Multi-country Study on Women's Health and Domestic Violence (Garcia-Moreno *et al.* 2005), and were 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. Programme implementation**

### **4.1 Overview of SASA! implementation in Kampala**

SASA! was implemented in the study intervention communities between 2008 and 2012. Owing to a number of interruptions to programming (discussed later), in practice this equated to two years and eight months of actual programming in the intervention communities.

## 4.2 Implementation process

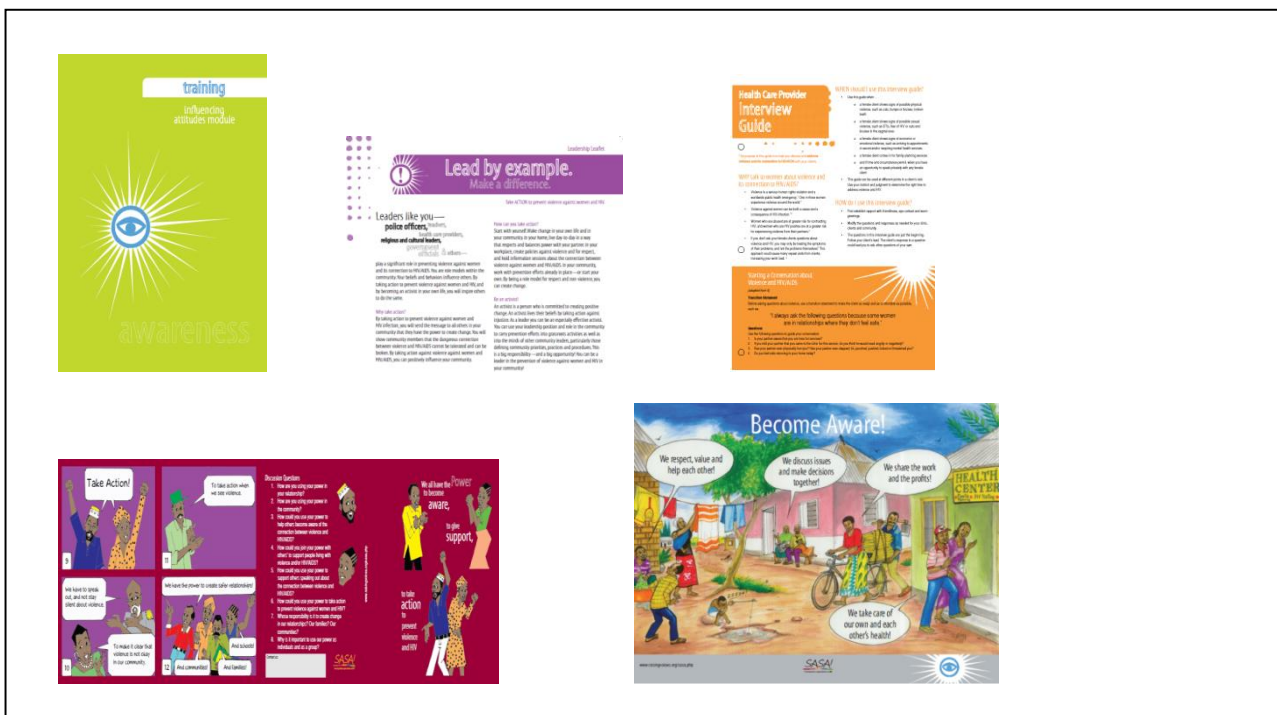
The study was implemented by CEDOVIP using a combination of four strategies. The first is *Local Activism*, through which CEDOVIP staff recruit and support male and female community-based activists who mobilise and engage with their fellow community members around issues of power and violence.

The second is *Media and Advocacy*. Raising Voices and CEDOVIP use a variety of media and advocacy channels to raise awareness around issues related to VAW, 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 discussions 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*, through which CEDOVIP staff and CAs are supported to strengthen their knowledge and skills continually, which in turn support community members to prevent VAW.

**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, healthcare providers, drama

activists and youth. Each activist committed to conducting four activities a month, but in practice they often conducted more. Over the intervention period, activists led more than an estimated 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 ongoing process and monitoring data, CEDOVIP estimates that SASA! activities reached over 260,000 community members in the six parishes in the Makindye and Rubaga divisions in Kampala District.

### **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 four 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 of community members who had been engaged through SASA! possibly moving out of intervention sites, including the possibility of their moving 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 of or participated in SASA! activities. Based on this data, there does not appear to be substantial contamination that would affect the study findings.
3. The CRCT design is challenging when used to evaluate an intervention model that is built on a social diffusion model. To try to minimise the risk of contamination of the control communities, a number of somewhat unnatural restrictions were placed on the implementation of SASA! 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 CAs.
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 five 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 CAs' skills and confidence, and 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, while also encouraging CAs to reach out to community members in informal ways. During this period, CEDOVIP also continued to publicly recognise and celebrate individuals and groups that were standing up to prevent VAW.

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 CAs had to continually engage new community members.

## 5. Results

The findings of the SASA! study break new ground. While previous studies have shown that violence can be reduced among 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 *et al.* 2012).

### 5.1 Primary outcomes

The findings are extremely positive. For each of the six 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 to 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 VAW 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; AOR 1.28 [1.07–1.52] for men). This was also supported by several quotes from the qualitative research.

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 per cent 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 quotes.

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*

**Table 2: Estimates of effect on primary outcome indicators,\* comparing prevalence of outcome in intervention versus control communities**

	Baseline		Follow-up		Unadjusted RR <sup>*</sup> (95% CI)	Adjusted RR <sup>**</sup> (95% CI)
	Intervention	Control	Intervention	Control		
<b>Reduced social acceptance of gender inequality and IPV</b>						
Acceptability of physical violence by a man against his partner±						
• Male attitudes	112/419 (27%)	107/445 (24%)	136/768 (18%)	544/634 (86%)	0.13 (0.01 – 1.19)	0.13 (0.01 – 1.15)
• Female attitudes	214/373 (57%)	203/343 (59%)	191/599 (32%)	311/528 (59%)	<b>0.54 (0.37 – 0.79)</b>	<b>0.54 (0.38 – 0.79)</b>
Acceptability that a woman can refuse sex						
• Male attitudes	223/419 (53%)	251/447 (56%)	744/768 (97%)	474/634 (75%)	1.31 (0.98 – 1.77)	<b>1.31 (1.00 – 1.70)</b>
• Female attitudes	152/374 (41%)	123/342 (36%)	542/599 (90%)	385/529 (73%)	<b>1.26 (1.04 – 1.53)</b>	<b>1.28 (1.07 – 1.52)</b>
<b>Decrease in women's experience of IPV</b>						
Past year physical IPV	75/302 (25%)	57/273 (21%)	46/504 (9%)	93/424 (22%)	0.45 (0.14 – 1.46)	0.48 (0.16 – 1.39)
Past year sexual IPV	38/303 (13%)	31/273 (11%)	70/504 (14%)	84/423 (20%)	0.76 (0.33 – 1.74)	0.76 (0.33 – 1.72)
<b>Improved response to women experiencing IPV</b>						
Appropriate community response to women experiencing IPV in past year			28/102 (27%)	18/139 (13%)	1.91 (0.46 – 7.94)	2.11 (0.52 – 8.59) <sup>‡</sup>
<b>Decrease in sexual risk behaviours</b>						
Past year concurrent sexual partners among non-polygamous men partnered in past year	109/270 (40%)	105/284 (37%)	139/508 (27%)	177/397 (45%)	0.60 (0.35 – 1.02)	<b>0.57 (0.36 – 0.91)</b>

Notes: <sup>\*</sup>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.

<sup>\*\*</sup>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.

<sup>\*</sup>Outcome not measured at baseline. Adjusted risk ratio instead controls for baseline measure of 'disclosed violence and found response helpful'.

<sup>‡</sup>Translation of items changed between baseline and follow-up, so a before/after comparison is not possible for this outcome.

#### *5.1.4 Appropriate community responses to violence experienced*

Those 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 realised I had support.

*Female community member*

Well, this programme is so good, especially for us women. Before this programme...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 concurrency.<sup>1</sup> In control communities, 45 per cent of men reported that they had other sexual partners outside of their primary intimate partnership. The equivalent figure in SASA! communities was 27 per cent (statistically significant at the 5 per cent level). The shift in their partner's behaviour was highly valued, especially by women.

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 of age versus 30–49 years of age; married versus unmarried; those

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<sup>1</sup> Additional sexual partners outside of their primary relationship.



living in the community for four 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 or cohabiting respondents may have experienced greater impacts than unmarried or non-cohabiting respondents, with respect to the acceptability of a woman refusing sex and past year concurrency.

Those living in the community for four 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 per cent 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 or cohabiting women,  $p = 0.05$ ); concurrency by marital status (greater effect among married or 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 randomised sites. 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.

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 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 earlier) 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. Despite this, we were still able to observe sizeable effects on most of our outcomes.

**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**

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

Note: \*Adjusted risk ratios calculated at the cluster level by entering site-level ratios of observed to expected outcomes into 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.

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 per cent CI excluded one 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, intercluster variation for these outcomes increased in control sites. This additional heterogeneity was unexpected—and as the statistical power of a CRCT is strongly determined by the degree of intercluster 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 and the 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 underestimate 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 overestimate 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. By its nature, SASA! would not comprise an identical package when implemented elsewhere, requiring considerable adaptation to different sociocultural contexts. Additionally, the characteristics of community members and baseline levels of outcomes will differ according to setting. For these reasons, it would not be valid to assume that 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 earlier are operating. Through 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 decisionmaking; and highlight non-violent ways to deal with anger or disagreement. This is resulting in improved intimacy between couples and a more deliberate effort to 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 partners experienced considerable or profound change in the way in which they interacted, which resulted in a reduction in violence and more cooperation and intimacy between them, as described earlier. Other participants described more limited change. For example, some women 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 (e.g. posters), while others had regular contact with the intervention through attending several activities or through a strong personal interaction with CAs. An 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 the 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 trying 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 to 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 and 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 ongoing monitoring and evaluation of programme implementation was an important aspect of learning. As part of this, six rapid assessment surveys were conducted in both intervention and control communities in order to assess the programme implementation process, including when communities were ready to move on to the next phase of SASA!. This information helped CEDOVIP to tailor the support given to CAs and improve programme implementation. Monitoring and evaluation tools and practices developed during the course of this study are also being advocated by Raising Voices in the rollout of SASA!, both to aid in the assessment of its rollout 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 (August 2014), the operational research suggests that an effective approach to working at a community level is to combine larger public engagement activities (such as dramas or marches) systematically with the ongoing engagement of key stakeholders (such as religious leaders, local leaders and the police), along with the ongoing cultivation of and support to local activists, who conduct small-scale, one-on-one activities. What also emerges from the qualitative findings is that the model of intervention delivery of engaging people in their day-to-day environment through 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 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 VAW to avoid a dynamic of blaming and judgement. 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 support the development of a critical consciousness and analysis of the ways in which different people may use or abuse the power that they have and the unacceptability of violence. They support couples to develop the skills to communicate with each other more and peacefully discuss and resolve any problems that they are facing.

### **5.4 Economic evaluation**

The findings from the economic evaluation are summarised here. As can be seen, the average total costs of delivering SASA! are low, with the annual costs of supporting CAs 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. Linking this cost data with the impact estimate on the reduction of IPV, the findings suggest an average cost of US\$346.79 per case of IPV instance averted.

**Table 4: Average total costs**

<b>Average Total Costs (2011 US\$)</b>	
Per person in intervention communities (15 yrs +)	\$17.84
Per person in intervention communities (10 yrs +)	\$15.49
Per CA supported per year	\$385.48
Per case of IPC averted	\$346.79

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 US\$385.48 per CA supported compares very favourably with the unit costs of other community-level interventions, such as the provision of support to community healthworkers. The estimate of US\$348.79 per case of IPV averted is also highly favourable in comparison to the only other published estimate of intervention cost-effectiveness using this measure (of between US\$710 and US\$213 per case of IPV averted).

## **6. 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 programme 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 VAW 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 the results are strongly suggestive of an impact on community levels of physical IPV. These intervention impacts, coupled with the more general conclusion that we can draw from the results—that norm change and violence prevention is possible—lead to these recommendations for the GoU:

- Continue to support the implementation of SASA! by the GoU-Irish Aid joint programme 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 VAW, which 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 and society), including government services providers and legislators. We have these recommendations for the GoU:

- Incorporate the SASA! training modules for health service providers and the newly developed training modules for police into national-level government programmes.
- Given the central importance of the Ministry of Gender, Labour and Social Development in the coordination of VAW prevention efforts, support their role in overseeing such initiatives.
- More broadly, see such initiatives as taking place as part of the implementation of the Domestic Violence Act across Uganda.

## **6.2 Lessons for activists, practitioners and implementing organisations**

The findings of the SASA! study also offer important insights for activists and organisations that seek to prevent VAW. The intervention impacted on attitudes towards VAW. 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.

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. It 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 implant a violence intervention with strong prevention and response components. The findings also suggest 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, which go beyond communicating knowledge about the HIV risks of multiple partnerships to improving levels of communication, trust and intimacy within relationships. Programmes for HIV prevention 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 VAW, 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 is important for engaging community members in ways that are most appealing to them. One 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 VAW 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 delivers 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, CAs may find it difficult to discuss issues of power and gender. Despite this, it is very important that intervention staff respect and trust CAs 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! are dependent on community ownership of, and trust in, intervention ideas.

### **6.3 For 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 VAW*, 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, which 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, which goes 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 CRCT of a community mobilisation intervention, it is feasible. Indeed, it suggests that when research is meaningfully embedded in interventions to prevent VAW and HIV, it can strengthen programming and inform policy.

### *6.4.1 Lessons for implementation of violence research*

Important lessons regarding the implementation of violence research have been confirmed by our experience of conducting this study. Due to 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 CRCT 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.

## **6.5 Recommendations for further research**

The study demonstrated that community mobilisation appears to be an effective mechanism through which community-level change can be achieved. Future evaluation research should seek to evaluate other community mobilisation approaches. 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 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 intercluster 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 intercluster 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 difficult and where there may be multiple outcomes.

## Appendix A: SASA!: an activist kit for preventing VAW

Raising Voices and CEDOVIP are non-governmental organisations 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, SASA! recognises that IPV results from a complex interplay of factors that 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 works with four groups of actors: 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 counsellors) 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 healthcare 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.<sup>2</sup> 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 behaviour stages of change theory of Prochaska *et al.* (1997), with 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 each phase, strengthening a critical mass committed and able to create social norm change.

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<sup>2</sup> Due to the trial, the media engagement and national advocacy piece was not done, so as to limit the contamination of control communities.

During the first phase (Start), CEDOVIP staff focuses 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 behaviour for men and women are also discussed and opened up to analysis. Time is also spent in 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 mobilisation in subsequent phases.

During the second phase (Awareness) and subsequently, CEDOVIP staff supports CAs and leaders 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 neighbours, 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 it.

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 to perpetuate VAW and HIV and AIDS risk, and to question the legitimacy of VAW and gender inequality. Alongside, local leaders, the police, healthworkers and other professionals receive training and support to improve their community-based prevention efforts and the provision of services. At an institutional level, police and healthcare leaders are engaged in a series of seminars introducing similar ideas and analysis of the role their sectors could play in addressing VAW.

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 local activism—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 on 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 VAW.

At an institutional level, with the support of CEDOVIP staff, leaders examine policies and practices to identify areas where changes could be made to increase the capacity of the police and the health sector to meaningfully respond to VAW.

The final phase (Action) aims to consolidate and normalise a greater sharing of power and non-violence, demonstrating the benefits of more equal relationships, and as a result, preventing VAW and reducing HIV and 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 formalising change within community groups, local leadership structures, service delivery points and institutions.

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



## Appendix B: Outcome measures

	Indicator	Respondents (denominator)	Items in composite indices	Expected direction of change due to intervention
<b>Social acceptance of gender inequality and IPV</b>	Acceptability of physical violence by a man against his partner	Men; Women	<p>Answers 'yes', a man has good reason to hit his wife in at least one of the following scenarios:</p> <ul style="list-style-type: none"> <li>• She disobeys him</li> <li>• She answers back to him</li> <li>• She disrespects his relatives</li> <li>• He suspects that she is unfaithful</li> <li>• He finds out she has been unfaithful</li> <li>• She spends time gossiping with neighbours</li> <li>• She neglects taking care of the children</li> <li>• She doesn't complete her household work to his satisfaction</li> <li>• She refuses to have sex with him</li> <li>• She accuses him of infidelity</li> <li>• She tells his secrets to others in the community</li> <li>• He is angry with her</li> </ul>	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
<b>Women's past year experience of IPV</b>	Past year experience of physical IPV	Women who have had regular partners/casual partners in the past year	<p>Reports that her partner/most recent partner has done at least one of the following things to her in the past year:</p> <ul style="list-style-type: none"> <li>• Slapped her or thrown something at her that could hurt her</li> <li>• Pushed her or shoved her or pulled her hair</li> <li>• Hit her with his fist or something else that could hurt her</li> <li>• Kicked her, dragged her or beat her up</li> <li>• Choked or burnt her on purpose</li> <li>• Threatened to use or actually used a gun, knife or other weapon against her</li> <li>• Threatened to use or actually used a <i>panga</i> (stick) against her</li> </ul>	Decrease
	Past year experience of sexual IPV	Women who have had regular partners or casual partners in the past year	<p>Reports that her partner/most recent partner has done at least one of the following things to her in the past year:</p> <ul style="list-style-type: none"> <li>• Forced her to have sexual intercourse by physically threatening her, holding her down or hurting her in some way</li> <li>• She had sexual intercourse because she was intimidated by him or afraid he would hurt her</li> </ul>	Decrease

	<b>Indicator</b>	<b>Respondents (denominator)</b>	<b>Items in composite indices</b>	<b>Expected direction of change due to intervention</b>
<b>Response to women experiencing violence</b>	Appropriate community response to women experiencing IPV in past year	Women who report in the survey having experienced physical and/or sexual IPV in the past year	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: <ul style="list-style-type: none"> <li>• Gathered other people from the community to help</li> <li>• Knocked on their door to stop the fighting</li> <li>• Separated her and her partner during the fighting</li> <li>• Informed a CA, <i>ssenga</i>, LC, or police or other authority</li> <li>• Talked to her afterwards and asked her how she wanted them to help her</li> <li>• Told her to talk to someone else, such as a family member, friend, CA, LC, <i>ssenga</i> or other authority figure</li> </ul>	Increase
<b>Sexual risk behaviour</b>	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 past 12 months, while being with his partner or most recent partner.	Decrease

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The Centre for Domestic Violence Prevention in Kampala implements SASA!, 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 as the root cause of violence against women, which supports HIV risk-related behaviours. SASA! challenges individuals and communities to think about their power and about how their use of power affects their intimate partners, as well as their interactions with community members. The SASA! cluster randomised trial was conducted between 2008 and 2012 in two administrative divisions of Kampala. The results showed that SASA! reduced the reported social acceptance of physical violence in relationships among both women and men. The intervention also increased the social acceptance of the belief that there are circumstances when a woman can refuse sex from her partner.

The levels of physical partner violence occurring in the past year reported by women were 52 per cent lower in the SASA! intervention communities compared to the control. At the community level, SASA! helped foster a climate of non-tolerance of violence against women. The results are the basis of a number of policy recommendations for the Ugandan government, organisations working to prevent violence against women and donors, as well as recommendations for further research.

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