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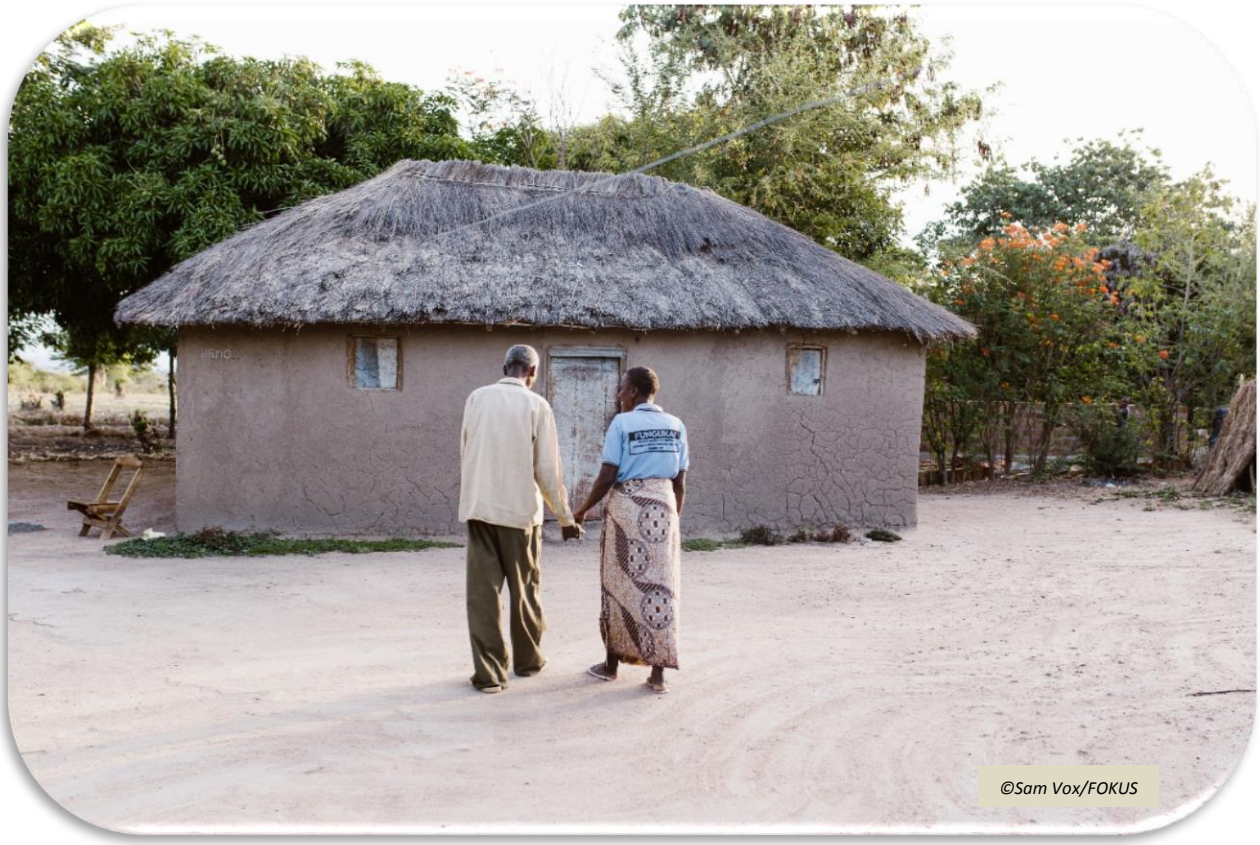

SASA! End Line Study Report

Kigoma Ujiji and Magu Districts, United Republic of Tanzania

May-August 2018

This study was commissioned by Forum for Women and Development (FOKUS) of Norway and conducted by Tanzania Women Research Foundation (TAWREF) with facilitation from FOKUS' implementing partners in Tanzania, namely Women's Promotion Centre in Kigoma and Kivulini Women's Rights Organization based in Mwanza.

The study provides insights into the impact of the SASA! programme and will guide future programming.

Acknowledgements

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The views expressed are those of the authors alone.

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CA	Community Activist
FOKUS	Forum for Women and Development.
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
LGA	Local Government Authority
LZIRB	Lake Zone Institutional Review Board
NIMR	National Institute of Medical Research
NORAD	Norwegian Agency for Development Cooperation
SASA!	Start -Awareness -Support –Act
SPSS	Statistical Package for Social Science
STI	Sexually Transmitted Infection
TAWREF	Tanzania Women Research Foundation
WHO	World Health Organization

1.0 PART 1 BACKGROUND

SASA! is a community mobilization intervention that was designed by the nonprofit organization Raising Voices of Uganda. SASA! walks communities through a process of change addressing a core driver of violence against women and girls: the imbalance of power between women and men, boys and girls. A key element of SASA! is the use of an Activist Kit for Preventing Violence against Women and HIV and the promotion of gender equality. This follow-up study was a pair matched cluster randomized controlled trial with baseline and end line cross sectional surveys aiming to measure the community-level impact of SASA! on reported relationship dynamics and HIV-related risk behaviours.

There has been an observation that there is a multiplicity of definitions for intimate partner violence (IPV). The common understanding of IPV includes all physical, sexual, or psychological harms aggravated by a current or former partner. IPV includes also threats of acts and coercion or arbitrary deprivations of liberty that may occur in public or someone's private life perpetrated by an intimate partner [1].

In Tanzania, the 2015-16 Demographic and Health Survey and Malaria Indicator Survey reported that as many as 42 percent of Tanzanian women have experienced spousal violence in their lifetime [2].

The SASA! programme in Tanzania was launched in 2014 when a Baseline Study was conducted and was made possible by a grant from Norad through Forum for Women and Development, FOKUS, of Norway.

The programme has been implemented by two local non-governmental organizations: The Women's Promotion Centre in Kigoma region and Kivulini in Mwanza region. SASA! stands for the four phases of the SASA! Intervention as follows:

Start – During the first phase, community members are encouraged to start thinking about violence against women and HIV/AIDS as interconnected issues and foster power within them to address these issues.

Awareness – The second phase of SASA! aims to raise awareness about communities' acceptance of men's use of power over women, fueling the dual pandemics of violence against women and HIV/AIDS.

Support – The third phase focuses on how community members can support women experiencing violence, men committed to change, and activists speaking out on these issues by joining their power with others.

Action – In the fourth and final phase, men and women take action to prevent violence against women and HIV/AIDS.

Rationale

Intimate Partner Violence (IPV) has not been adequately researched upon in Tanzania and there is a need to explore men and women's knowledge, attitudes and practices regarding IPV. SASA! is among the first community mobilization interventions in Tanzania that seeks to engage communities to understand and change harmful social

norms to be able to address power imbalances between women and men that perpetuate women's vulnerability to violence and HIV.

This End Line Study seeks to determine the efficacy of the intervention conducted in the four intervention wards, two in Magu District in the Mwanza region and two in Kigoma-Ujiji District in the Kigoma region. The study was conducted in four study sites to be able to determine whether a four-year SASA! intervention targeting selected outcomes could effectively reduce risk factors associated with Intimate Partner Violence (IPV) in the intervention communities. Two wards in each district were selected to serve as control villages. The Baseline Survey for the same was conducted in 2014 to investigate the community's perceptions, attitudes and practices of Intimate Partner Violence prior to the intervention. The baseline prevalence rate was approximately the same as the national level (36.5% for Baseline versus 33% nationally) [3]. The baseline also revealed that men had generally more progressive attitudes towards IPV than women who seemed to accept violence as a part of their lives.

The study provides mixed methods evidence that evaluate the potential for community mobilization interventions to improve relationship dynamics and reduce HIV-related risky behaviours. New and important knowledge has been acquired through this study, insights that will be used to guide future programming.

End Line Study Objectives

The primary goal of the study is to examine whether the community mobilization intervention SASA! has resulted in a change in social norms, attitudes and behaviours in the intervention communities, with the aim of preventing violence against women and HIV/AIDS. These communities include Bukandwe and Kitongosima wards of Magu District, Mwanza region and Gungu and Bangwe wards of Kigoma-Ujiji District, Kigoma region, Tanzania.

Research objectives include:

Objective 1: Examine the level of social acceptance of gender inequality and Intimate Partner Violence (IPV) and compare baseline and end line data for both intervention and control communities.

Objective 2: Examine the experience and perpetration of IPV and compare baseline and end line data for both intervention communities and control communities.

Objective 3: Examine the community response to women experiencing violence and compare baseline and end line data for both intervention communities and control communities.

Objective 4: Examine sexual risk behaviours associated with HIV and compare baseline and end line data for both intervention communities and control communities.

Objective 5: Examine known exposure to SASA! materials, activities and multimedia events and compare data from intervention communities with data from control communities.

1.1 Methodology

1.1.1 Study Design

Study Setting: A cluster randomised controlled trial was used to collect data in the years 2014 and 2018 in four wards of Kigoma-Ujiji Municipality and four wards of Magu district, Mwanza region. Data for this report are extracted from a cross-sectional study.

1.1.2 Research questions answered at Outcome:

- Has acceptability of Intimate Partner Violence decreased after intervention?
- Has acceptability of a woman refusing sex with her husband increased?
- Has occurrence of physical violence from an intimate partner decreased?
- Has occurrence of sexual violence from an intimate partner decreased?
- Has appropriate community response to women's disclosure of violence increased?
- Has concurrent sexual behaviour among men decreased?
- Has there been a known exposure to SASA!, including participation in activities, multimedia events and reception of materials in intervention communities?

1.1.3 Measures

Variables that were collected included background information (age, sex, marital and education status, and religious affiliation) of the respondent, knowledge and attitudes to IPV, and women were also asked to report on exposure to intimate partner violence (physical, sexual and emotional). The components for the assessment of IPV were threats and actual physical violence, sexual and emotional violence by a partner (within the past year). Men were also asked questions on potential concurrent sexual behaviour.

Detailed measures of outcomes

(i) a. Acceptability of violence

Questions on the acceptability of violence were adapted from those used in the WHO multi-country study on women's health and domestic violence. Respondents were asked a series of questions with the introduction: 'In your opinion, does a man have good reason to hit his wife if;' followed by different scenarios. Respondents who answered yes to at least one of the mentioned scenarios will be coded as having attitudes accepting of IPV.

(i) b. Acceptability of a woman refusing to have sex.

Respondents were asked: 'In your opinion, is it acceptable if a married woman refuses to have sex with her husband if she does not feel like it?' A positive response is taken to indicate acceptability of a woman refusing sex.

(ii) a. Measures of Physical IPV

Respondents were asked about their experiences of specific acts of IPV without reference to leading terms such as abuse or violence. Each of the questions were asked for the time frame '**in the last 12 months'**. An affirmative answer to any of the physical items for the last 12 months is taken to indicate past year exposure to physical violence; a positive answer to any of the sexual items for the last 12 months is taken to indicate past year exposure to sexual violence.

Question introduction: Please tell me if your husband/partner/most recent partner, or any other partner, has ever done the following things to you: (with a following question about whether each has occurred in the past 12 months)

(ii) b. Measures of Sexual IPV

Here women's reports of experience were chosen over men's reports of perpetration because it is anticipated that men are more likely to give socially desirable responses about their own behaviour and thus under-report perpetration.

(iii) Appropriate community response to women disclosing violence

This outcome was measured among women reporting past year experience of physical and/or sexual IPV. Respondents were asked: 'When the experiences you have told me about were happening or afterwards, did anyone in your community try to help you?' *(Yes/No).* Those answering in the affirmative were then read a series of questions on how that person/those people tried to help them. If the respondent reported that someone tried to help them, and they did so with at least one appropriate response, this was coded as an appropriate community response. Appropriate responses reflect actions encouraged by the intervention and include someone taking the following actions: gathering other people from the community to help; knocking on the door to stop the fighting; separating the woman and her partner during fighting; informing police or other authority; talking to the woman afterwards and asking her if she wanted them to help; or telling the woman to talk to someone else such as a family member, friend, community activist, or other authority figure.

(iv) Partners' Concurrent Sexual Behaviour

Concurrency among men partnered in the last 12 months was assessed using the following question: 'Have you had a sexual relationship with any other woman in the last 12 months, while being with your wife/partner/most recent partner?' Polygamous men were excluded from the denominator as the intervention was not expected to impact on concurrent sexual behaviour of men in polygamous marriages. Questions on sexual behaviour were asked in accordance with widely accepted guidelines. Confidentiality was stressed throughout the interview process and interviews were conducted in private by an interviewer of the same sex as the respondent.

(v) Known exposure to SASA! Materials, activities and multimedia events (*yes to all three categories*)

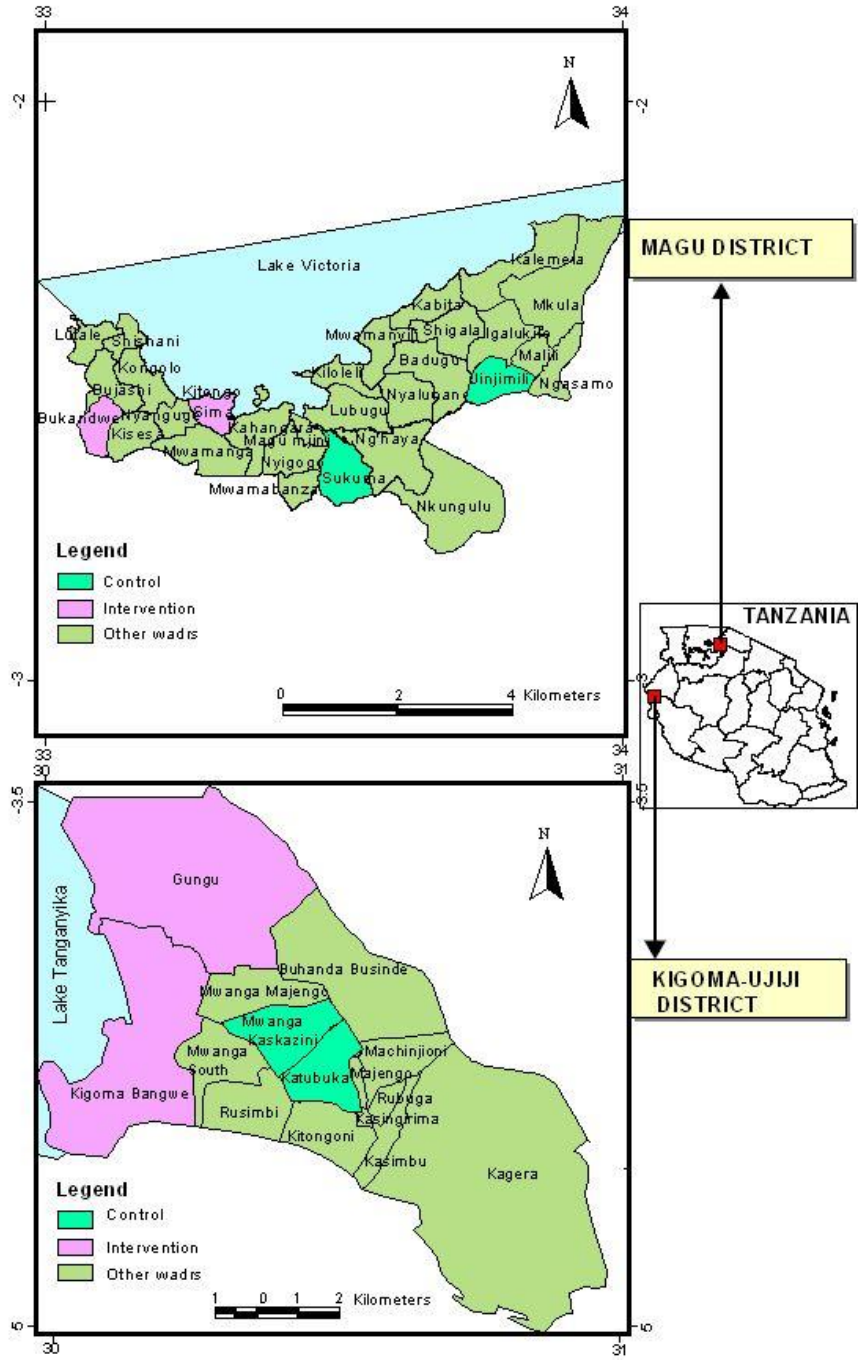
These outcome measures were assessed in the End line Study through qualitative interviews, namely; Focus Group Discussions with community members and Semi-Structured Interviews with community activists, service providers and community leaders.

1.1.4 Sampling and Sample Size

For the Quantitative Survey, we estimated a sample of 1600 independent adults (aged between 18 to 49 years), women and men. The eight study communities (4 interventions and 4 controls) range in size from 10,167 to 25,224. At the 95% confidence level and a confidence interval of 6.88, the number of study respondents per community was 200. In total, 1591 people were surveyed (794 men and 797 women).

The Qualitative Data was collected through four Focus Group Discussion Sessions with a total of 33 discussants and through semi-structured interviews involving 70 respondents. This involved 70 people represented by 40 community activists (20 males and 20 females), 30 service providers (police, health workers, social welfare officers and community leaders, males and females).

Figure 1: Map of Sampled Project Area



1.1.5 Recruitment methods and selection criteria

As in the baseline study, the target population for the community survey sampling was chosen to reflect the population most likely to have repeated and extensive contact with intervention activities and materials, those living in close proximity to the community activists (in intervention sites) or passive volunteers (in control sites).

A multistage stratified random sampling process used at baseline was employed to sample individuals within sites. To ensure the safety and confidentiality of the respondents, a maximum of one person per household was selected to complete the survey. A person was eligible for inclusion if he/she was between the ages of 18 and 49 years, had lived in the village for at least a year, usually shared meals with the household, and was of the same sex as the community activist (CA) by whom he/she was sampled.

In each ward, streets were selected randomly and then we systematically selected each second household targeting eligible women and men until the required sample size was attained. For the Focus Group Discussions, community members were mobilized and assembled by the respective host organizations with the assistance of local leaders and community activists. Kivulini and WPC sampled 2 Focus Groups per site made up of 8 males and 8 females, in total 32 community members' irrespective of socio-economic status. For the semi-structured interviews, interviewees were selected purposively, meaning that they were strategically selected because of their specific knowledge and role in the SASA! programme. They included community activists, local leaders and service providers. The 70 interviewees consisted of 40 community activists (20 males and 20 females) and 30 service providers (police, health workers, social welfare officers and community leaders) and were interviewed one-on-one using a qualitative semi-structured interview guide (added at End Line). The hypothesis was that the sampled population was likely to have noted reduced violence in the past 12 months as compared to the period before.

1.1.6 Quantitative Data and Quantitative Data Collection

The same tools used for quantitative data collection at baseline were used for control and intervention communities at end line to make direct comparison of graphs and tables between control and intervention communities possible and thus determine the impact of the intervention. Interviewers were trained for two days on issues such as research confidentiality, protocols, ensuring common understanding of questions, and standard ethical procedures.

The respondents were ready to participate upon signing the consent form. We ensured safety of both respondents and of the interviewer. By consenting, the respondents were assured of a respectful and non-threatening participation and were informed of their freedom to withdraw at any time. No personal identifiers were collected from any study participant. To facilitate freedom of expression, all interviews were gender-matched; a female participant was interviewed by a female interviewer and a male by a male interviewer. All interviews were conducted in a private setting in the surroundings of the home of the respondent with a calm environment to allow both freedom of expression and to enhance confidentiality. Female respondents were treated with special caution as per WHO regulations.

Qualitative data collection was conducted in the intervention communities only. It involved two Focus Group Discussions for community members, one for males and another for females per site. The original qualitative questions were adjusted to capture any comparative changes that had occurred during the intervention period. The semi-structured interviews were added at follow-up to capture in-depth opinions from community activists, local leaders and service providers. This facilitated the collection of participants' subjective experiences of SASA! and provided

us with richer data. The interviews were audio recorded, transcribed verbatim and analyzed using thematic analysis. The data was compared to the baseline data from 2014.

1.1.7 Literature Review

Studies on IPV were analyzed to support triangulation of the findings. Triangulation was used to capture prevailing dimensions of the phenomenon and to get good understanding from different prospects.

1.2 Data Analysis

1.2.1 Quantitative Data Analysis

Quantitative analysis was conducted using SPSS to compare secondary outcomes in intervention and control communities. Based on preliminary assumptions that both outcome prevalence and intervention effects would differ between men and women, the descriptive statistical analysis was made separately for male and female respondents (IPV knowledge and attitudes, physical, sexual and emotional violence as outcome variables). Further analysis was made to compare differences in outcomes between intervention and control communities and between baseline and end line values. The point difference was calculated in percentages. This enabled measurement of change along all study indicators and the overall impact of the intervention. Basically, outcome measures were determined between control and intervention communities.

1.2.2 Qualitative Data Analysis

The transcribed Focus Group Discussions and the responses from the in-depth interviews were coded to identify themes, patterns and relationships and were analysed using thematic analysis. This was followed by interpretation to capture the meanings, values, experiences, and opinions of community members, service providers, community leaders and activists living and working in the community where women have experienced intimate partner violence.

The findings were triangulated with empirical data obtained by quantitative methods. Triangulation captured different dimensions of the phenomenon to obtain a good understanding from different perspectives. The quantitative end line survey data was compared to baseline data from 2014. Triangulation was completed by getting perceptions of other researchers during the analysis phase with the aim of strengthening the analysis further.

1.2.3 Ethical Considerations

Before conducting the End Line Study, a permit to conduct research in the respective wards was sought from the Regional Administrative Secretaries of each implementation region and ethical clearance was sought from the Lake Zone Institutional Review Board (LZIRB). All respondents and discussants provided written informed consent, which assured them of confidentiality of what they would disclose. The guiding principle was that a person's decision to participate in the study was to be voluntary and based on adequate information and understanding of both the study

and the implications of participation. Interviews took place in a safe and private place of their choice. To our knowledge, SASA! is the only community mobilization intervention of its kind in Tanzania that seeks to engage whole communities to change harmful social norms and address power imbalances between women and men that perpetuate IPV and HIV risk. For all data collection methods, the key principles in research ethics were followed to protect the human rights of respondents.

1.2.4 Particular considerations related to domestic violence research

For female respondents, interviews were conducted in a more private setting as per WHO regulations. The study was framed as a study on women's health and family relations to enable the respondent to explain the survey to others safely. The interviewer training included practice on how to terminate an interview if the impact of the questions on the respondent became too negative. Research Assistants were trained to refer women requesting assistance to available local services and sources of support.

1.3 Study Strengths and Limitations

The study being a randomized controlled trial prevented potential bias. The design of semi-structured questionnaires and Focus Group Discussion questions facilitated important insights into pathways of change as reported by the discussants. However, there are several potential limitations, including:

(i) A possibility of reporting bias since men and women interviewed were not in the same intimate relationships, so the respondents or discussants might not have told the researchers the full truth when responding, since only one member of the couple was interviewed. The results might have been different if both members of a couple were interviewed.

(ii) Another limitation is that there is a possibility of 'contamination' between the intervention and control sites in the sense that SASA! messages might have reached the control villages as well, through the dissemination of communications materials and movement of people between sites, which might have had an impact on the intervention effects.

(iii) The duration of the SASA! intervention in Kigoma and Mwanza is limited, which might make it harder to document a clear intervention effect on behavior, attitudes and social norms, since this usually require long-term efforts. It is well-known that changing behavior, attitudes and social norms related to violence against women and gender inequality require long-term efforts. There are no simple solutions.

(iv) Asking about past events is influenced by memory capacity. Therefore, we cannot rule out the recall bias.

(v) There were respondents who refused to answer some of the most sensitive questions thus weakening the results. The most sensitive questions were those concerning women's past year experience of violence and married men's concurrent sexual partners in the past year.

(vi) The Tanzania Demographic and Health Survey (TDHS) investigated whether women seek support after experiencing violence and what is the most common source of support. It would have been interesting to see how this has evolved over time. TDHS reports that 'More than half of women who have experienced physical or sexual violence sought help to stop the violence. The most common sources of help for these women are the woman's own family (56%) and her husband's or partner's family (42%)'.

Despite the limitations mentioned above, the intensive training of researchers conducted prior to data collection ensured that the SASA! End Line Study 2018 was conducted with as few methodological limitations as possible. We believe that the study has managed to assess the impact of the SASA! approach as it set out to do, bearing in mind that the intervention is a community mobilization approach that walks communities through a process of social change with the aim of addressing gender discriminatory social norms, violence against women and HIV risk behaviours.

2.0 PART II FINDINGS

2.1 Demographic characteristics of study respondents

The demographic information collected was as follows: age of respondents, education level, marital status and religious affiliation. The total number of End Line survey respondents aged 18 to 49 was 1591 (794 males and 797 females). Moreover, 33 men and women participated in the Focus Group Discussions and semi-structured interviews were conducted with 70 people, making a grand total of 1694. The qualitative study participants were aged 18 to above 50. When comparing with the Baseline study and survey respondents, there were slight differences. There were in total 1629 survey respondents at baseline and 24 Focus Group discussants, and no semi-structured interviews were conducted. The semi-structured interviews were more relevant at End Line as this allowed for a more in-depth exploration of the community members' perceptions of the SASA! programme.

Age: The dominating age group for the quantitative survey was 18-28 in both intervention and control communities. The minority were aged 40-50. This corresponds to the age structure for respondents at Baseline.

Marital Status: As at Baseline, most of the respondents in the End Line Study communities were married, 590 (74.4%) in intervention areas and 485 (61.8%) in control villages. Single respondents were the second largest group, with 143 (18%) for intervention communities and 159 (20%) for control communities. The 'other' category had fewer respondents, which is comparable to Baseline values.

Religious Affiliation: As at baseline, the study reached more Christians (37%) followed by Muslims (24%), while the rest of the respondents were either following traditional religion or had no religious affiliation. Catholics made up the largest group among Christian respondents.

Education: The overall level of education among respondents is low, as it was at Baseline, with notable differences between men and women. 15.1% of respondents, mostly women, had no formal education, nearly half (49.9%) had completed primary school education and 14% had secondary education, while only 1.4 % had technical or university education, with fewer women at such higher levels. The rest had partially completed primary or secondary education. This means that most of the project beneficiaries were primary school leavers, which affects their capacity to make informed decisions in their lives.

Economic Participation: This was a financial inclusion component. Compared with 2014, there was a significant increase in the number of women that are engaged in business activities, from 55.6% to 81.1% in intervention areas and from 47.7% to 75.1% in control areas, suggesting that their economic independence has increased. The findings are more or less constant for men compared to 2014. Consequently, at end line women in both intervention and control communities are more likely to have earned money in the past three months, just like men.

The findings indicate that both Baseline and End Line communities were still comparable demographically.

This demographic information for survey participants is presented in Table 1, organized by type of community (intervention and control) and by sex as compared to Baseline.

Table 1. Demographic Information

	Baseline				End Line			
	Intervention		Control		Intervention		Control	
	Women n=378 %(N)	Men n=486 % (N)	Women n=415 % (N)	Men n=351 %(N)	Women n=427 %(N)	Men n=426 %(N)	Women n=370 %(N)	Men n=368 %(N)
Age								
18 – 28	153 (40.5%)	205 (42.2%)	179 (43.1%)	142 (40.5%)	159 (39.8%)	170 (42.7%)	146 (36.7%)	187 (47.0%)
29 – 39	150 (39.7%)	165 (34%)	171 (43.1%)	111 (31.6%)	136 (34.1%)	134 (33.8%)	137 (34.4%)	96 (24.2%)
40 – 50	75 (19.8%)	112 (23%)	65 (15.7%)	97 (27.6%)	132 (33.1%)	122 (30.7%)	87 (21.9%)	85 (21.5%)
No answer		4 (0.8%)		1 (0.28%)				
Marital status								
Single	48 (12.7%)	132 (27.2%)	28 (6.7%)	70 (19.9%)	42 (10.5%)	101 (25.3%)	40 (10.1%)	119 (29.8%)
Married	275 (72.8%)	317 (65.2%)	308 (74.2%)	238 (67.8%)	296 (74.5%)	294 (74.2%)	262 (66.1%)	223 (57.4%)
Co-habiting	17 (4.5%)	27 (5.6%)	50 (12%)	37 (10.5%)	26 (6.4%)	16 (4%)	23 (5.7%)	12 (2.9%)
Widowed	19 (5%)	0	17 (4.1%)	1 (0.3%)	29 (7.3%)	8 (1.9%)	21 (5.3%)	3 (0.7%)
Divorced	19 (5%)	8 (1.6%)	12 (2.9%)	4 (1.1%)	34 (8.6%)	7 (1.8%)	21 (5.4%)	7 (1.7%)
No answer		2 (0.4%)					3 (0.8%)	4 (1.09%)
Religion								
No religious affiliation	18 (4.8%)	39 (8%)	25 (6%)	20 (5.7%)	13 (3.4%)	48 (12.2%)	48 (12.3%)	76 (19.4%)
Catholic	102 (27%)	155 (31.9%)	134 (32.3%)	99 (28.2%)	98 (24.9%)	124 (31.3%)	92 (23.3%)	91 (23%)
Born again	44 (11.6%)	37 (7.6%)	54 (13%)	28 (28.2%)	46 (11.5%)	31 (7.8%)	46 (11.5%)	26 (6.5%)
Lutheran	37 (9.8%)	36 (7.4%)	40 (9.4%)	42 (12.0%)	10 (2.5%)	10 (2.5%)	8 (2%)	19 (4.9%)
Muslim	113 (29.9%)	142 (29.2%)	75 (18.1%)	98 (27.9%)	131 (32.7%)	126 (31.4%)	58 (14.5%)	80 (19.9%)
Other	63 (16.7%)	76 (15.6%)	85 (20.5%)	61 (17.4%)	125 (27.7%)	86 (21.8%)	115 (29.3%)	76 (19.2%)
No answer	1 (0.2%)	1 (0.2%)	2 (0.4%)	3 (0.8%)	4 (0.9%)	1 (0.2%)	3 (0.8%)	

Education								
No formal education	75 (19.8%)	41 (8.4%)	63 (15.2%)	15 (4.3%)	93 (23.3%)	44 (11.4%)	78 (19.7%)	24 (6%)
Some primary	56 (14.8%)	28 (5.8%)	55 (13.3%)	32 (9.1%)	48 (12.1%)	47 (11.8%)	49 (14.1%)	50 (13.6%)
Completed primary	201 (53.2%)	287 (59.1%)	242 (58.3%)	156 (44.4%)	215 (54.4%)	226 (57%)	187 (47.2%)	161 (40.8%)
Some secondary	16 (4.2%)	32 (6.6%)	24 (5.8%)	32 (9.1%)	29 (7.3%)	18 (4.5%)	20 (5%)	24 (6.1%)
Completed second	27 (7.1%)	92 (18.9%)	30 (7.2%)	107 (30.4%)	36 (9.1%)	70 (17.6%)	27 (7.3%)	94 (23.6%)
Technical course					3 (0.7%)	3 (0.8%)	1 (0.3%)	2 (0.5%)
University degree	1 (0.3%)	6 (1.2%)	1 (0.2%)	9 (2.6%)	0 (0.0%)	2 (0.5%)	3 (1.0%)	7 (1.7%)
Other					1 (0.3%)	15 (3.7%)	1 (0.3%)	6 (1.4%)
No answer	2 (0.5%)				2 (0.5%)	1 (0.2%)	4 (2.2%)	
Worked for money in the past 3 months	210 (55.6%)	397 (81.7%)	198 (47.7%)	295 (84.1%)	301 (70.5%)	379 (89.0%)	275 (74.3%)	308 (83.7%

Source: Field Data Collection at End line May/June 2018

2.2 Knowledge of Intimate Partner Violence against Women

The study aims to document changes in the level of knowledge of intimate partner violence against women in the intervention communities compared to the situation at baseline and compare this with the situation in control communities. We want to examine changes, if any, in knowledge and awareness of IPV, including what community members consider violence and what they think might trigger it and whether the SASA! intervention has contributed to changed perceptions.

The level of knowledge was tested across five categories and respondents were provided with statements that they were asked to agree or disagree with. For the first statement on the issue of **financial control by husbands as a source of violence**, women in both intervention and control communities stood out as increasingly seeing financial control

as a source of violence from Baseline to End line. In intervention communities, the figure went up to as much as **87.8% from 48.1%** at Baseline and in control communities it went up to **69.5% from 60%** at Baseline. The same applies to men, but to a lesser extent as the figure in the intervention communities went up to **56.6%** from **40.3%** at Baseline. In contrast, the figure decreased in the control communities to **39.4%** from **41.6%** at Baseline. In general, the intervention communities portrayed a bigger shift at End Line compared to Baseline.

The study also wanted to explore respondents' perceptions concerning the statement that "IPV affects children who witness it". The findings reveal that fewer women supported this statement at End Line, with figures going down from 63.5% to 52.2% in the intervention communities. For men in the intervention communities, in contrast, the figure increased from 49.4% at baseline to 73.5% at end line. In the control communities, there was also a decrease among women from 58.8% at baseline to 53.0% at end line and a significant increase among men from 44.7% at baseline to 79.6% at end line. These findings reveal that men generally perceive that IPV negatively affects children to a larger extent than women both in intervention and control communities.

Another statement was that **"disclosure of HIV infection by women leads to violence**", and here nearly all women in the intervention communities (up to **92.7% from 64.8%** at Baseline) agreed to the statement, as well as many women in control communities **(75.4% from 63.6%** at Baseline). As for male respondents, there was an insignificant rise from **65.0% to 68.3%** in intervention communities and a decline from **65.5% to 58.7%** in control communities. There was an observed difference in perceptions between men and women regarding what triggers violence against women, where women seemed to be more progressive, meaning that they had higher understanding of factors that lead to violence. The findings also suggest that there is denial among men regarding violence related to women disclosing their HIV status.

Alcohol increases risk of violence: More than 80% of respondents in all communities at Baseline concurred that alcohol was a risk factor for violence against women, with a further increase at End line. The figure was particularly high in intervention communities, suggesting that the SASA! intervention might have influenced the knowledge level in this category.

To summarize, the level of knowledge has increased significantly among women and men in the intervention communities with only minor increases in the control communities.

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To summarize, the level of knowledge has increased significantly among women and men in the intervention communities with only minor increases in the control communities.

These findings were further supported by the in-depth interviewees:

> "[SASA!] is an appropriate project because women used to be beaten a lot. So now they have been empowered." *Service provider*
>
> "Violence against Women was enormous a few years ago. Men used force without getting women's consent. Women and men accepted this situation because of ignorance."
> *Focus group discussant*
>
> "Education has been helpful, we now see women going to the gender desk and to the religious leaders."
> *Focus group discussant, Kigoma*

Looking at the respondents who agreed with all of the above statements (see Table 2 below), the number of female respondents in intervention communities that agreed with all of the above statements increased by 22.8 percentage points from baseline and for men it increased by 10.2 percentage points. For women in control communities there is a similar increase (20.2 percentage points), while for men in control communities there is only a 1.9 percentage point increase. There is thus a large variation between men in intervention and control communities. Overall, the findings document that the SASA! intervention has been effective in terms of increasing knowledge of IPV, especially when comparing individual statements that assess knowledge. However, the knowledge of IPV has also increased in control communities since baseline, although to a lesser extent for men.

The findings are presented in Table 2: Intervention communities compared with control communities at Baseline and End Line.

Table 2. Level of Knowledge of Intimate Partner Violence

	Baseline				End Line				Point difference intervention		Point difference control	
Agreement with the following statements	Intervention		Control		Intervention communities		Control communities					
	Women n=378 %(N)	Men n=486 %(N)	Women n=415 %(N)	Men n=351 %(N)	Women n=427 %(N)	Men n=426 %(N)	Women n=370 %(N)	Men n=368 %(N)	**W %**	**M %**	**W**	**M**
Husband controlling finances is a form of violence	182 (48.1%)	196 (40.3%)	249 (60%)	146 (41.6%)	375 (87.8%)	241 (56.6%)	257 (69.5%)	145 (39.4%)	39.7	17.2	9.5	-2.2
IPV affects children who witness it	240 (63,5%)	240 (49,4%)	244 (58.8%)	157 (44.7%)	223 (52.2%)	313 (73.5%)	196 (53.0%)	293 (79.6%)	-11.3	24.1	-5.8	34.9

Disclosure of HIV by women leads to violence	245 (64.8%)	316 (65.0%)	264 (63.6%)	230 (65.5%)	396 (92.7%)	291 (68.3%)	279 (75.4%)	216 (58.7%)	27.9	3.3	11.8	-6.8
Husband violence increases the risk of HIV	265 (70.1%)	310 (63.8%)	269 (64.8%)	239 (68.0%)	393 (92%)	350 (82.2%)	279 (75.4%)	214 (58.2%)	21.9	18.4	10.6	-9.8
Alcohol increases risk of violence	324 (85.7%)	390 (80.3%)	347 (83.6%)	297 (84.6%)	412 (96.5%)	378 (88.7%)	313 (84.6%)	308 (83.7%)	10.8	8.4	1	-0.9
Agrees with all of the above statements	57 (15.1%)	53(10.9 %)	62 (14.9%)	66(18.8 %)	162 (37.9%)	90 (21.1%)	130 (35.1%)	76 (20.7%)	22.8	10.2	20.2	1.9

Source: Field Data Collection at End line May/June 2018

2.3 Attitudes towards Intimate Partner Violence Against Women

There were several attitudinal questions that were asked to identify community members' perceptions of potential justifications for intimate partner violence that revealed significant differences between intervention and control communities. **There was a notable decrease by more than half of the baseline values in the number of women and men in the intervention communities that accepted the reasons given for a husband beating his wife.** The justifications given in the survey were as follows: If she disobeys him; if she answers him back; if she disrespects his relatives; if he suspects that she is unfaithful; if he finds out that she has been unfaithful; if she spends her time gossiping with neighbors; if she neglects taking care of the children; and if she does not complete her housework to his satisfaction. Basically, many women and men in intervention communities no longer accept wife beating for any reason. It was interesting to note that men in intervention communities were exhibiting quite progressive attitudes. On the other hand, there were overall only minor changes in control communities.

This demonstrates that the intervention communities are progressively changing attitudes toward intimate partner violence.

Contrary to this, in the Tanzania Demographic Health Survey (2016), it is stated regarding attitudes toward IPV that:

> '58% of women and 40% of men agree that a husband is justified in beating his wife for at least one of the following reasons: if she burns the food, argues with him, goes out without telling him, neglects the children, or refuses to have sex with him. The most common reason for both women and men to agree that wife beating is justified is a wife neglecting the children (48% and 31%, respectively).'

These results show that without any violence prevention intervention, acceptability of violence against women remains high in many communities in Tanzania.

Other attitudinal questions included whether **respondents agreed that a married woman can refuse to have sex with her husband if she does not feel like it**. The findings show that compared with baseline values, there is a substantial increase in the number of women and men in intervention communities that agree with the statement. In control communities, there is a slight decrease for women and men who agree with the statement. The most significant change was noted among women but also among men in the intervention communities. This is an important attitude shift for both men and women.

Regarding the question whether a woman should tolerate violence from her partner to keep her family together, again compared to baseline, the number of women and men in the intervention communities that were supportive of this statement decreased significantly, while there were only minor changes among men and women in the control communities.

On the question of whether women should be blamed for the violence their partners perpetrate against them, there was a significant decrease among women in the intervention communities compared with baseline values (from 25.1% to 5.4%). The corresponding value for men actually increased by 1.1 percentage points. This means that 17.6% of male respondents in the intervention communities still think that women are to be blamed for the IPV perpetrated against them. The reason why this figure has decreased so much for women could be due to increased awareness among women of their human rights and thus reduced acceptance of IPV. It is however surprising that there was a slight increase among men in intervention communities, suggesting that for certain indicators, the SASA! intervention has had limited effect on male respondents and more targeted efforts might be needed in the future SASA! programme. The differences in control communities were only minor.

Furthermore, the in-depth interviewees were asked to comment on the statement that women are responsible for the violence they experience and there were mixed answers, including:

‘It is not true that women are responsible for violence perpetrated against them, it is the inbuilt structures that have made violence to be part of their lives.’

‘I do not agree with the statement. There is no justification of exercising violence against women.’

‘No I don’t agree, nobody can make another person use violence against them.’

(*Quotes belong to female interviewees*)

While these quotes demonstrate non-acceptance of IPV, there were some in-depth interviewees that still openly accepted IPV, as seen below:

‘The statement is true. Sometimes women provoke their husbands, then they are beaten.’

‘The sentence is accurate –look at the way women dress, the way they answer back etc., what do you expect?”

(Quotes belong to male interviewees)

When it comes to the acceptability of women revealing their experience of IPV to others, there is a significant increase for women in the intervention communities (37.9 percentage point increase) and there is also a noticeable increase among women in control communities (15.7 percentage point increase). Interestingly, there is also a significant increase among male respondents in intervention communities (29.5 percentage point increase), while for men in control communities there is a decrease of 3.1 percentage points. This suggests that the SASA! intervention has had a significant impact on men and women's acceptability of women being subject to IPV revealing their experiences to others in the intervention communities.

The question regarding the acceptability of a woman asking her husband to use a condom shows a significant increase only for women and men in the intervention communities, up from 33.9% to 46.1% for women and up from 28.2% to 58.9 % for men, suggesting that the intervention had an impact in this area.

The acceptability of outsiders intervening when a woman is subject to IPV is also higher in intervention communities (up from 27.3% to 67% for women and 37.7% to 68.1% for men) than in control communities, where the changes were insignificant**.**

These findings suggest that overall there has been a positive change in attitudes toward violence against women in the intervention communities from baseline to end line, resulting in a decrease in the overall acceptability of IPV. There has also been an increase in the acceptability of a married woman's right to refuse to have sex with her husband if she does not feel like it. However, for some indicators, the change in attitudes is significantly higher for women than for men, suggesting that more activities targeting men specifically might be beneficial when scaling up the SASA! intervention to other communities.

All these are in line with the hypothesized outcome number one that "Acceptability of Intimate Partner Violence has decreased after the intervention".

The responses are summarized in Table 3 below.

Table 3. Attitudes towards Intimate Partner Violence against Women

	Baseline				End Line				Point difference in intervention		Point difference in control	
	Intervention		Control		Intervention		Control					
	Women n=378 % (N)	Men n=486 % (N)	Women n=415 % (N)	Men n=351 % (N)	Women n=427 %(N)	Men n=426 %(N)	Women n=370 %(N)	Men n=368 %(N)	W %	M %	W %	M %
A husband has a good reason to beat his wife if:												
She disobeys him	246 (65.1%)	206 (42.4%)	241 (58.1%)	145 (41.3%)	125 (29.3%)	77 (18,1%)	226 (61.1%)	128 (34.8%)	-35.8	-24.3	3.0	-6.5
She answers back to him	181 (47.9%)	126 (25.9%)	226 (54.5%)	95 (27.1%)	94 (22.0%)	56 (13.2%)	189 (51.1%)	130 (35.3%)	-25.9	-12.7	-3.4	8.2
She disrespects his relatives	190 (50.3%)	160 (32.9%)	239 (57.6%)	99 (28.2%)	71 (16.6%)	42 (9.9%)	171 (46.2%)	97 (26.4%)	-33.7	-23.0	-11.4	-1.8
He suspects that she is unfaithful	160 (42.3%)	144 (29.6%)	182 (43.9%)	95 (27.1%)	94 (22.0%)	66 (15.5%)	140 (37.8%)	124 (33.7%)	-20.3	-14.1	-6.1	6.6
He finds out that she has been unfaithful	240 (63.5%)	183 (37.7%)	271 (65.3%)	103 (29.3%)	150 (35.1%)	78 (18.3%)	259 (70.0%)	140 (38.0%)	-28.4	-19.4	4.7	8.7
She spends her time gossiping with neighbours	178 (47.1%)	140 (28.8%)	212 (51.1%)	89 (25.4%)	78 (18.3%)	51 (12.0%)	153 (41.4%)	95 (25.8%)	-28.8	-16.8	-9.7	0.4

She neglects taking care of the children	209 (55.3%)	145 (29.8%)	238 (57.4%)	120 (34.2%)	83 (19.4%)	79 (18.5%)	172 (46.5%)	126 (34.2%)	-35.9	-11.3	-10.9	0
She does not complete her household work to his satisfaction	129 (34.1%)	94 (19.3%)	168 (40.5%)	72 (20.5%)	68 (15.9%)	35 (8.2%)	151 (40.8%)	87 (23.6%)	-18.2	-11.1	0.3	3.1

Attitudes Towards Intimate Partner Violence against Women Continued

A married woman can refuse to have sex with her husband if she doesn't feel like it	160 (42.3%)	303 (62.4%)	204 (49.2%)	258 (73.5%)	301 (70.5%)	365 (85.5%)	192 (51.9%)	247 (67.1%)	28.2	23.1	2.7	-6.4
A woman should tolerate violence from her partner to keep her family together	225 (59.5%)	266 (54.7%)	229 (55.2%)	177 (50.4%)	141 (33.0%)	144 (33.8%)	195 (52.7%)	172 (46.7%)	-26.5	-20.9	-2.5	-3.7
Women are to blame for the violence their partner perpetrate against them	95 (25.1%)	80 (16.5%)	79 (19.0%)	86 (24.5%)	23 (5.4%)	75 (17.6%)	43 (11,6%)	126 (34.2%)	-19.7	1.1	-7.4	9.7

It is okay for her to tell others if she has been beaten by her husband	81 (21.4%)	110 (22.6%)	112 (27.0%)	119 (33.9%)	253 (59.3%)	222 (52.1%)	158 (42.7%)	136 (37.0%)	37.9	29.5	15.7	3.1
It is acceptable for a married woman to ask her husband to use a condom	128 (33.9%)	137 (28.2%)	139 (33.5%)	151 (43.0%)	197 (46.1%)	251 (58.9%)	108 (29.2%)	130 (35.3%)	12.2	30.7	-4.3	-7.7
If a husband beats his wife, others outside the couple should intervene	103 (27.3%)	183 (37.7%)	141 (34.0%)	141 (40.2%)	286 (67.0%)	290 (68.1%)	166 (44.9%)	149 (40.5%)	39.7	30.4	10.9	0.3

Source: Field Data Collection at End line May/June 2018

2.4 Experience of Intimate Partner Violence by Women

Female respondents were asked about their experience of intimate partner violence during the preceding 12 months.

The findings reveal that incidences of Physical IPV like slapping or throwing objects registered a decline by 14.7 percentage points in the intervention communities and a decline of 5.7 percentage points in the control communities. "Pushing, shoving or pulling her hair" registered a decline of 9 percentage points and 5.6 percentage points in the intervention and control communities respectively. For Sexual IPV, the indicator measuring forced sex using physical violence, there was a decline of 7.8 percentage points in the intervention communities, while there was an insignificant increase by 0.2% percentage points in the control communities. When it comes to women accepting sex out of fear of being hurt, the findings show a decrease of 7.2 percentage points in the intervention communities, from 13.8% to 6.6%, while there was a slight increase in control communities. A graphical presentation of the findings for both intervention and control communities is shown in Figure 2 below.

There was a decrease in the number of women in intervention communities that experienced one or more acts of physical violence in the past year by 15.4 percentage points from 120 (31.8%) at baseline to 70 (16.4%) at end line. For women in the control communities, there was an increase by 3.3 percentage points from 35.4% to 38.7%. Similarly, there was a decrease in the number of women in intervention communities that reported experience of one or more acts of sexual violence by 7 percentage points from 66 women (17.5%) at baseline to 45 women (10.5%) at end line. Among women in control communities there was an increase by 13.1 percentage points, from 80 women (19.3%) to 120 women 32.4%).

When looking at the combined prevalence of physical and sexual IPV among female respondents in intervention communities, 23.2% of women report having experienced one or more acts of physical and/or sexual IPV in the past year at end line, which is a significant decrease from 36.5% at baseline. This represents a reduction of 13.3 percentage point and a percentage decrease of 28.3%, further documenting the effectiveness of the SASA! intervention on IPV reduction.

Nationally, 38% of all ever-married Tanzanian women report having experienced physical, sexual or emotional violence in the past year, while as many as 50% have been exposed to IPV in their lifetime, according to the DHS 2015/2016. The IPV prevalence levels in the intervention communities are thus currently significantly lower than the national average. It is however important to note that only the experiences of ever-married women are included in the DHS, while all women in the SASA! survey that had been in an intimate relationship in the past 12 months were asked about their experiences of violence in the past year. While the IPV prevalence rate decreased in the intervention communities, it increased in the control communities. Indeed, there was an increase in the number of women that experienced one or more acts of IPV from 178 women (42.9%) at baseline to 222 women at end line (60%), which is significantly higher than the national IPV prevalence rate. This demonstrates that the SASA! programme has succeeded in reducing IPV in the intervention communities and determines at the same time an urgent need of scaling up violence prevention efforts in the control communities.

A limitation with this part of the study is that some women did not want to answer the sensitive questions on exposure to violence, ranging from 8.9% to 9.8% of respondents for the various questions in intervention communities. For control communities, the range was from 6.2% to 17.6%. The questions on sexual IPV proved to be particularly sensitive. This may suggest that some women are still too afraid to disclose IPV even when their confidentiality is guaranteed. Then again; the reason for them refusing to answer might also be because they are uncomfortable responding to sensitive questions of this kind without necessarily having been exposed to IPV themselves.

Most respondents in the semi-structured interviews reported a similar decline in violence cases, as presented below:

'I like SASA! Because it reduces violence in the community. HIV is very dangerous. Violence was at the peak.'
Community Activist from Magu

'In my village there has been a notable decrease in marriage break down. In this place we have witnessed that violence cases are becoming less due to use of public meetings'
Respondent from Kigoma

'We no longer see women being beaten on the road.'
Respondent from Magu

'Relations have improved; violence has decreased all due to the SASA! Intervention. The married partners now understand each other, polygamy has been reduced, even widow inheritance. Violence has gone down, SASA! has helped. Violence cases have been reduced even at the Village Chairperson's office due to the SASA! intervention.'
Service provider from Kigoma

One discussant in the Focus Group Discussion for men in Magu shared:

'Sexual IPV has gone down after SASA! came in. Before that violence was at the peak and there was no support. Most cases were about wife beating and the local leaders were overwhelmed.'

'Most of us are now educated on the importance of preparing our wives before the sexual act.'

All in all, from the quotations above it is evident that cases of IPV are becoming less frequent in the intervention communities in both Magu and Kigoma. One reason for this is that most community members are trained through public meetings and group discussions and there is more support for women experiencing violence. The main support is from family members that are now aware of SASA! and report the cases to community activists.

However, it was reported by one CA that sexual IPV still occurs:

'One woman was beaten by her husband till her pants were torn and her leg was dislocated. This was because she refused to have sex with her husband after coming back from the labour room.'
Community Activist, Magu

'I have a friend who got four children without his wife's consent.'
Male Focus Group Discussant, Kigoma

On source of violence: 'There are women who feel that they are not getting their rights if they are not beaten.'
Male Focus Group Discussant, Kigoma

The above indicates that some men in Kigoma still believe that beating women is a right and that women expect and accept to be beaten and keep quiet.

Table 4 displays the Findings of this crucial part of the survey.

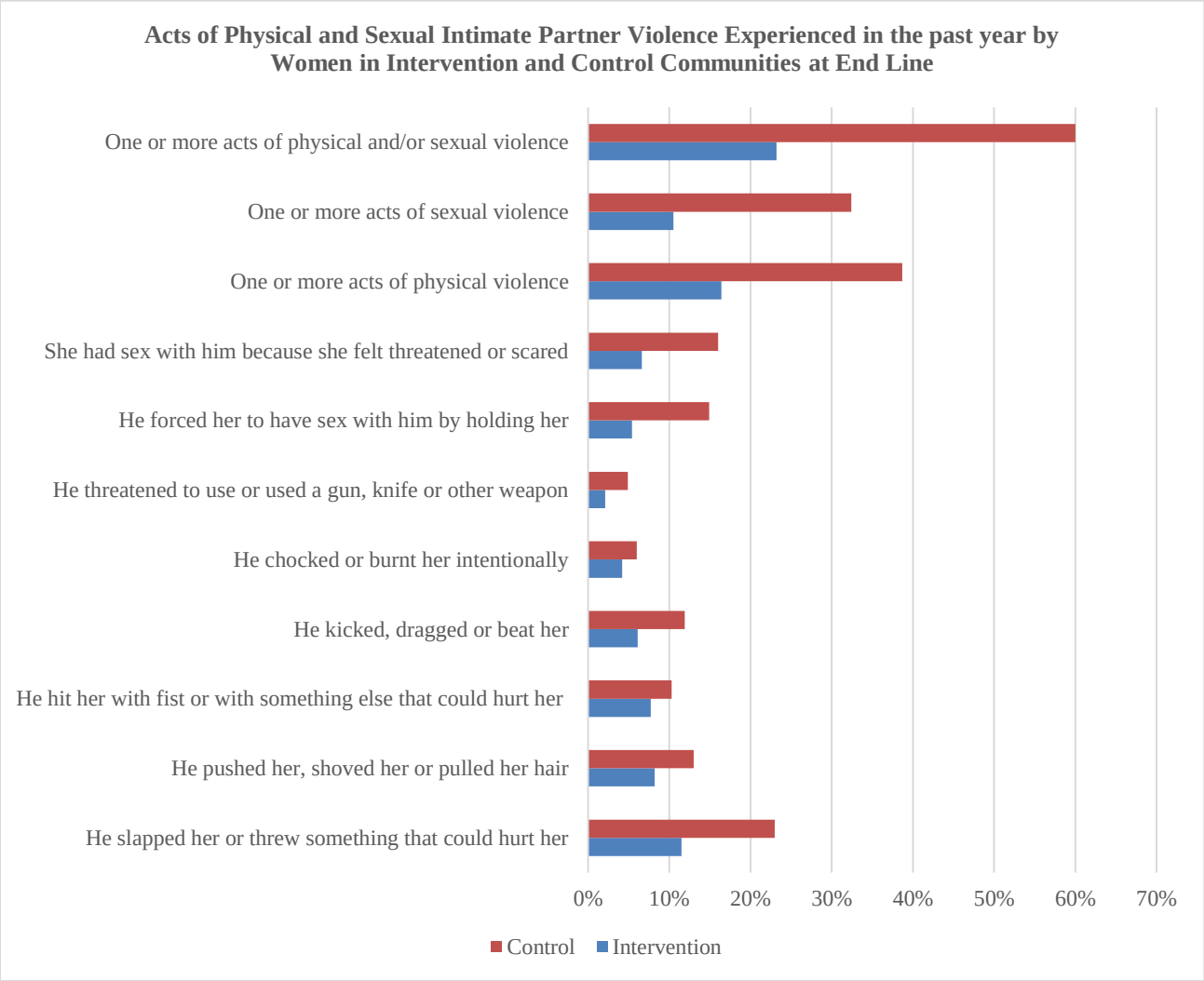
Table 4. Acts of Physical and Sexual IPV Experienced by Women in the Past 12 Months

	Baseline			End Line					
	Intervention	No answer	Control	No answer	Intervention communities	No answer	Control communities	No answer	Point difference Intervention	Point difference Control
	Women n=378 % (N)		Women n=415 % (N)		Women n=427		Women n=370		Women (%)	Women (%)
He slapped her or threw something that could hurt her	99 (26.2%)	10 (2.7%)	119 (28.7%)	5 (1.2%)	49 (11.5%)	39 (9.1%)	85 (23.0%)	23 (6.2%)	-14.7	-5.7
He pushed her, shoved her or pulled her hair	65 (17.2%)	8 (2.1%)	77 (18.6%)	4 (1.0%)	35 (8.2%)	40 (9.4%)	48 (13.0%)	39 (10.5%)	-9	-5.6
He hit her with fist or with something else that could hurt her	69 (18.3%)	9 (2.4%)	76 (18.3%)	3 (0.7%)	33 (7.7%)	38 (8.9%)	38 (10.3%)	48 (13.0%)	-10.6	-8
He kicked, dragged or beat her	62 (16.4%)	9 (2.4%)	88 (21.2%)	0 (0%)	26 (6.1%)	39 (9.1%)	44 (11.9%)	46 (12.4%)	-10.3	-9.3
He chocked or burnt her intentionally	27 (7.1%)	10 (2.7%)	47 (11.3%)	1 (0.2%)	18 (4.2%)	40 (9.4%)	22 (6.0%)	49 (13.2%)	-2.9	-5.3
He threatened to use or used a gun, knife or any other weapon on her	16 (4.2%)	12 (3.2%)	16 (3.9%)	4 (1.0%)	9 (2.1%)	40 (9.4%)	18 (4.9%)	49 (13.2%)	-2.1	1.0
He forced her to have sex with him by holding her	50 (13.2%)	17 (4.5%)	61 (14.7%)	13 (3.1%)	23 (5.4%)	40 (9.4%)	55 (14.9%)	52 (14.1%)	-7.8	0.2
She had sex with him because she felt threatened or scared that he might hurt her	52 (13.8%)	18 (4.8%)	62 (14.9%)	16 (3.9%)	28 (6.6%)	42 (9.8%)	59 (16.0%)	65 (17.6%)	-7.2	1.1

One or more acts of physical intimate partner violence	**120 (31.8%)**	**147 (35.4%)**	**70 (16.4%)**	**143 (38.7%)**	**-15.4**	**3.3**
One or more acts of Sexual intimate partner violence	**66 (17.5%)**	**80 (19.3%)**	**45 (10.5%)**	**120 (32.4%)**	**-7**	**13.1**
One or more acts of physical and/or sexual intimate partner violence	**138 (36.5%)**	**178 (42.9%)**	**99 (23.2%)**	**222 (60%)**	**-13.3**	**17.1**

Source: Field Data Collection at End line May/June 2018

Figure 2: Acts of physical and sexual IPV experienced by women in the past 12 months in Intervention and Control Communities at End Line



Source: Field Data Collection at End line May/June 2018

The study sought to test if the women who had experienced IPV had received help from someone in the community and if so, what kind of help they received.

Overall, the number of women subject to IPV in the past 12 months in intervention communities that received help from someone in the community following the violence increased by 0.8 percentage points**.** In control communities, the figure decreased by 13.1 percentage points.

Generally, control communities displayed lower levels of help giving in each category and there is a major difference between control and intervention communities. However, the increase in community response in the intervention communities is only minor. This might be attributed to the already declining trend of IPV as such in intervention communities, and to the fact that women know where to go for help rather than wait for support, which might result

in fewer cases being directly supported by community members. In any case the effect of the intervention is observed. Also see Figure 3 below. The findings are displayed in Table 5.

Table 5 Community Response to Women Subject to IPV in the Past 12 Months

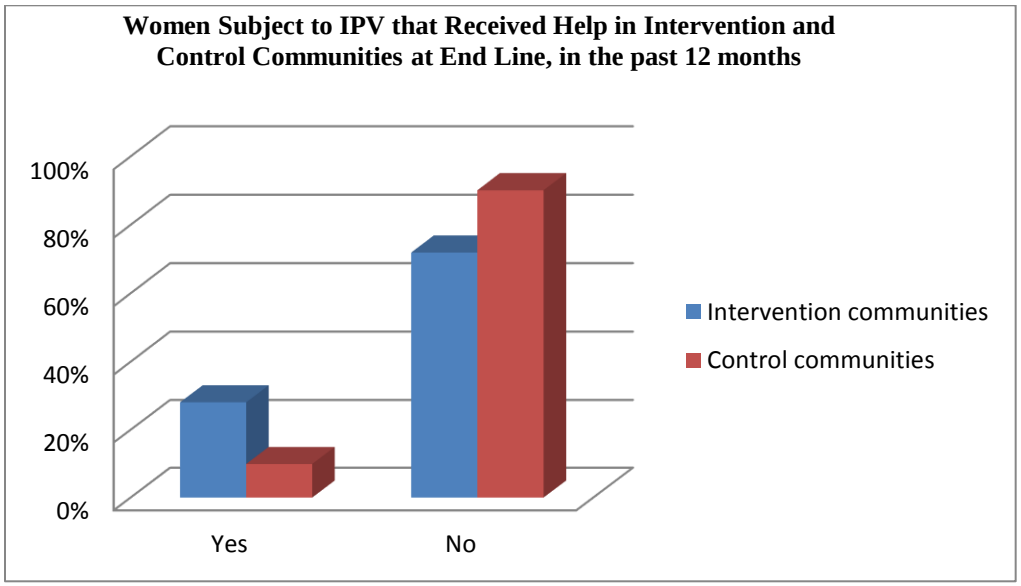
	Baseline		End Line			
	Intervention	Control	Intervention communities	Control communities	Point difference in intervention	Point difference in control
	Women n= max 138 % (N)	Women n=max 178 % (N)	Women n=max99 %(N)	Women n=max 222 %(N)	Women %	Women %
Received help from someone in the community	**38 (27.5%)**	**41 (23.0%)**	**28 (28.3%)**	**22 (9.9%)**	**0.8**	**-13.1**
Someone gathered others in the community to help	24 (17.3%)	22 (12.4%)	22 (22.2%)	16 (7.2%)	4.7	-5.2
Someone knocked on the door and stopped the fight	25 (18.1%)	31 (17.4%)	20 (20.2%)	15 (6.8%)	2.1	-10.6
Someone separated the victimizer and the woman during the violent episode	26 (18.8%)	32 (18.0%)	22 (22.2%)	10 (4.5%)	3.4	-13.5
Someone informed the police or other law	15 (10.9%)	10 (5.6%)	14 (14.1%)	7 (3.2%)	3.2	-2.4

enforcement institution						
Someone asked her if she needed assistance	25 (18.1%)	27 (15.2%)	17 (17.2%)	6 (2.7%)	-0.9	-12.5

Source: Field Data Collection at End line May/June 2018

Note: Baseline data has been revised and a few calculations have been corrected

Figure 3: Women subject to IPV that received help, in the past 12 months



Source: Field Data Collection at End line May/June 2018

2.5 Skills and Behaviour

The respondents were asked about their experience with offering help to women subject to intimate partner violence and of their compliance with a range of gender-specific stereotypes. Being a culture-specific construct, gender portrays significant differences in what women and men can or cannot do.

In both intervention and control communities, men were more likely than women to have helped someone who had experienced IPV (statistically significant). In intervention communities, women were more likely than men to have told a local leader about domestic violence in a nearby home. Men in intervention communities exhibited a higher likelihood of speaking out on violence against women to others in the community and of doing things that are typically thought of as the role of the other gender. For example, there was an insignificant difference in regularly helping with washing dishes comparing with women reporting getting regular help from their husbands. For women

in intervention communities, the rate of doing things that are typically thought of as the other gender's role increased from 41.5% to 33.3%, and for men it went up from 47.5% to 89.7%. This suggests that the SASA! intervention changed attitudes to sharing domestic chores.

Moreover, the number of women in intervention communities that usually feel respected by their partner increased by 4.1 percentage points, indicating a shift in how men perceive and value their female partners. However, slightly fewer men report that they usually feel respected by their partner in intervention communities and a decreasing trend was also noticed in the control communities.

Women in intervention communities displayed an increase by 48.9% for telling leaders about domestic violence experienced by someone else. Interestingly, in control communities, men generally exhibit a more progressive role (26.2%) than women (-1%) for having told a local leader about IPV experienced by someone else.

Findings on gender roles and decision-making power in the past 12 months indicate that in control communities, more men say that they have done things that are typically regarded as women's role than women saying that they have done something considered to be men's role. The difference here is statistically significant.

Moreover, many more women than men in control communities reported that the partner makes most of the decisions about when to visit family or relatives.

These findings are indicative of increased acceptability of equality in gender roles by men in the intervention communities, suggesting that the SASA! programme has succeeded in promoting more equal gender roles and relations at the family and community levels.

In the semi-structured interviews, it was also highlighted that joint decision-making has been strengthened as a result of the SASA! Intervention:

> 'We now sit with my wife and we plan things without quarreling or arguing. We follow the SASA! model. I have added skills and knowledge and also improved my relations and performance. The project has taken me out of deep sleep. I thought after the bride price is paid, I was there to implement things the way I wanted.'
> *Community Activist, Kigoma*

Regarding doing work typically assigned to the opposite sex:

> 'I have changed. I was not washing clothes, fetching water and cooking. Now I love my wife very much. Also, by being an activist and helping people, I have been appointed to buy cotton at our selling point. Now I do not choose what to do whether it is usually done by female or male, I take my child to the clinic, I wash clothes, I fetch water, fetch firewood and take cereals for milling when she is not around"; " There are things I wasn't doing. The SASA! Project has opened me up. I can now do women's roles like fetching water though on a bicycle.'
> *Service Provider, Magu*

Women also gave testimonies;

> 'He used to beat me whenever he got drunk; I used to get psychological violence and to be abused sexually by force. He would wash my clothes so that I keep quiet. But now he has changed. He cooks, he fetches water and our family is a role model. The community is bringing cases to me.'
> *Community Activist, Magu*

The 2015-16 TDHS-MIS asked currently married women about their participation in three types of household decisions: her own health care, making major household purchases, and visits to family or relatives and the results were as follows:

'Married women in Tanzania are most likely to have sole or joint decision-making power with regard to their own health care (72%) and less likely to make decisions about visiting family or relatives (58%) or major household purchases (46%). Overall, 35% of married women participate in all three decisions. Eighteen percent do not participate in any of the three decisions". The TDHS-MIS also reported on problems in accessing health careby saying that "two- thirds of women in Tanzania report at least one problem in accessing health care. The most common problems are getting money for advice or treatment (50%) and distance to the health facility (42%).'

Among the interviewees there were more views regarding improved gender relations:

> 'The families have improved relations; they know the importance of working together. Men and women collaborating – this was never the case before. Relations have improved by about 60%. The project has improved relationships. We men have changed, and we are working side by side with women. The project is appropriate; it has opened us from the previous beliefs which did not value women in Kigoma. SASA! education has opened us. We did not know that a woman also has a voice in the family.'
> *Service Provider in Kigoma*

As seen in Table 1 above, there was a significant increase in the number of women who worked for money in the past three months thus giving them higher economic empowerment, acceptability and opportunities for participation in family decisions and reduced economic violence. This suggests that the SASA! intervention has also had a positive secondary effect of boosting women's economic empowerment, which was supported by a female CA from Magu:

> 'In the past, men sold cotton by themselves. This has changed, they manage the income together. Men left us to do everything from working on the farm, fetching water, firewood, but now even the children are happier and also we are discussing issues in the home. And people are building good homes. There are no longer secret groups like before. They are open, and dad and mom are all contributing. Cooperation is great, and results are big. Women are taking loans to do business, they have stopped being dependents. Men are happy, and the relations are getting better, we are soon taking dividend, one million each, you are invited to witness.'
> *Female Community Activist, Magu*

Regarding intervening when a woman in the community has been subject to IPV they had this to say:

> 'If we know in time we intervene'; 'I usually intervene during the fight. I give them examples of people who have been hurt through this and who now live in harmony.'; 'I usually talk with women who have experienced violence and encourage them to report to authorities.'; 'I refer them to various places like the hospital, police and everything is done at same centre. I follow them up.'; 'Whenever I see a fellow woman being beaten I take action.'; 'When I meet a woman who has experienced violence, I listen to her to determine the degree of violence and talk to the culprit. I refer them either to the police, hospital or to Kivulini lawyers.'; 'They get medical and legal support. We follow them up.' 'Yes, I work on violence against women and it depends on the type of violence. If I can't manage it, I give referral to other service providers like the police, social welfare or Kivulini activists.'
> *Focus Group Discussion, Magu*

Table 6 below displays the findings on reported help giving to women subject to IPV and gender-specific behavior among women and men, in the past 12 months.

Table 6 Help given to women subject to IPV and gender-specific behavior among women and men, in the past 12 months

	Baseline				End Line				Point Difference			
	Intervention		Control		Intervention		Control		Intervention		Control	
	Women n=378 % (N)	Men n=486 % (N)	Women n=415 % (N)	Men n=351 % (N)	Women n=427 %(N)	Men n=426 %(N)	Women n=370 %(N)	Men n=368 %(N)	W %	M %	W %	M %
Helped a woman subject to violence at home	153 (40.5%)	147 (30.3%)	113 (27.2%)	124 (35.3%)	188 (44.0%)	233 (54.7%)	130 (35.1%)	149 (40.5%)	3.5	24.4	7.9	5.2
Told a local leader about domestic violence in a home nearby	38 (10.1%)	106 (21.8%)	52 (12.5%)	74 (21.1%)	252 (59.0%)	126 (29.6%)	143 (38.7%)	74 (20.1%)	48.9	7.8	26.2	-1.0
Spoken out on violence against women to others in my community	94 (24.9%)	170 (35.0%)	105 (25.3%)	120 (34.2%)	92 (21.6%)	282 (66.2%)	37 (10.0%)	171 (46.5%)	-3.3	31.2	-15.3	-12.3
Done things that are typically thought of as the other gender's role	157 (41.5%)	231 (47.5%)	167 (40.2%)	187 (53.3%)	142 (33.3%)	382 (89.7%)	108 (29.2%)	219 (59.5%)	-8.2	42.2	-11.0	6.2
Regularly helped (men) or received help from	64 (16.9%)	232 (47.7%)	115 (27.7%)	218 (62.1%)	103 (24.1%)	356 (83.6%)	68 (18.4%)	208 (56.5%)	7.2	35.9	-9.3	-5.6

men (women) with washing dishes in the home												
Gotten her/his way most of the time during arguments with partner	125 (33.1%)	162 (33.3%)	141 (34.0%)	117 (33.3%)	144 (33.7%)	48 (11.3%)	74 (20.0%)	120 (32.6%)	0.6	-22.0	-14.6	-0.7
Had her/his partner make most of the decisions about when they could visit family/ relatives	210 (55.6%)	136 (28.0%)	258 (62.2%)	130 (37.0%)	190 (44.5%)	125 (29.3%)	188 (50.8.%)	47 (12.8%)	-11.1	1.3	-11.4	-24.2
Usually felt respected by partner	235 (62.2%)	356 (73.3%)	288 (69.4%)	254 (72.4%)	283 (66.3%)	304 (71.4%)	251 (67.8%)	216 (58.7%)	4.1	-1.9	-1.6	-13.7

Source: Field Data Collection at End line May/June 2018

2.6 HIV Risk Behaviour by Men

As indicated in the background section, there are important interlinks between HIV and Intimate Partner Violence. Research conducted worldwide shows that power imbalance between women and men expands male sexual freedom. This also increases women's and men's risk and vulnerability to HIV. Male respondents participating in the study were asked if they had had a sexual relationship with someone else than their primary partner/spouse during the preceding 12 months.

In the intervention communities, the sexual risk behavior among married men and men with a primary partner actually went up to 20.2% from 15.2% at baseline, and in the control communities it went up to 26.4% from 3.1% at baseline. This represents a significant change and confirms that sexual risk behavior among men is still a challenge, even in the intervention communities. This is also supported by statements made by the focus group discussants and interviewees, arguing that men are still hampering the realization of greater social change. Some of the barriers mentioned include: 'Some men are still not close to their families'; 'Patriarchal beliefs are still dominant in some areas'; 'Some men are still too slow to change'.

However, it is important to note that the findings might not be indicative of the larger population because the total number of male respondents denying answering the question was 86 (20.1%) for intervention and 90 (24.5%) for control, as seen in Table 8 below. Nevertheless, the relatively large number of men admitting to having had a concurrent sexual partner might come as a result of entrenched patriarchal social norms and values condoning male extra marital affairs. See Table 7 below for the full overview of responses.

Table 7. Reported sexual concurrency among married/partnered men, in the past 12 months

	Baseline		End Line		Point difference	
	Intervention	**Control**	**Intervention**	**Control**	**Intervention**	**Control**
	Men n=486	Men n=351	Men n=426	Men n=368	Men (%)	Men (%)
Has had a sexual relationship with someone else than spouse/primary partner during the last 12 months	74 (15.2%)	11 (3.1%)	86 (20.2%)	97 (26.4%)	5	23.3

Source: Field Data Collection at End line May/June 2018

Table 8. Male respondents that denied answering question on concurrent sexual behavior at End Line

Intervention communities			Control communities		
Yes	No	No answer	Yes	No	No answer
86 (20.1%)	254 (59.6%)	86 (20.1%)	97 (26.4%)	181 (49.2%)	90 (24.5%)

2.7 Exposure to Violence Prevention Messaging

The study also sought to examine the extent to which the communities were exposed to violence prevention messaging and initiatives compared to the situation at baseline prior to programme initiation. Findings indicate that 3 to 4 times more respondents in the intervention communities from both sexes report having seen people in the community working to prevent violence against women and that they have participated in sensitization activities on healthy and safe relationships more than twice as much as at baseline and in the control communities. The differences in the control communities were insignificant. This suggests that there has been significant exposure to violence prevention messages in the SASA! communities.

Table 9. Exposure to violence prevention messages, in the past 12 months

	Baseline				End Line				Point difference			
	Intervention		Control		Intervention		Control		Intervention		Control	
	Women n= 378 % (N)	Men n=486 % (N)	Women n=415 % (N)	Men n=351 % (N)	Women n=427 %(N)	Men n=426 %(N)	Women n=370 %(N)	Men n=368 %(N)	W (%)	M (%)	W (%)	M (%)
Has seen people in the community working to prevent violence against women	66 (17.5%)	116 (23.9%)	84 (20.2%)	122 (34.8%)	344 (80.6%)	351 (82.4%)	96 (26.0%)	149 (40.5%)	63.1	58.5	5.8	5.7
Has participated in activities on healthy and safe relationships	135 (35.7%)	202 (41.6%)	159 (38.3%)	184 (52.4%)	310 (72.6%)	348 (81.7%)	85 (23.0%)	142 (38.6%)	36.9	40.1	-15.3	-13.8
Once	57 (15.1%)	72 (14.8%)	38 (9.2%)	42 (12.0%)	62 (14.5%)	75 (17.6%)	20 (5.4%)	34 (9.2%)	-0.6	2.8	-3.8	-2.8
Twice	21 (5.6%)	60 (12.4%)	35 (8.4%)	51 (14.5%)	90 (21.1%)	102 (23.9%)	35 (9.5%)	35 (9.5%)	15.5	11.5	1.1	-5.0
More than twice	59 (15.6%)	72 (14.8%)	76 (18.3%)	198 (56.4%)	157 (36.8%)	169 (39.7%)	34 (9.2%)	76 (20.7%)	21.2	24.9	-9.1	-35.7

Source: Field Data Collection at End line May/June 2018

2.8 Qualitative Results

2.8.1. Responses of leaders and other service providers

(i) PERCEPTIONS OF SASA! RELEVANCE AND INITIAL COMMUNITY RESPONSE:

70 service providers, local leaders and community activists gave the following responses: 'SASA! is a project that helps to prevent violence against women and HIV'; 'It is a project bringing change in the community'; 'It is a project that will bring positive change'.

- Regarding how the community received the project, this is what was reported: 'The community received the project well.'; 'Those with vision saw that it will help them and those without vision saw it as a project that will dismantle the community. We targeted those people in order to make them change.' 'Men thought power was being taken away from them. Women felt happy and said God's grace had fallen upon them'.

- 'What I do not like is staying for a long time without getting training. Because we tend to forget we need to keep being reminded'; 'SASA! is doing our work, it is surfacing violence, people will get used and push development further'; 'Yes, appropriate project because in this community girls were not going to school';

(ii) ROLE IN PREVENTING AND RESPONDING TO VIOLENCE AGAINST WOMEN

The service providers in the intervention wards of both districts portrayed a high level of participation and positive response to the project.

- Those interviewed reported on how they were participating in the implementation of SASA!: 'The project has made me participate in a Multisectorial Approach (Health, Community Development Officers, Police, Court)'; 'I do distribute Leaflets, I have conducted group discussions using posters for 4 years'; 'Distributing leaflets in offices and schools so that children can read and be sensitized.'; 'Through SASA!, the government has learnt to work together with other key players to further develop projects.'; 'I am teaching community members on the 4 types of violence I feel important in my community.'

- When asked whether they talk to culprits: 'We talk to the culprits, by warning them against the hazards/consequences of violence on women'; 'I do follow with perpetrators by reminding them of their responsibility'; 'Yes I talk to perpetrators and ask them questions like 'How do you feel when you have to carry buckets of shit'.'

(iii) PERSONAL LEVEL CHANGE REPORTED DUE TO EXPOSURE TO SASA! INTERVENTION IN THE PAST 2 YEARS

Being part of the SASA! intervention led to significant changes reported also at the personal level, as presented below.

- All service providers, local leaders and community activists interviewed had attended the SASA! training: 'I have attended SASA! training and got to understand the 4 phases of SASA!. I have learnt about Physical Violence, Sexual Violence, Psychological Violence and Economic Violence. Power within and Power Against Someone'; 'Now I feel competent in handling women's experience with violence', 'As part of SASA! I have now changed in terms of performing my roles, I have improved the way of attending to my community'; 'SASA! has helped me change my way of life and behavior'. 'SASA! has made me acquire new knowledge to be able to understand violence and steps of referrals.'; 'The training gave me good direction on how to live well in the community.'

- 'I can now give education with self-confidence.' 'Before: I felt bad, there was no teamwork. Now there is teamwork and development. Yes, I have new capacity. I am more innovative.'; 'Yes, SASA! has changed my life' 'Before I felt like violence was something normal and part of a woman's life. Now I feel very sad [whenever a woman is subject to violence].' 'My family is more stable; things were really bad. The community has now trust in me and I have changed my lifestyle, even my sub-village chair knows, they are bringing cases to me.'; 'I feel more innovative'; 'SASA! education has added more urge in me to keep educating even without payment'; 'I would like to use more actions like dancing, drama, poems to attract communities'; 'Before SASA!, I thought the violence had nothing to do with me. Now, it is painful I do not accept this to happen, I want to provide counseling'. 'I will keep educating without any payment even when the project ends.'

(iv) COMMUNITY LEVEL CHANGES IN THE PAST 2 YEARS REPORTED DUE TO EXPOSURE TO SASA! INTERVENTION

More changes were reported at the community level, particularly increased trust and cooperation in families. Some were positive changes in relationships between men and women due to reduced violence. Some significant changes have been reported such as:

- Reporting violence: 'There is increased self-awareness and reporting of incidences in the project wards', Kigoma. 'The perpetrators are being taken to court and facing judgment,' Bangwe, Kigoma.

(v) REPORTED BARRIERS/CHALLENGES TO CHANGE

A range of barriers were mentioned, including traditions and gender discriminatory social norms and practices, men's patriarchal nature, women's lack of self-confidence and structural issues:

- Social norms and harmful practices, including the payment of bride price: For example, in one ward in Magu, 'A woman was beaten until she lost her teeth, but when she went to her family her father sent her back claiming that he had already taken bride price, so she couldn't go back', Magu. 'Some men are against SASA!, especially violent men, because they ask why should we be accused of beating our wives while it is our property. Men's relatives being slow to accept changes. Some men are not ready to do women's roles out of fear of being laughing stocks.'
- Lack of self-confidence by women: 'Some women find it difficult to believe that they can have equal power with men. Some women are not courageous enough to pursue their rights.'
- Men as barriers: 'Some men are still not close to their families.'; 'Patriarchal beliefs are still dominant in some areas'; 'Some men are still too slow to change and are not active in groups. A few men are still difficult to change – They don't believe that women can have power. Some men find it difficult to let women own property'; 'Men denouncing violence.'
- Infrastructure: 'Low frequency and coverage of films affect women who cannot travel to distant places. The project supports a small project area. Fare for seeking referral is a challenge [lack of transportation]'.'Some women fail to get proper healthcare because they have no health insurance'. CDO Magu.

2. 8.2 VOICES OF 33 WOMEN AND MEN IN THE COMMUNITY REGARDING THE PROJECT THROUGH FOCUS GROUP DISCUSSIONS

Theme	Women	Men
Gender Relations: Role of a man and woman in a relationship; Challenges men and women have in their relationship	1. Women of Mwanza identified their roles as: participate in her family roles, knowing her rights, family caretaker and security and be involved in family properties especially when selling. 2. The role of women in Kigoma is to be responsible for communication, implementer of what has been agreed with her husband, staying at home,	1. The role of a woman in a relationship: 'Family care, assistant of father in home care, must spare time for husband, prime minister in the home, assistant of president' (Magu) 2. The role of a man in a relationship: 'Family head, Family care, Family supervisor, family owner, sets family vision'(Kigoma)

	housekeeping, advisor to her husband and respect for her husband. 3. Roles of a man in Mwanza are to involve family when planning, family caretaker and to make sure they get their daily needs. Participating in all family work. 4. The role of Kigoma man is to take care of the family, head of the household, ensure he is taking care of the children and participating in community work	
Violence against Women Attitudes, Behaviors, Response and Perceptions of Change: Frequency of violence after SASA! intervention; Causes of physical violence; Are they helping people who experience violence? Experience of violence against women with disabilities.	1. 'I met a woman who was chased away by her husband after being beaten and we directed her to Kivulini for help.' (Bukandwe-Magu) 2. 'One woman was beaten until she lost her teeth. When she went to her family, the father sent her back.' (Magu) 3. 'One man forced his wife to have sex without her willingness!' (Magu) 4. 'One day a woman was beaten and her pants were torn by her husband because she was not ready to have sex. She was just back from labor ward and was forced to have sex to the extent of dislocating her leg!' (Magu) 5. Other men use force claiming that 'It is what brought you as a woman here –(sex).' (Kigoma)	1. Challenges in relationships: 'Lack of cooperation if one of the partners does not listen to the other.' (Magu) 2. 'Violence has gone down in our area. Support to women who experience violence has increased.' (Kigoma) 3. 'The culprits are being held accountable. One woman took her husband to court for being abandoned. He is now paying her 50,000/= per month as maintenance.' (Kigoma) 4. 'Violence has decreased after SASA!. In the past women would be beaten without getting any support but now men are aware and no longer misuse their power when women refuse to have sex with them.' (Magu) 5. 'Nowadays women are reporting to the leaders and to the Kivulini activists and sometimes we gather ourselves and help out. However, a few women keep quiet when they experience violence.' (Magu)

	6. 'There was one child who is living with disability in the Ward and was raped. The case was taken to the court.'	
Reception to SASA! in the community: If they have heard about "SASA!"; What it means to them; Community feelings regarding SASA! Any resistance and by who? Frequency of SASA! activities in community.	1. 'We normally see SASA! activities once per month. We like the cinema approach and would like to be shown four (4) times per month. We also like to have discussions at ward level. This is because people like cinemas and discussions approaches better than any other method. We also like public meetings. 2. 'I heard of SASA! from WPC, through training provided by activists in this place.' 3. 'But there are some people that are against SASA!, especially violent men. They keep saying why should they be accused of beating their wives as offence while it is their property [because of the bride price system]'. 4. Women from Magu heard about SASA! from the group of Community Activists and they thought it was just about change. Others understood it as training specifically on violence and others thought it was community awareness only. Many people heard about SASA! Through seminars. Women who did not go complained. They see different changes from church ceremonies and different posters/leaflets. Some who heard about SASA! felt good about it but some who did not know about	1. 'At first we thought education was brought here so that women start oppressing us but later we understood the good intention.' (Magu) 2. 'We understand that SASA! Came to demolish violence against women and girls, also HIV.' (Magu) 3. 'Here we do not talk about SASA!, we know Kivulini and their good work of teaching the community.' (Magu) 4. 'Since 2015 when I attended a seminar, I got to know what SASA! is and I can tell anyone about it.' (Kigoma) 5. 'Nobody is resisting SASA! people are happy with it.' (Kigoma)

	it feared it. 5. 'No one has shown any resistance to the SASA! Approach. This was because Community Activists started mobilizing us through cinema, which we like. We also like public meetings. We don't like home visits as time will not be enough to go to each house'. 6. Another from Kigoma went on saying that SASA! is responsible for helping those in need, provision of training, help in fighting against violence, awareness for people living with HIV and AIDS. 7. Those men who are against have done violence and were worried of their future. Some women were even demanding payment for the forced sex. Community activists had to struggle trying to change their attitudes through meetings, counseling and advice. SASA! Activities are heard every day from morning to evening.	
Perceptions of CAs and SASA!'s Impact: If violence has gone down after SASA! and reasons; any increase in support options for women experiencing violence? How are perpetrators held accountable?	1. Magu women agreed that Community Activists (CAs), both men and women, are well known. They accept that they provide training and other support needed. According to these women, the impact of SASA! is there since the cases arising from violence have been reduced very much due to training provided. 2. 'In this place they witnessed that violence cases are becoming less. This is because most community members are trained through public meetings and group	1. 'The CAs do give us education in our VICOBA groups, so we thank WPC because we didn't know we were doing wrong things.' (Kigoma) 2. 'Some used to remain quiet in the village but now thanks to Kivulini there is a relief." (Magu) 3. 'People now feel better with the new education, violence has gone down, before there were a lot of deaths and HIV transmission'. (Magu)

	discussions.' (Kigoma) 3. Kigoma women argued: 'There are slight changes since SASA! started due to community awareness. People feel comfortable when they see changes.' 4. Magu women get support from CAs according to the need. Kigoma women on the other hand said that CAs are talking to them through meetings, giving advice and use posters. 5. 'Perpetrators are reported and dealt with according to the violence done.' (Kigoma) 6. 'Yes, those who perpetrate violence are held responsible for their actions and even further taken up to the court.' (Magu)	4. 'The impact is there but there are still some difficulties. If a man decides to help his wife with washing clothes people will not understand him.' (Magu) 5. 'The CAs are doing good work. Let them continue with education but we need a counseling center in the village instead of going to the local leaders.' (Magu) 6. 'SASA! activities are conducted 2-3 times a week in our area. We love posters.' (Kigoma.) 7. 'I once reconciled a man and his wife after he had beaten her. He has not repeated that act.' (Kigoma)
Recommendations: Making SASA! more effective in the community	1. 'More training and refreshment for CAs on what was done earlier is important.' (Mwanza) 2. 'Expansion of SASA! to other areas where it is found needed and important.' (Mwanza) 3. 'More seminars are needed to different categories of people (youth, children, elders).' (Mwanza) 4. To use international Women events like '16 days against violence.' (Mwanza) 5. 'To help SASA! become more effective, more resources in reducing violence are needed such as posters, cinemas, actors and	1. 'Give protection to the CAs, identity cards and greater collaboration with other service providers for more efficiency and less duplication.' (Kigoma) 2. 'Women to understand that family property belongs to them too. Let them make noise so that they get their rights.' (Magu) 3. 'Keep educating the community. If possible hire permanent trainers rather than part time.' (Magu) 4. 'Reduce other work load for the activists.' (Magu)

	different pictures illustrating violence.' (Kigoma). 6. 'Support on financial resources needed since everything is money.' (Kigoma) 7. 'Women claim that children should get films more frequently as they will help convince parents. Children also like posters and actually when they see them, they rush to them. So, these services should be availed for them.' (Mwanza) 8. Magu women further insisted that the CAs needed more training for them to become strong. 9. 'More education is needed especially for men so that they soften up.'	5. 'Good for activists to visit house to house to educate the families.' (Kigoma) 6. 'Make violence a permanent agenda in the village and sub village meetings and the violence law to be popularized.' (Kigoma) 7. 'The activists need to have a schedule of going around different parts of the sub-village because they are big and some parts are not reached.' (Kigoma)

Source: Field Data Collection at End line May/June 2018

3.0 DISCUSSION

This study has examined the outcomes of the SASA! intervention by comparing baseline data from 2014 with end line data from 2018 for both intervention and control communities. The phenomenon under study is intimate partner violence, which is a human rights violation that has diverse and profound consequences on families and societies, including social, physical and psychological, and even death in the most extreme cases. IPV also hinders economic productivity and educational attainment and women's full and equal participation in society, thus hampering societal development efforts as such. The findings of this study suggest that there have been significant changes between baseline and end line in the intervention communities and between intervention and control communities. Kigoma-Ujiji and Magu are thus fortunate to have been among the first districts in Tanzania where the SASA! intervention is implemented.

Regarding pathways through which change occurs, most participants underlined that SASA! has added value to their intimate relationships. Some also described how improved relationships manifested itself in better communication, negotiation and agreement on important issues among partners, including the importance of preparing women before sex rather than forcing them into it; and the need to be faithful to one another. However, a change in men's risky sexual behaviours is still lacking to some extent.

Status of Outcomes

The study was looking for results based on the following envisioned Outcomes:

(i) Decreased acceptability of violence and increased acceptability of a woman refusing to have sex if she does not feel like it.

Women in intervention communities were likely to have increased their knowledge on the importance of not accepting physical, psychological, economical or sexual violence from their partner, including the right to refuse to have sex with their partner if they do not feel like it. To a large extent men's knowledge, attitudes and practices regarding violence has also improved, though with some exceptions that might be attributed to entrenched patriarchal societal norms and beliefs.

(ii) Decreased prevalence of Physical and Sexual IPV

The effectiveness of the intervention was also evidenced by the 15.4 percentage point decrease in the number of women in intervention communities that experienced one or more acts of physical IPV in the past year, as shown in Table 4 above. In contrast, there was an increase of 3.2 percentage points among women in control communities. The study has also documented a decrease by 7 percentage points in the number of women in intervention communities that had been subject to one or more acts of sexual IPV in the past year. Overall, 23.2% of women in intervention communities report having experienced one or more acts of physical and/or sexual intimate partner violence in the

past year, which represents a decrease of 13.3 percentage points from baseline. This is also well below the national prevalence figures. Indeed, in the DHS 2015/2016, 38% of all ever-married Tanzanian women reported having experienced physical, sexual or emotional intimate partner violence in the past year. In control communities, however, the rate was at 60%, which is a significant increase from baseline (17.1 percentage points).

The IPV prevalence levels in the intervention communities are thus currently significantly lower than the national average. It is however important to note that only the experiences of ever-married women are included in the DHS, while all women in the SASA! survey who had been in an intimate relationship in the past 12 months were asked about their experiences of violence. Additionally, there were also some women that did not want to respond to the questions on exposure to IPV, as seen above. Regardless of this, the findings demonstrate that the SASA! programme has succeeded in reducing IPV in the intervention communities in Magu and Kigoma Ujiji.

(iii) Strengthened community response to women disclosing violence

Generally, control communities displayed lower levels of help giving in each category and there is a major difference between control and intervention communities. However, the increase in community response in the intervention communities is only minor. This might be attributed to the already declining trend of IPV as such in intervention communities, and to the fact that women know where to go for help rather than wait for support, which might result in fewer cases being directly supported by community members. Although the quantitative survey did not differentiate between individual and professional response, it is likely that some of the women who experienced IPV sought support from service providers on their own. Women in intervention communities also reported their experiences of violence directly to local leaders rather than waiting for community support to a greater extent than women in control communities. Interestingly, more men reported to have been more proactive in offering help in intervention communities compared to baseline values and in the qualitative interviews participants also stated that they had supported women who experienced violence.

(iv) Decrease in partners' Concurrent Sexual Behaviours

Contrary to expectations, married men and men with an intimate partner reported a slight increase in sexual concurrency at end line (5 percentage points). However, this is a sensitive question and few of the male respondents were willing to respond to the question – 20.2% of respondents in intervention communities denied responding and 24.5% in control communities. As a result, it is challenging to conclude other than stating that there still appears to be relatively high acceptability of men having extra marital affairs.

(v) Known exposure to SASA! materials, activities and multimedia events (*yes to all three categories*)

The study expected progressive responses within this area. All semi-structured interviewees reported to have undergone the SASA! training and were likely to have been exposed to leaflets, posters, films, scripts, but with reservations on the frequency of films and they wanted more pictures than words: 'Films reach and change more people of all ages and we need more of that.' Also looking at the results of the quantitative surveys, it is likely that the changes in the quality of relationships and improved decision-making in the family and most outcomes indicating a move towards the hypothesized direction suggest that the exposure to SASA! has been effective. Furthermore, findings indicate that 3 to 4 times more respondents in the intervention communities from both genders reported having seen people in the community working to prevent violence against women and that they had participated in sensitization activities on healthy and safe relationships more than twice as much as at baseline and in the control communities.

4.0 LESSONS LEARNT

a) Through addressing the social and cultural contexts in which IPV occurs and involving the whole community, it is possible to prevent IPV and change gender discriminatory social norms.

b) A notable paradigm shift from women accepting IPV to women denouncing violence in intervention communities is achievable.

c) Community Activists are the backbone of the SASA! intervention and key to transforming knowledge, attitudes and behavior to end violence against women and promote gender equality.

d) Community Response to violence against women can also be strengthened when walking communities through the SASA! process of change.

e) The SASA! intervention will not necessarily lead to a change in the risky sexual behaviours of married men or men with an intimate partner, potentially not reducing the risk of HIV transmission.

5.0 CONCLUSION

(i). The SASA! Model is working! Reduction in Physical and Sexual IPV is supported by evidence. The SASA! intervention has impacted positively on reducing violence and to some extent HIV-related risk behaviours and strengthening relationship dynamics in the intervention communities. Changes have been witnessed by different categories of those involved, including community activists, service providers, leaders and community members. The findings demonstrate that violence against women is preventable. The programme has had a positive impact on people's attitudes and knowledge, and we can therefore use the evidence to demonstrate to other actors in the field that SASA! is a successful model when it comes to community-based VAW prevention. We can confidently conclude that the impact is seen. Congratulations to FOKUS, WPC and Kivulini, together you have made a difference in women's lives and the lives of community members at large.

(ii) Other researchers got similar results, including Kyegombe et al. that conducted a study on the SASA! Intervention in Uganda and below is a comparison of the two studies:

Outcome level	SASA! intervention in Uganda	SASA! intervention in Tanzania
Decreased acceptability of violence and increased acceptability of a woman refusing to have sex if she does not feel like it.	SASA! findings in Uganda are more significantly presented in terms of transforming quality relationships: • 'SASA encouraged deeper and more meaningful communication including about women's right to refuse sex" particularly in intervention in communities.' • 'Improvement in relationship quality and intimacy, supportive gender roles, increased levels of joint decision-making. Some form of violence persisting in some relationships.' • 'Women in intervention communities felt more able to refuse sex with their partners than women in control communities, a very significant impact in settings where there is a pervasive sense of male entitlement to sex within relationships, and women have limited control over sex.'	Women in intervention communities were likely to have increased their knowledge on the importance of refusing rather than accepting all forms of violence from physical to sexual, including the right to refuse sex with their partners, to psychological and economical violence. To a large extent, men's knowledge, attitudes and practices related to violence has improved, with some exceptions related to patriarchal societal beliefs.
Decreased prevalence of Physical and Sexual IPV	• Women were 'less likely to report past year experience of sexual IPV'. • There were manifestations of decreased IPV prevalence	• There was a 15.3 percentage point decrease in the number of women in intervention communities that experienced one or more acts of physical intimate partner violence and

	reported through improved relationships, improved communication, negotiation and agreement on important HIV-related risk behaviours, such as the use of condoms; when to have sex; and the need to be faithful to one another. • The same was reflected in qualitative interviews results that shifts operated in broader improvements in relationships like increased trust and cooperation that were likely to lead to reduced violence from men.	an increase of 3.3 percentage points in control communities. • Also, there was a decrease by 7 percentage points in the number of women in intervention communities that reported experience of one or more acts of sexual IPV and an increase of 13.1 percentage points in control communities. • The number of women reporting past year exposure to both physical and sexual IPV decreased by 13.3 percentage points, from 36.5% at baseline to 23.2% at end line. In contrast, there was a significant increase of 17.1 percentage points in control communities, from 42.9% at baseline to 60% at end line.
Increased community response to women disclosing violence	This outcome has not been reported upon in the SASA! Uganda study	• Results indicate almost no change in intervention communities when it comes to women receiving help from someone in the community. However, in control communities, in contrast, the number of women subject to IPV reporting that they received help from someone in the community decreased by 13.1 percentage points. • Generally, control communities displayed lower levels of help giving in each category.

Decrease in partners' Concurrent Sexual Behaviours	Contrary to the SASA! findings in Tanzania, 'Reported sexual concurrency was significantly lower among men in intervention communities.'	• In the Intervention Communities, the reported sexual concurrency among married men/men with primary partner actually went up to 20.2% from 15.2% at baseline, while in control communities it went up to 26.4% from 3.1% at baseline. This suggests that sexual risk behavior among partnered men is still an issue, even in the intervention communities. Many male respondents also declined to answer the question (20.1% in intervention communities and 24.5% in control communities). • The above is also supported by the barriers mentioned by the focus group discussants and the semi-structured interviewees that men were a barrier to realizing greater changes. Some of the barriers mentioned included; 'Some men are still not close to their families', 'patriarchal beliefs are still dominant in some areas; some men are still too slow to change'.
Known exposure to SASA! materials, activities and multimedia events	This is evidenced below: • 'During the session the facilitators encouraged us to test for HIV, so after the session I agreed and we went to test.' • 'We talk about bedroom issues. In those days before SASA!, when my husband wanted sex it was a must, I had to give it to him, but now, if I don't feel like having sex	Through qualitative interviews there was a lot of evidence of exposure to SASA! Activities demonstrated by the statements below: • 'We normally see SASA! activities once per month. We like the cinema approach and would like to be shown four (4) times per month. We also like to have discussions at Ward level. This is

	I will just tell him and he will understand.' (CF1 Female) • They also reported more equitable relationship dynamics, especially in relation to joint decision-making and more open communication with their partners with broader impacts seen among women reporting at least moderate exposure to SASA!. • Barriers to change include partial uptake of SASA!, partner resistance, fear and entrenched previous beliefs	because people like cinemas and discussions approaches better than any other method. We also like public meetings. • 'Since 2015 when I attended a seminar I got to know what SASA! is and I can tell anyone about it'.

To summarize, we agree with Kyegombe et al. that 'SASA! is the only community mobilization intervention in a low- or middle-income country that seeks to engage communities to change harmful social norms and address power imbalances between women and men that perpetuate IPV and HIV risk'.

IPV is still a major public health problem putting women at risk. More resources and programs should be mobilized by policymakers, public health experts and researchers to address the problem of IPV throughout Tanzania.

6.0 RECOMMENDATIONS:

(i) Work to increase women's participation and empower women to be more proactive and break the remaining silence on violence against women to enable them to report the violence and take action.

(ii) A more strategic approach focusing on men only is needed to address sexual risk behaviour among married and partnered men and to produce even stronger behavior and attitude changes within the area of IPV. As put forward by one Community Activist: 'More education is needed, especially for men so that they soften up.'

(iii) Almost all focus group discussants and semi-structured interviewees recommended ongoing education, which also 'reaches school children as prevention before cure'. They also suggested more sessions of educational films that attract more people and educate people.

(iv) Make more use of national and international events to make SASA! more popular.

(v) Research Ethics oblige FOKUS, WPC and Kivulini to scale up the SASA! intervention to the control communities that contributed to the study without getting the privilege of the intervention.

(vi) Based on the hypothesis of IPV and HIV coexistence, there is a need to scale up strategies that address the problem of IPV.

(vii) For sustainability reasons, increase involvement of local government leaders and faith-based organizations to facilitate increased ownership of SASA!. The project might consider providing more skills, such as paralegal counseling, livelihood skills and other exit strategies to the volunteering community activists. Particular attention should be given to Kivulini Women's rights Organization in this regard for maintaining a big team of Community Activists that are motivated to keep serving the community without any payment. This achievement owes a lot to the recruitment policy, which screens them based on the values of commitment, volunteerism and readiness to conduct quality work. This is what SASA! is all about and is why we recommend a replication.

7.0 DISSEMINATION OF STUDY FINDINGS

The following is the Dissemination Plan

1. Community and local level

Produce a reader-friendly report based on the reported findings and share it with the community and LGAs.

2. Regional level

Hold a meeting with key decision-makers, government officials and non-government officials at a regional level including the RC, RCDO, RSWO of Mwanza and Kigoma regions etc.

Use of social media to disseminate the end line study findings to a larger audience and this will eventually target journalists through Kivulini, WPC and TAWREF websites.

Use infographics, which make scary numbers reader-friendly and easier to digest, so people will be more likely to access findings instead of feeding them a lengthy discussion of our research analysis.

3. National level

Arrange a meeting with National strategic officials and invite TAWREF to present the findings. Through the NPA-VAWC committee, Minister of Gender, Chairperson of members of Parliament who is representative of GBV, in-charge of all Police Gender Desks, Regional police commanders in Mwanza and Kigoma regions. Hold a press conference to present the findings to the national strategic officials, media and other non-governmental GBV actors.

4. International level

Use of international events such as 16 Days of activism to hold a joint launch as a platform to disseminate the findings, it should be held before 25th of November. The joint launch will be held in Tanzania (maybe in Mwanza or Kigoma) and in Norway simultaneously. Use other occasions, such as the Commission on the Status of Women.

The end line study results will be shared with Raising Voices and all relevant stakeholders. The results will feed into FOKUS' programmatic work and will be included in future programme proposals.

8.0 ANNEXES

Annex 1. Various pictures

Kivulini researchers in Mwanza

WPC researchers in Kigoma

Focus Group Discussions with women in Kigoma Ujiji and men in Magu

Interviews with service providers.

Annex 2: Various Research Permits.

LAKE ZONE INSTITUTIONAL REVIEW BOARD (LZIRB)

National Institute for Medical Research
Mwanza Medical Research Centre
P.O. Box 1462, Mwanza
Tel: +255 28 2541935
Fax: +255 28 2500654
e-mail: mwanza@nimr.or.tz

MR/53/100/234

Ms Dafrosa Itemba
Tanzania Women's Research Foundation (TAWREF)
Mwanza – Tanzania

24th July 2014

CLEARANCE CERTIFICATE FOR CONDUCTING MEDICAL RESEARCH

This is to certify that the research entitled **"A baseline study for a community intervention to reduce the prevalence of Intimate Partner Violence (IPV) and HIV related drivers in Mwanza and Kigoma Regions, Tanzania (Itemba D *et al*)"** has been granted ethics clearance by LZIRB.

The Principal Investigator (PI) of the study must ensure that the following conditions are fulfilled

1. Progress report is submitted to the Ministry of Health and Mwanza Medical Research Centre, Regional and District Medical Officers after every six months.
2. Permission to publish the results is obtained from NIMR Headquarters.
3. Copies of final publications are made available to the Ministry of Health & Social Welfare Mwanza Medical Research Centre and the National Institute for Medical Research Headquarters.
4. Any researcher, who contravenes or fails to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine. NIMR Act No. 23 of 1979, PART III Section 10(2).
5. Approval is for this study, any other changes should be communicated to the committee for approval.
6. Approval is for one year: 24th July 2014 to 23rd July 2015.

Name: Dr Sophia Kalokola
Signature: _____
Chairperson

Name: Mr Mansuet Temu
Signature: _____
Secretary

CC: Regional Medical Officer
District Medical Officer

JAMHURI YA MUUNGANO WA TANZANIA

OFISI YA RAIS

TAWALA ZA MIKOA NA SERIKALI ZA MITAA

MKOA WA MWANZA
Anwani ya Simu: "REGCOM"
Simu: 028-2500690 -2500686
Fax : 028-2501057/2541242
E-mail: rasmwanza@pmoralg.go.tz
Unapojibu tafadhali taja

OFISI YA MKUU WA MKOA
S.L.P. 119
MWANZA

Kumb.Na. DB.39/193/01/35 **10 Mei, 2018**

Mkurugenzi Mtendaji (W),
Halmashauri ya Wilaya,
Magu.

YAH: KUFANYA TATHMINI YA MRADI WA KUHAMASISHA JAMII KUZUIA NA KUPAMBANA NA UKATILI WA KIJINSIA KATIKA KATA ZA BUKANDWE, KITONGOSIMA, NYANGUGE NA JINJIMILI

Tafadhali rejea mada tajwa hapo juu.

Ofisi ya Katibu Tawala wa Mkoa imepokea barua Kumb.Na. KIV/FOK/03/2018 ya tarehe 27/04/2018 kutoka shirika la "Women Rights Organization" (Kivulini) kuhusiana na mada tajwa hapo juu.

Kwa mujibu wa barua hiyo, napenda kuwajulisha kuwa shirika la Kivulini kwa kushirikiana na shirika la TAWREF watafanya tathmini ya mradi wa **"Kuhamasisha jamii kuzuia na kupambana na ukatili wa kijinsia kazi waliyoifanya tangu kwa mwaka 2015 hadi 2018"** wilayani Magu. Tathmini hiyo itafanyika kuanzia tarehe 26/05/2018 hadi 27/05/2018 chini ya uratibu na usimamizi wa Afisa Maendeleo ya Jamii Mkoa, Mtakwimu kutoka Sekretarieti ya Mkoa kwa kushirikiana na Afisa Maendeleo ya Jamii wilaya ya Magu, Watendaji wa Kata, vijiji na wenyeviti wa vitongoji, vijiji katika kata husika.

Nashukuru kwa ushirikiano wako.

Isaac S. Ndassa
Kny: KATIBU TAWALA MKOA,
MWANZA.

UNITED REPUBLIC OF TANZANIA
PRESIDENTIAL OFFICE

MINISTRY OF REGIONALADMINISTRATION AND LOCAL GOVERNMENT

KIGOMA/UJIJI MUNICIPAL COUNCIL

Presidential Office

MINISTRY OF REGIONAL

Tel. No. 028 2802535

Fax No. 028 2802535

Re. No. C.50/53/114

KIGOMA UJIJI MUNICIPAL COUNCIL

Municipal Director's Office,

Kigoma/Ujiji Municipal Council,

P.O. Box 44,

KIGOMA.

Date: 08th May,2018

EXECUTIVE DIRECTOR,
WOMEN PROMOTION CENTRE,
P.O.BOX 765,
KIGOMA.

REF: PERMISION TO CONDUCT AN ENDLINE SURVEY IN BANGWE, GUNGU, KATUBUKA AND MWANGAKASKAZINI WARD.

Reference is made to your letter Ref. No. WPC/ED/ 2018/0014 of 05 May, 2018.

Kigoma/Ujiji Municipal Council make an appreciation to your efforts and permit the end line survey to be conducted in the above motioned areas to measure the outcome of your new approach (SASA) as requested.

Adherence to the principals and regulations is highly insisted.

Thanks!

MAJIRA JABIRI
For: MUNICIPAL DIRECTOR
KIGOMA/UJIJI

y. MKURUGENZI WA
KIGOMA/ UJIJI

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