Mobilising communities to end violence against women. Findings from the SASA! Study

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STRIVE Learning Lab
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Overview

• SASA! – what is it?
• The SASA! Study
  – Overview of the SASA! Study
  – Impacts on IPV
  – Pathways to reductions in IPV
• Conclusions
What is SASA!?
The SASA! Activist Kit

• developed by Raising Voices
• community mobilization approach
• changing social norms that perpetuate violence against women and HIV
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
SASA! in Kampala

~3 years of programming

Over 400 activists
‘regular’ women and men in community, local government and cultural leaders, ssengas, police, health care providers, drama activists, youth, etc

leading over 11,000 activities
community conversations, door-to-door discussions, quick chats, trainings, public events, poster discussions, community meetings, film shows, soap opera groups, etc

reaching more than 260,000 community members in 6 parishes in Makindye and Rubaga

• Implementation led by CEDOVIP
• Technical assistance and monitoring by Raising Voices
SASA! is a method, not a proscribed list of actions

Three key features

1. Process
   *phasing in ideas systematically*
   *led by community members*

2. Reach
   *creating critical mass across all sectors*
   *multiple strategies for intense exposure*

3. Content
   *language of power is thought provoking*
   *decreases defensiveness, gets personal*
SASA! Study overview
The big question: Is violence preventable at the community-level?

- Current evidence that violence is preventable assesses the impact among the direct recipients of intervention programs &/or their partners

- First trial in sub-Saharan Africa to assess impact at community level of a VAW prevention intervention
SASA! Study team

Collaboration between LSHTM, Raising Voices, CEDOVIP and Makerere University

• Principal Investigators:
  – Charlotte Watts (LSHTM)
  – Lori Michau (Director of Raising Voices)
  – Tina Musuya (Director of CEDOVIP)

• LSHTM team:
  – Tanya Abramsky, Karen Devries, Ligia Kiss (social epidemiologists)
  – Nambusi Kyegombe, Elizabeth Starmann (qualitative researchers)
SASA! Study Overview

Cluster Randomized Controlled Trial
Baseline: 1583 respondents
717 female 866 male
Follow up: 2532 respondents
1130 female 1402 male

Qualitative Research
Baseline: 64 in-depth interviews and 12 FGDs
Follow up: 92 in-depth interviews

Operations Research
6000+ process reports
750+ impact monitoring
6 rapid assessment surveys

Costing Study
Economic costing
SASA! logic framework

Levels of SASA! Activities reaching each Circle of Influence

- **Societal**
  - Nat’l policy makers, media
- **Community**
  - Police, Local Leaders, Health Care Providers, Ssengas
- **Relationship**
  - Relatives, elders, friends, neighbors
- **Individual**
  - Women, men, youth, community activists

Initial Outcomes

- **Knowledge**
  - Recognizing VAW as problem
  - Types of VAW
  - Consequences of VAW
  - VAW/HIV linkage
- **Awareness**
  - Root cause as imbalance of power between women and men
  - Change can happen
- **Critical Thinking and Dialogue**
  - Public debate and discussion
  - Personal reflection
- **Participation**
  - Activists at grassroots, in leadership, in institutions

Intermediate Outcomes

- **Skills**
  - Response to women experiencing violence
  - Hold men accountable
  - Promote balanced power
  - Support activists/couples
- **Action**
  - Intention to act
  - Personal change: balancing power
  - Public change: sanctions against VAW
  - Acceptability of expanded gender roles
- **Acceptance and Influence**
  - Attitudes toward power, gender, human rights
  - Silence broken
- **Connection**
  - Activists/leaders/professionals increasingly connected and active

Longer term outcomes

- **Individual & Collective Capacity**
  - Supportive environment
  - Enhanced ability to prevent and respond to VAW
- **Behaviors**
  - Balancing power
  - Communication with partners
  - Decreased risk behaviors
  - Community activism
- **Sustained Action**
  - Changed policies
  - Organized groups
  - Changed practice in relationships, community, institutions

Impact

- Reduced social acceptance of gender inequality and IPV
- Decrease in experience/perpetration of IPV
- Improved response to women experiencing violence
- Decrease in HIV/SRH risk behaviors

SASA! Phases / Process of Change
Cluster RCT aims

• To estimate **community** impact of SASA on a range of primary and secondary outcomes relating to:
  
  • Social acceptance of gender inequality and IPV
  • Experience and perpetration of IPV
  • Responses to women experiencing IPV
  • HIV risk behaviours
  • Relationship dynamics

• Also to explore pathways of change, and individual and contextual factors that may modify impact
Study Setting

- Eight sites selected as eligible for intervention
- (c.67,000 HHs)
- Pair matched, and one from each pair randomly selected to receive the intervention (4 intervention, 4 control)
Data collection

• Two cross-sectional surveys of community members (male and female) (baseline in 2008, and follow-up in 2012)
• Stratified random sample of households in enumeration areas in which community activists lived (passive volunteers in control sites)
• Randomly sampled one eligible person (18-49 years old) per household
Baseline survey
1120 households sampled (560 for female sample, 560 for male sample)
905 (81%) households completed household selection procedure (431 in female sample, 474 in male sample)
816 households identified as having eligible member (387 in female sample, 429 in male sample)
793 (97%) successfully completed questionnaires (374 females, 419 males)

Follow-up survey
1680 households sampled (805 for female sample, 875 for male sample)
1539 (92%) households completed household selection procedure (711 in female sample, 828 in male sample)
1385 households identified as having eligible member (606 in female sample, 779 in male sample)
1368 (99%) successfully completed questionnaires (600 females, 768 males)

Baseline survey
1120 households sampled (560 for female sample, 560 for male sample)
922 (82%) households completed household selection procedure (432 in female sample, 490 in male sample)
806 households identified as having eligible member (352 in female sample, 454 in male sample)
790 (98%) successfully completed questionnaires (343 females, 447 males)

Follow-up survey
1677 households sampled (837 for female sample, 840 for male sample)
1425 (85%) households completed household selection procedure (698 in female sample, 727 in male sample)
1185 households identified as having eligible member (537 in female sample, 648 in male sample)
1164 (98%) successfully completed questionnaires (530 females, 634 males)
Ethical and safety issues

- Adhered to WHO guidelines for research on VAW
- Whole study design affected by need to prioritise women’s safety
- One respondent per household, single sex sample in each enumeration area
- Protect confidentiality: essential to ensure women’s safety and data quality
- Selection, specialised training and on-going support for research team
- Take actions to reduce any possible distress to participants (referrals, information).
- Ensure findings are properly interpreted and used
Trial registration

• Registered with ClinicalTrials.gov, registration number NCT00790959

• Study protocol peer reviewed and published in Trials journal
SASA!'s impacts on IPV
Analysis of impacts on IPV

• Aim – To explore impacts of SASA! on women’s past year experience of:
  – different types of IPV
  – severe forms of each type of abuse
  – New onset of each type of IPV (primary prevention)
  – Continuation of each type of IPV (secondary prevention)

• Analysis – Cluster level ITT analysis comparing outcome in intervention versus control communities at follow-up (controlling for site-pair, age, marital status and baseline EA-level prevalence of the outcome)

• Assess evidence using criteria of plausibility as well as probability
Estimates of effect on overall past year prevalence of women’s experience of different types of IPV, comparing prevalence of outcome in intervention versus control communities

<table>
<thead>
<tr>
<th>Past year experience of IPV (among partnered in past year)</th>
<th>Follow-up</th>
<th>Adjusted RR(^{\text{a}}) (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention</td>
<td>Control</td>
</tr>
<tr>
<td>Past year experience of IPV (among partnered in past year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical IPV</td>
<td>46/504 (9%)</td>
<td>93/424 (22%)</td>
</tr>
<tr>
<td>Sexual IPV</td>
<td>70/504 (14%)</td>
<td>84/423 (20%)</td>
</tr>
<tr>
<td>Any emotional IPV</td>
<td>130/504 (26%)</td>
<td>161/424 (38%)</td>
</tr>
<tr>
<td>Any controlling behavior</td>
<td>224/504 (44%)</td>
<td>253/423 (60%)</td>
</tr>
<tr>
<td>Fear of partner in past 12 months</td>
<td>82/500 (16%)</td>
<td>121/419 (29%)</td>
</tr>
</tbody>
</table>

\(^{\text{a}}\)Risk ratios calculated at the cluster-level, adjusting for community-pair, age, marital status and EA-level summary of baseline measure of outcome indicator, and weighted according to the number of observations per village

*\(P<0.05; \ **P<0.10\)
## Estimates of effect on women’s past year experience of severe IPV, comparing prevalence of outcome in intervention versus control communities

<table>
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<th>Follow-up</th>
<th></th>
<th>Adjusted RR** (95% CI)</th>
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<tr>
<td></td>
<td>Intervention</td>
<td>Control</td>
<td></td>
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<tr>
<td>Past year experience of severe/high intensity IPV (among those partnered in past year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeated/severe physical IPV</td>
<td>35/504 (7%)</td>
<td>82/424 (19%)</td>
<td>0.40 (0.14 - 1.17)**</td>
</tr>
<tr>
<td>Injury from physical/sexual IPV</td>
<td>15/504 (3%)</td>
<td>53/421 (13%)</td>
<td>0.20 (0.04 - 1.07)**</td>
</tr>
<tr>
<td>High intensity emotional aggression</td>
<td>40/504 (8%)</td>
<td>95/424 (22%)</td>
<td>0.37 (0.16 - 0.85)*</td>
</tr>
<tr>
<td>High intensity controlling behaviours</td>
<td>133/504 (26%)</td>
<td>190/423 (45%)</td>
<td>0.61 (0.39 - 0.95)*</td>
</tr>
</tbody>
</table>

*Risk ratios calculated at the cluster-level, adjusting for community-pair, age, marital status and EA-level summary of baseline measure of outcome indicator, and weighted according to the number of observations per village

*P<0.05; **P<0.10
NEW ONSET OF IPV IN PAST YEAR (AMONG THOSE WITH NO PRIOR EXPERIENCE)

New onset of physical IPV

New onset of sexual IPV

New onset of emotional aggression

New onset of controlling behaviours

New onset of fear of partner

CONTINUATION OF IPV IN PAST YEAR (AMONG THOSE WITH PRIOR EXPERIENCE)

Continuation of physical IPV

Continuation of sexual IPV

Continuation of emotional aggression

Continuation of controlling behaviours

Continued fear of partner

Primary and secondary IPV prevention impacts

adjusted relative risk
Intervention impact on IPV – overall summary

- Impacts in hypothesised direction for all types of IPV – greatest for physical IPV and emotional aggression
- Impacts largest when the more severe/intense forms of abuse considered
- Both primary and secondary prevention effects observed – slightly stronger impacts observed in relation to secondary prevention (except for controlling behaviours)
- Impacts observed at the community level, not just among those reporting SASA! exposure
- Limitations include wide CIs, potential reporting biases
How did SASA! reduce IPV?
Pathways probably not neat and tidy

- Factors operating at different levels (community, relationship, individual)
- Different pathways in different people - e.g. pathways to cessation among those already experiencing IPV, different to pathways that reduce risk of new onset of IPV
- Individual might not need to be exposed themselves
- Multiple pathways of change might be experienced by one individual
- So, probably not $A \rightarrow B \rightarrow C$

But, more like...
SASA

Community

Individual Man

- Improved communication
  - Reduces/Resolves discords in non-violent manner
  - Improved sexual satisfaction
  - Less infidelity and suspicion

- Reducing concurrency/suspicion of infidelity
  - Reduces potential for conflict

- Reduced drinking
  - Less likely to use violence

- Disclosure of IPV
  - Helped to stop violence

- Attitudes related to gender norms
  - Less tension over lack of fulfillment of male gender roles; less conflict over woman working, etc.

- Attitudes about IPV; right of women to refuse sex
  - Reduced perpetration; increased help seeking

- Normative attitudes
  - Influence community responses to IPV; individual’s attitudes (about IPV, gender roles, relationship dynamics, sexual concurrency); individual’s behaviors (men fearing repercussions, women feeling able to seek help)

- Community responses to violence
  - Influence normative attitudes; individual’s attitudes; individual’s behaviors (men fearing repercussions, women feeling able to seek help); directly intervene, to help women leave abusive relationships and men to stop using violence

Individual Woman

- More equitable distribution of power; less rigid gender roles
  - Reduces discords over lack of fulfillment of gender roles, economic problems

- Disclosure of IPV/help seeking
  - Help to leave abusive relationships; man helped to stop violence

- Attitudes related to gender norms
  - Criteria for choosing partners; less conflict in relationships over lack of fulfillment of male gender roles

- Attitudes about IPV; right to refuse sex
  - Lead women to choose partners using different criteria; leave abusive relationships

Decreased IPV Risk

Prevent new cases occurring
Prevent old cases continuing

KEY
Bold = Factors influenced by SASA!
Italic = Mechanisms through which changes in these factors would affect IPV
Potential mediators of SASA!’s impact on physical IPV

- **community-level factors** (responses to IPV occurring in the community, and normative attitudes towards IPV, women’s right to refuse sex or request condom use, and broader gender roles)

- **relationship-level factors** (communication between partners, relationship power dynamics, extra-spousal sex partners, relationship dissolution)

- **individual-level factors** for both men and women (drinking behaviour and attitudes relating to IPV, a woman’s right to refuse sex and broader gender roles).

Aimed to explore their role in mediating impact on women’s past year experience of physical IPV and men’s past year perpetration of IPV

(NOT to model a sequential chain of causation).
Analysis of pathways

- Explored impact of intervention on potential mediators (cluster-level ITT analysis)
- Explored associations between each mediator and past year IPV experience (women)/ perpetration (men) – using modified poisson regression models (with sandwich variance estimators)
- Modelled effect of SASA! on past year IPV experience (women)/ perpetration (men), adjusting for each potential pathway variable separately - examined the extent to which each variable’s inclusion in the basic model attenuated intervention impact on IPV
Okay for others in community to intervene if they know IPV is occurring

People who have witnessed/heard violence who have responded appropriately

Acceptable for a man to use violence against his partner

Okay for a woman to ask her husband to use a condom

Man’s role to decide if his wife can work

% change in aRR of intervention impact on IPV, after addition of community-level mediators to the models of intervention impact
% change in aRR of intervention impact on IPV, after addition of relationship-level mediators to the model

- Male partner often suspicious that female partner is unfaithful
- Concurrent partners
- Woman refused a job because husband doesn’t want her to work
- Man helps around house
- Joint decision making
- Discuss what both like during sex
- Discuss things that happen in day

Men's model
Women's model
% change in aRR of intervention impact on IPV, after addition of individual-level mediators to the model

- Drunk at least once a month
- Man’s role to decide if his wife can work
- Okay for a woman to ask her husband to use a condom
- Okay for a woman to tell others if she is experiencing violence
- Acceptable for a man to use violence against his partner

Men's model | Women's model
Pathways to reduced violence

Quantitative analyses reveal important patterns:

– Community-level factors
  • Community norms, in particular norms relating to the acceptability of a man’s use of violence against his partner, are the major mediators of intervention effect on both female experience and male perpetration of IPV (more important than relationship- or individual-level mediators)

– Relationship-level factors
  • Reduced suspicion that the woman is unfaithful appears to be an important pathway to reduced violence, with improved communication also having a role
  • SASA! appears to have made relationships better, rather than made women leave abusive relationships

– Individual-level factors
  • Men’s attitudes to IPV mediate SASA!’s impact on men’s perpetration of IPV, more than women’s attitudes mediate impact on women’s experiences of IPV.
  • Among men, attitudes on acceptability of IPV are more important mediators than broader attitudes towards gender equality – need to address attitudes towards IPV specifically

Note of caution...
– Cross-sectional data (reverse causality possible)
– Overlap/confounding by other pathway variables likely to exaggerate role of any specific mediator – can’t just ‘add’ results together
Conclusions and implications

• Community level change is possible - Community mobilization is an effective intervention model to support social norm change

• Wide scope of impacts attributable to SASA!’s focus on underlying causes (power and power imbalances) rather than distinct manifestations of violence

• Validates the approach of engaging entire communities and using multiple strategies to achieve both primary and secondary prevention through multiple pathways

• Need to prioritize research on community-level interventions and the process of how to scale them up
Moving forward with SASA!

• Now being implemented in diverse settings by diverse groups
  – by the Government of Uganda in 8 districts
  – By over 60 organizations in 20 countries in sub-Saharan Africa

• Major adaptations completed in Haiti and for faith-based communities, and underway in Ethiopia and the South Pacific
SASA! papers


- Kyegombe N, Abramsky T, Devries K, Michau L, Nakuti J, Starmann E, Musuya T, Heise L, Watts C: What is the potential for interventions designed to prevent violence against women to reduce children's exposure to violence? Findings from the SASA! study, Kampala, Uganda. *Child Abuse Negl* 2015, 50


Thank you

www.raisingvoices.org
www.genderviolence.lshtm.ac.uk

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