# *SASA! Together* Radio Booster

## Study Protocol

**Study title:** *SASA! Together* Radio Booster

**Protocol version:** 6

**Key study team members:**

| Name | Role in study |
|---|---|
| Ana Maria Buller | Principal Investigator, London School of Hygiene and Tropical Medicine |
| Janet Nakuti | Co-Principal Investigator, Raising Voices |
| Gabriella Pinto | Project coordinator, Raising Voices |
| Sophie Namy | Senior advisor, Raising Voices |
| Tanya Abramsky | Research Fellow, London School of Hygiene and Tropical Medicine |
| Alice Witt | Research Assistant, London School of Hygiene and Tropical Medicine |

**Sponsor/funder of the study:** Wellspring Philanthropic Fund

**Collaborating institutions of the study:**

Raising Voices

Peripheral Vision International (PVI)

Uganda Network on Law Ethics and HIV/AIDS (UGANET)

London School of Hygiene and Tropical Medicine

Research World International (RWI) – data collection firm

**Signed:**

Ana Maria Buller

Principal Investigator, London School of Hygiene and Tropical Medicine

Janet Nakuti

Co-Principal Investigator, Raising Voices

**Background**

Violence against women (VAW) is a major global public health, human rights and development concern. Globally, an estimated 27% of ever-partnered women aged 15 to 49 years have experienced physical and/or sexual intimate partner violence (IPV) at least once in their lives. Violence begins early, with almost a quarter of 15-19 year-old girls already subjected to IPV at least once in their lives(1).

The consequences of VAW are severe and far-reaching, impacting on women's physical and mental health (2-4), the health of their children and families(5), and their participation in social and economic activities. Communities burdened by high rates of violence experience lost wages and productivity and incur high costs for response services. Ultimately, VAW denies women, their families and communities the opportunity to reach their full potential.

The past decade has seen a rapid growth in research on VAW, including an increasing evidence base for violence prevention programming(6). One prevention approach that has received a lot of attention is community mobilisation, aimed at shifting the gender norms, roles and attitudes that underlie high community levels of VAW. A recent review of evidence suggests that the success of such approaches depends on very strong design and implementation(7).

The first such community-mobilisation intervention to show community level impacts on IPV was the *SASA!* Intervention(8), developed in Uganda where 56% of women are survivors of IPV(9). Involving all levels of the community, SASA! trains and works with community activists to implement a phased and intensive programme of activities to change the social norms and attitudes that underpin the imbalances in power between men and women that are key drivers of VAWG. A cluster randomised trial of the intervention in Uganda showed that, after three years of programming, the intervention was associated with a 52% reduction in past year experience of physical intimate partner violence among women (0.48, 95% CI 0.16 to 1.39) as well as statistically significant reductions in the acceptability of IPV(10). Among those with prior experience of IPV, statistically significant impacts were also observed for cessation of physical IPV, sexual IPV and emotional aggression(11). Since the trial, the SASA! Intervention – and the 2020 revision known as SASA! Together - has been adapted and implemented in 35 countries by over 60 organizations.

There is now interest among partner organisations and donors on how to intensify *SASA! Together* scale up efforts, including in 'hard to reach' communities. Furthermore, the continuing COVID-19 pandemic is challenging the VAW prevention field to find innovative ways to engage communities effectively and safely, including during lockdowns and other restrictions to public gathering. This includes exploring the role that media can play in violence prevention programming, and how it can complement other community engagement activities.

To date, the evidence base around social marketing campaigns and 'edutainment' as a means to prevent VAW is limited. Campaigns that use mass communication such as television or radio are attractive as they can reach large numbers of people at relatively low cost. They aim to raise awareness about issues and services, provoke discussion, discourage harmful norms and promote positive norms. The role of media in shifting attitudes and norms around violence against women, and IPV in particular, has gained more traction in recent years with multicomponent interventions including radio programmes associated with positive impacts on IPV knowledge and awareness, decreases in gender-inequitable attitudes, increases in joint decision-making and increases in communications about domestic violence and sexual decision-making (12-14). Examples of more comprehensive IPV edutainment campaigns include Soul City in South Africa(12) and Puntos de Encuentro's Sexto Sentido in Nicaragua(13), which integrated social messages into popular high-quality radio and television drama series/talk shows. However, few such interventions have been

subject to rigorous evaluations, and doubts remain about the potential for media interventions alone to lead to sustained change in community-levels of IPV because of their didactic one-way nature(15). A recent review of interventions to prevent IPV concluded that such interventions 'may have a role in combination with other components of interventions designed to impact at a community level'(7).

In response to current challenges and evidence gaps, this project will create and evaluate a *SASA! Together* 'Radio Booster', that will be implemented alongside SASA! Together community programming in Kasese District in Western Uganda. The booster is intended to expand SASA! Together scalability and address barriers to in-person programming, such as conflict, humanitarian emergencies, sparsely populated (and/or geographically isolated) communities, and individual-level factors such as restricted mobility.

**Aims and objectives**

The overarching aim of the project is to assess the potential for a 'radio booster' to strengthen and expand existing in-person *SASA! Together* programming to prevent VAW.
The project comprises two strands, the development and implementation of the *SASA! Together* Radio Booster, and a program of research to evaluate this 'booster'. Each strand has specific aims and objectives.

***Intervention development***

The *SASA! Together* Radio Booster aims to enhance program reach, inclusivity, and impact at this critical moment when innovative prevention strategies are urgently needed. Specific objectives are to:

- create a high-quality adaptation of *SASA! Together* content for radio;
- implement *SASA! Together* Radio Booster programming;
- create a '*SASA! Together* for Radio' programming guide to support partners in implementing the radio components alongside community *SASA! Together* programming

***Evaluation research***

The evaluation research aims to assess the ways in which the *SASA! Together* Radio Booster strengthens the delivery and *potential for* impact of *SASA! Together* community programming. Specific objectives are to:

1. *Explore the extent to which the Radio Booster expands the reach of SASA! Together, overall and among specific subgroups of the community (e.g. by sex, age, disability status)*
    a) Measure radio access within the communities
    b) Measure proportion of the community that are aware of the Radio Booster, and the means through which they have heard about it
    c) Measure exposure to the *SASA! Together* Radio Booster, including frequency and regularity of listening
    d) Explore motivations/facilitators for listening (including acceptability, enjoyment of content, personal relevance of content, community importance of content, educational purposes, etc)
    e) Explore barriers to listening (no access to radio, timing of broadcasts, too busy, content unacceptable to self/others in household or community, fear of being overheard, not engaged by content, etc)

f) Estimate numbers reached by Radio Booster alone, *SASA! Together* community activities alone, or both
g) Explore the extent to which listeners have discussed the Radio Booster with others (content/ideas with other listeners; recommended programme to non-listeners)
h) Explore staff and community activists' experiences of implementing the radio drama intervention

2. *Qualitatively assess potential mechanisms of 'booster' effects of the radio programming:*
    a) Assess the extent to which listening to the radio programme promotes increased engagement with *SASA! Together* community activities (and vice versa)
    b) Explore whether (and how) *SASA! Together* core ideas are reinforced by the addition of the Radio Booster?
    c) Explore the role of 'listener groups' in promoting critical thinking about Radio Booster content/facilitating links with *SASA! Together* ideas
    d) Document any ethical /unexpected issues emerging from the airing of the Radio Booster.

3. *Assess community members'/leaders' perceptions of the Radio Booster's influence:*
    a) How do listeners describe their engagement with the programme? (e.g. Which characters do they like/dislike? Which storylines resonate more/less?)
    b) To what extent does listening prompt critical reflection, deepen reflection over *SASA! Together* ideas, influence new ways of thinking/acting/ etc?
    c) Do listeners perceive the Radio Booster to have led to any changes in their intimate relationships, tolerance of violence, help seeking intentions/behaviours, level of personal activism? What role has the radio booster played in these changes?
    d) Do listeners perceive that the Radio Booster has led to any changes in their relationships with others, beyond their intimate relationships, e.g., with children, extended family, community members etc.?
    e) Do listeners perceive the Radio Booster to have led to any positive changes among others in the community (increased awareness/discussion of VAW, improved responses to VAW, activism, quality of intimate relationships, relationships with others, levels of violence, etc)?
    f) Explore acceptability of Radio Booster content to community leaders, and the influence they perceive it to have had on institutional practices.

4. *Quantitatively assess change among community members (over the course of radio programming), in relation to:*
    - Attitudes relating to intimate relationships and the acceptability of IPV against women
    - Quality of intimate relationships (trust, communication, decision-making, sexual decision-making etc.)
    - Activism/intention to prevent or respond to IPV

    and to compare this change between listeners/non-listeners. (Exposure levels permitting, this will be further broken down to compare outcomes in four exposure groups: Listen to radio + participate in *SASA! Together* community activities; Listen to radio only; Participate in community activities only; No exposure to radio or community activities.)

This research protocol henceforth outlines methods for the research component of the project.

## Methods/design

### *Setting*

The study will assess the implementation of the Radio Booster alongside *SASA! Together* community programming in Kisinga Sub County of Kasese District in Western Uganda. Kisinga Sub County comprises 6 parishes and 37 villages (smallest administrative unit) spread across urban, peri-urban and semi-rural areas.

The population of Kasese District as a whole is young, with over half of the inhabitants under 18 years of age(16). It is a predominantly agricultural District, with most households engaged in subsistence farming. Though there are three tribes indigenous to Kasese District, the vast majority of the population in Kisinga Sub County belong to the Bakonjo tribe and speak the Lukonzo language.

Access to schooling is lower than the national average. At the time of the 2014 National Census, in Bukonjo County East (in which Kisinga Sub County is situated), only 85% of primary school aged children were attending primary school. The corresponding figure for secondary school attendance among secondary school aged children was 29%. Literacy rates are lower for women than men, with 44% of women and 25% of men reported as illiterate(16).

Kasese has high rates of child marriage, with the Census showing 14% of 10-19 year old females having ever been married, and 18% of 12-19 year old females having ever given birth. According to regional estimates from the 2016 Demographic and Health Survey, 58% of 15-49 year old ever-married women have experienced physical, sexual or emotional IPV during their lifetime(9). Patriarchal norms are prevalent, with 40% of women and 42% of men expressing the belief that it is acceptable for a husband to use violence against his wife.

In Uganda, radio is the most popular form of media, with a plethora of national, regional and local radio stations. The 2015 BBC World Service's nationally representative survey found that the majority (87%) of the Ugandan adult population had a working radio, in contrast to only a third (34%) having a working TV(17). Radio listenership is high in both urban and rural areas (80% in urban, 76% in rural), unlike television viewing which is much more heavily skewed towards urban populations(18). For most households in Kasese District, as well as nationally, radio provides the main source of information and news.

### *Partners*

The project is a collaboration between several partners with established working relationships and shared feminist values: Raising Voices, London School of Hygiene and Tropical Medicine (LSHTM), Peripheral Vision International (PVI), and Uganda Network on Law Ethics and HIV/AIDS (UGANET).

Raising Voices and PVI will adapt *SASA! Together* content for radio. Raising Voices will create a 'SASA for Radio' programming guide to support partners in implementing radio components alongside community SASA! Together programming. UGANET will implement the Radio Booster alongside their ongoing community *SASA! Together* programming, with technical support from Raising Voices. LSHTM will lead the evaluation research.

A brief summary of each partner organization is provided below:

Raising Voices is an NGO based in Kampala, Uganda, working toward the prevention of violence against women and children. Raising Voices has produced two evidence-based methodologies for preventing violence against women and children, with their work translated into more than 15

languages, used in over 30 countries and 75 organizations, and regularly identified as global good practice.

UGANET is a women's rights organisation based in Uganda with extensive experience implementing *SASA!* across the country, including through scale-up under the Spotlight Program to End Violence Against Women and Girls.

Peripheral Vision International (PVI) is an award-winning media NGO that uses media, technology, and popular culture to catalyse social change in East Africa and beyond. For the last decade, PVI has produced and distributed a variety of entertainment-education in Uganda and the broader region, including top rated television shows, audio narratives, public service announcements and telenovelas.

LSHTM is a world-leading centre for research and postgraduate education in public and global health. Its mission is to improve health and health equity in the UK and worldwide; working in partnership to achieve excellence in public and global health research, education and translation of knowledge into policy and practice. The LSHTM Gender, Violence and Health Centre (GVHC) is a multi-disciplinary research group dedicated to investigating the extent, causes, consequences and prevention of violence against women and children.

***SASA! Together***

*SASA! Together* is the 2020 revision of *SASA!*, an evidenced based community mobilization approach to prevent violence against women (Michau and Namy, 2021). Both *SASA!* and *SASA! Together* aim to transform imbalances of power by sparking community-wide critical discussion and positive action. *SASA!* is both a Kiswahili word that means "now", underscoring the urgent need to prevent VAW, and the acronym for its four phases:

- Start: Involves learning about the community through a baseline survey, relationship building and the selection and training of women and men who live and work in the community to connect with their *power within*.
- Awareness: Introduces (or deepens) a feminist analysis of men's *power over* women as the root cause of IPV and the community's silence about this injustice as key drivers that enable violence to continue.
- Support: Builds momentum as more and more community members learn skills around balancing power and join their *power with* others to support women experiencing violence, couples trying to change, and community activists speaking out and holding men who use violence accountable; and
- Action: Cultivates the *power to* take action and formalize mechanisms that sustain new norms that reject VAW.

*SASA! Together* is typically implemented over a three-to-four year period. The process involves three core strategies, facilitated by different groups of community members as described below:

- **Local Activism strategy** led by community activists--women and men who live and work in the community—selected, trained and mentored by organizational staff. Community activists use thought provoking materials (games, posters, comics, quick chats, community conversations, etc.) to facilitate reflective activities in the community, encouraging changes at the individual and interpersonal levels.

- **Community Leadership strategy** led by community leaders—a diverse group of formal and informal leaders including faith leaders, *ssengas*, local government representatives, etc.--who are selected, trained and mentored by organizational staff. Community Leaders use *SASA! Together* materials (talking points, sermon notes, social media posts, etc.) to integrate new ideas into their leadership roles and platforms, with the aim of influencing broader transformation and social norms at the community level.
- **Institutional Strengthening** is a collaboration between organizational staff and 'allies' working at one or two institutions that influence how the community addresses VAW (such as a religious institution or media house) or serves women experiencing violence (e.g., health services, police department, local government, etc.). This strategy moves through a structured process to enhance operational culture (values, employee morale, and power dynamics) and create/revise policies to ensure alignment with best practice in violence prevention and response.

***The Radio Booster***

The Radio Booster was conceptualized as a way to amplify the reach of *SASA! Together* ideas and messages. Radio was recognized as a particularly relevant strategy to reach communities in a context of COVID-related restrictions on large community gatherings.

The Radio Booster will consist of a series of 33 episodes, with themes and ideas aligned to the four Phases of *SASA! Together* – Start, Awareness, Support, and Action – as described above.

The Radio Booster will be piloted in partnership with UGANET in the district of Kasese. UGANET has been implementing *SASA! Together* in Kasese since 2019 and is currently in the Awareness Phase. The timing of movement into subsequent phases will depend on community readiness as assessed by UGANET and activists involved in implementation. Because community-based programming is already well underway, implementation of the radio content will serve to review and deepen engagement with *SASA! Together* ideas, but will not run precisely parallel to community implementation of each Phase.

For this initial pilot of the Radio Booster, episodes will be aired on 3 local radio stations in Kasese. New episodes will air once per week, with each episode repeated once during the week.

Community Activists – who have been trained by UGANET in effective facilitation of conversations around power and violence – will promote the radio drama and will be supported and equipped to convene 'Listening Groups' with small numbers of community members to listen together and then unpack the content of each episode. This follow-on in-person discussion will help listeners to further deepen their engagement with the ideas and issues raised in the episode.

***Evaluation design***

The evaluation is designed to assess the potential for the *SASA! Together* Radio Booster to strengthen the delivery and *potential* impacts of *SASA! Together* community programming. The main focus is on process related indicators (Objectives 1 to 3), but we will also chart indicators of attitude and behaviour change in the community over the course of implementation (Objective 4). The Radio Booster is in the early stages of development and it is important to understand its potential to strengthen VAW prevention initiatives before conducting a full-scale impact evaluation. Learning from the research will also be used to strengthen content in future iterations of the program.

The study will employ mixed methods to answer the specified objectives, including: repeated cross-sectional surveys of community members; and focus groups and in-depth interviews with

community members, listener groups, *SASA! Together* Community Activists, staff members involved in SASA! Together/Radio Booster implementation, and community leaders.

***Community-member surveys***

The quantitative component of the study will comprise two cross-sectional surveys of community members. The first (baseline) will be conducted approximately 6 weeks after the Radio Booster begins airing. The second survey (endline) will be conducted shortly after Radio programming finishes (approximately 37 weeks). At both time-points, the survey will measure indicators relating to the Radio-Booster's reach/listenership, and attendance/involvement in other SASA! Together activities. It will also measure indicators relating to: attitudes towards IPV and intimate relationships; quality of intimate relationships; and activism/intervention to prevent or respond to IPV.

*Sampling strategy and sample size*

At the first time-point (baseline) we aim to survey 650 community members (325 women and 325 men) aged 18 and above. At the second time-point (endline), we aim to survey 980 community members (490 women and 490 men) aged 18 and above. The endline sample size has been increased in relation to baseline due to freed-up resources from a cancelled midline survey, as detailed in the Protocol Amendments section below.

*Sampling frame*

The study site is Kisinga Subcounty, comprising 25 villages (LC1). *SASA! Together* community programming is currently underway in 23 of these villages. From these 23, one will be purposively selected for questionnaire piloting based on logistical considerations. The other 22 will form the sampling frame for the community members survey. We will employ a multi-stage sampling strategy, with village as the primary sampling unit (PSU).

*Sampling of villages*

The original plan was to conduct the survey in all remaining 22 villages. However, this plan was modified due to seven of the villages being relatively inaccessible (3-4 hours walk from the next nearest village). For logistical purposes therefore, we decided to drop four of the less accessible villages from the sampling frame, while still retaining three of them in order to be able to estimate intervention reach to these more remote locations. Among the remaining 18 villages, stratified random sampling (stratifying by urban/rural and population size) will be used to select half of these (9) to form the basis of the sample of female community members. The other half (9) will form the basis of the male sample. This designation of male/female villages will remain the same for both survey timepoints to maintain comparability between survey rounds.

*Sampling of households within villages*

Allowing for failure to contact respondents, refusals to participate, and households without any eligible members, we will oversample households by 10% in order to achieve our target sample size of 650 respondents at baseline and 980 respondents at endline.

Within each village, 40 households will be sampled at baseline and 60 at endline. Different households will be sampled at each time-point, with the sampling strategy explicitly designed to avoid resampling the same households in multiple survey rounds. This both minimises respondent burden and eliminates the risks (discussed below) that might arise if two different members of the same household were selected to participate in the study in separate survey rounds.

Households will be selected using systematic sampling based on the 'random walk' procedure from a central point in the village (identified with the help of local officials), with direction of travel established by spinning a bottle, and sampling interval pre-determined as 3. Selection of households for baseline, and listing of households (using GPS coordinates) for endline, will be undertaken during the same 'random walk', with endline households listed (and then randomly selected) from within the baseline sampling interval. This will ensure that both samples are drawn from the same neighbourhoods. Interviewers will continue in a village until they have selected and attempted to contact the target number of households. No substitutions will be made where interviewers are unable to make contact with a selected household or where households refuse to participate.

*Sampling of individuals within selected households*

We will randomly select one eligible person from each selected household to participate in the survey. A household selection form will be used to ascertain whether the selected household has any members eligible to complete the community member survey. Where more than one eligible household member is identified, one will be randomly chosen for interview (with no substitutions made for refusals or failure to subsequently contact this person).

The limit of one survey respondent per household, and the use of single sex samples in any given village, are designed to maximise respondent safety. While we will not ask directly about experience/perpetration of VAW, a woman could still potentially be put at risk if other members of the household/neighbourhood know she is participating in a survey about a violence prevention intervention and have concerns about potential disclosures she might make.

*Study precision/power*

Sample size has been determined based on a combination of pragmatic and theoretical considerations. As discussed, since the Radio Booster is in the early stages of development, smaller scale process-oriented research is deemed necessary before investment in a larger impact evaluation is undertaken. We thus focus here on study precision and power in relation to Objective 1, estimating Radio Booster listenership. After determining a feasible sample size based on logistical and resource constraints, we estimated the precision with which we would be able to estimate Radio Booster listenership overall, among respondents with access to a radio, and separately by sex (Table 1). (NB: These calculations were done prior to the increase in planned endline sample size, and therefore assume a sample size of 650 respondents at each time-point.) We also estimated study power to detect statistically significant differences (significance level 10%) in listenership between those participating and not participating in *SASA! Together* community activities, and between women and men (Table 2). We present precision and power estimates for a range of scenarios, in which we vary assumed values for listenership prevalence, prevalence differences between sub-groups (where applicable), and inter-village variation in listenership (as represented by the design effect [DE]). Study precision and power are high in most of these scenarios. We expect that the DE will be close to 1 as the study site is small and radio station coverage is high throughout the site.

*Inclusion and exclusion criteria*

Individuals from selected households will be eligible for inclusion in the survey if they are aged 18 years or above and are proficient in the Lukonzo language. Eligibility will also depend on sex: in villages chosen to form the basis of the female sample, only women will be eligible for inclusion; while in villages chosen to form the basis of the male sample, only men will be eligible for inclusion.

Among randomly selected participants, efforts will be made to include those with intellectual or other disabilities where possible. However, the survey will not be administered to individuals who do not have the capacity to understand the questions being asked, or in cases where privacy would be compromised by the involvement of another household member to help complete the questionnaire.

*Informed consent and survey procedure*

The survey will be carried out by a data collection company (Research World International), with training of enumerators overseen by LSHTM and Raising Voices staff.

Fieldwork supervisors will be responsible for selecting households for participation in the survey, in accordance with the systematic sampling strategy as set out by LSHTM. Help in locating selected households will be provided by the supervisor and, where necessary, LC1 or other leaders familiar with the communities.

Upon making contact with a selected household, enumerators will identify the household head or another adult able to complete the household selection form (providing the first names and ages of all household members). If no one is present or available to complete the household selection form, a maximum of two further visits will be made to this household in an attempt to complete the form. In the event of lack of completion of the household selection form after three visits, this will be recorded on the survey administration form (along with the pre-coded reason, for example failure to locate household members, refusal to participate, etc).

Where a household selection form is completed, the enumerator will use this information to identify all eligible members of the household, and randomly select one of these to participate in the survey. This random selection process will take place as follows: the enumerator will write the name of each eligible person on a separate piece of paper, place the pieces of paper in a bag, and ask a household member to blindly pick one piece of paper from the bag. The name that is drawn will be the person subsequently invited to participate in the survey. No substitutions will be made where that person is unavailable or unwilling to participate. In the event that the selected person is unavailable at the time of the visit, up to two further visits will be made to the household to locate the selected person.

Once contact has been made with the selected individual, the enumerator will explain the nature, purpose and procedures involved in the study, and provide them with a study information sheet. Participants will have opportunities to ask questions throughout this process. Their consent will then be sought to participate in the survey. Individual written informed consent will be obtained for all community members participating in the community member survey. An information sheet about the study will be read aloud to all participants by data collection staff. In cases where the participant is unable to read or write, an impartial witness must be present during the consent procedures and must print and sign their name, with the date, on the consent form on behalf of the potential participant. Participants who are unable to write will use thumbprints in place of signatures to sign the consent form. This informed consent process has been designed in accordance with that used in other studies of domestic violence in societies with low literacy, including the original SASA! CRT.

Survey interviews will be conducted in a private place of the respondents choosing, and conducted by interviewers that are the same sex as the respondent. The survey will be conducted in accordance with international guidelines for the collection of data on violence against women(19). These guidelines seek to minimise reporting bias and risk of harm posed to the respondents and interviewers involved in the survey. Interviewers, all fluent in the main local language (Lukonzo), will

undergo at least 3 weeks of preparatory training on ethical and methodological issues surrounding the conduct of a survey relating to IPV. This includes sessions on how to ensure the privacy, confidentiality and safety of the respondent, how to build rapport, and how to talk about difficult topics in a non-judgmental, sensitive and supportive manner. Interviews will be conducted in Lukonzo.

Table 1: Precision estimates (based on a confidence level of 95%) for estimates of prevalence of Radio Booster listenership, assuming 650 respondents (325 men, 325 women) complete the survey at each time-point*

| Indicator | Sample | Sample size | Estimated prevalence | Precision of estimate if DE=1 | Precision of estimate if DE=1.5 | Precision of estimate if DE=2 |
|---|---|---|---|---|---|---|
| | | | | | | |
| Have listened to Radio Booster in last 4 weeks | Overall | 650 | 30% or 70% | ±3.52% | ±4.32% | ±4.98% |
| | | | 40% or 60% | ±3.77% | ±4.61% | ±5.33% |
| | | | 50% | ±3.84% | ±4.71% | ±5.44% |
| | | | | | | |
| | Among those with access to a radio | 520 (based on 80% having access to a radio) | 30% or 70% | ±3.94% | ±4.83% | ±5.57% |
| | | | 40% or 60% | ±4.21% | ±5.16% | ±5.95% |
| | | | 50% | ±4.30% | ±5.27% | ±6.08% |
| | | | | | | |
| | Disaggregated by sex | 325 in each sub-group | 30% or 70% | ±4.98% | ±6.11% | ±7.06% |
| | | | 40% or 60% | ±5.33% | ±6.53% | ±7.54% |
| | | | 50% | ±5.44% | ±6.67% | ±7.70% |

*Estimated using survey software provided by surveysystem.com ( Sample Size Calculator - Confidence Level, Confidence Interval, Sample Size, Population Size, Relevant Population - Creative Research Systems (surveysystem.com) ), based on calculations by Lwanga and Lemeshow (1991)

Table 2: Estimates of study power to detect a difference in prevalence of Radio Booster listenership in past 4 weeks between sample sub-groups, with significance level set at 10%*

| Comparison groups | Sub-group 1 (sample size) | Subgroup 2 (sample size) | Prevalence of listenership in sub-group 1 | Prevalence of listenership in sub-group 2 | Prevalence difference | Power to detect difference if DE=1 | Power to detect difference if DE=1.5 | Power to detect difference if DE=2.0 |
|---|---|---|---|---|---|---|---|---|
| By participation in *SASA! Together a*ctivities in past 3 months | Have participated, (325) | Haven't participated, (325) | 70% | 50% | 20% | 99.9% | 99.6% | 98.1% |
| | Have participated, (325) | Haven't participated, (325) | 60% | 50% | 10% | 84.9% | 67.2% | 56.6% |
| | Have participated, (325) | Haven't participated, (325) | 60% | 40% | 10% | 99.9% | 99.5% | 97.7% |
| | Have participated, (325) | Haven't participated, (325) | 50% | 40% | 20% | 82.2% | 67.2% | 56.6% |
| | Have participated, (390) | Haven't participated, (260) | 70% | 50% | 20% | 99.9% | 99.5% | 97.7% |
| | Have participated, (390) | Haven't participated, (260) | 60% | 50% | 10% | 80.8% | 65.9% | 55.4% |
| | Have participated, (390) | Haven't participated, (260) | 60% | 40% | 10% | 99.9% | 99.4% | 97.3% |
| | Have participated, (390) | Haven't participated, (260) | 50% | 40% | 20% | 80.8% | 65.7% | 55.1% |
| By sex | Women (325) | Men (325) | 60% | 70% | 10% | 84.9% | 70.4% | 59.6% |
| | Women (325) | Men (325) | 50% | 70% | 20% | 99.9% | 99.6% | 98.1% |
| | Women (325) | Men (325) | 50% | 60% | 10% | 82.2% | 67.2% | 56.6% |
| | Women (325) | Men (325) | 40% | 60% | 20% | 99.9% | 99.5% | 97.7% |

*Estimated using Stata SE v17.0, *power twoproportions* command, based on a two-sided hypothesis test (Pearson's chi-squared test)

*Quantitative data management*

Survey responses will be entered directly on to a tablet computer using the ODK software with automatic encryption. The software includes in-built filters and checks to minimize the level of missing or erroneous data. The data recorded on the tablet computer will be uploaded daily to a password-protected Sharepoint study database (administered by LSHTM) and further checked for missing and/or erroneous data. Any data queries will be sent to the field supervisors to be resolved with the researchers conducting the interviews. The research firm, Research World International, will make weekly data backups on to a password-protected secure drive. Data backups will also be made weekly by LSHTM. No personal identifying information will be collected - all electronic data are anonymous, with each respondent allocated a unique study identifier.

Consent forms will be stored securely in locked filing cabinets in secure locations arranged by Research World International. These will be transferred to locked filing cabinets in Raising Voices' offices upon completion of each survey round.

Data and paper records will be stored for a minimum of 10 years after study completion.

At the conclusion of our main study analyses, anonymised data from the quantitative survey will be deposited in the LSHTM Data Compass digital repository for research outputs. Any variables that present risk of reidentification will be removed before the data are deposited, as will any variables that could be stigmatising to communities involved in the research. Due to the sensitive nature of the data, it will be made available under restricted access terms (i.e. users will need to apply for access, meet access conditions including applying for ethical approval, and sign an agreement on use). Requests for data use will be reviewed on a case-by-case basis by LSHTM and Raising Voices before decisions are made as to whether or not to grant access. The study protocol and community-member survey will be openly available to all on LSHTM Data Compass.

*Statistical analysis*

Data will be analysed in Stata SE. Analyses will take account of the clustered nature of the data. A detailed analysis plan will be drawn up prior to conducting the final analysis, but key elements are outlined below.

Objective 1a, b, c, f, g:

Descriptive data will be produced at each time point for all of the indicators relating to the Radio Booster's reach. In addition to producing overall proportions, we will disaggregate the data by sex, age and other key demographic characteristics. Chi-squared tests of association and regression analysis with cluster robust standard errors will be used to assess differences in the Radio Booster's reach between these subgroups.

Objective 2a:

Chi-squared tests of association and/or T-tests will be used to assess the association between listening to the booster and attendance at SASA! Together activities.

Objective 4:

Differences between baseline and endline community-level attitudes towards IPV and intimate relationships, quality of intimate relationships, and activism to respond to/prevent IPV, will be assessed with the use of appropriate statistical tests. A difference-in-difference analysis (or similar)

will be conducted to assess whether changes differ between radio booster listeners and non-listeners, after accounting for other *SASA! Together* community exposure and key demographics.

If there is sufficient variation in frequency with which respondents listen to the Radio Booster, we will conduct a dose-response analysis to assess whether greater exposure to the Booster is associated with better outcomes at endline. This will comprise logistic regression (for binary outcomes) or linear regression (for continuous outcomes), with independent variables comprising Radio Booster exposure level, village-level baseline measure of the outcome, exposure to *SASA! Together* community activities, and key demographics.

***Qualitative***

The qualitative component of the evaluation will comprise in-depth interviews (IDIs), key informant interviews (KIIs), focus group discussions (FGDs) and recorded listener groups. IDIs, KIIs and FGDs will be longitudinal in design, interviewing the same cohort of people at more than one time-point.

*In-depth interviews*

IDIs will be conducted with community members in Kisinga subcounty who have listened to the Radio Booster ("listeners").

Each listener will be interviewed at two time-points – approximately 19 weeks after the Radio Booster begins airing, and shortly after Radio programming finishes (approximately 37 weeks) – allowing us to explore how experiences of and engagement with the Radio Booster change over time.

At the first time-point, we will conduct 24 IDIs with listeners (12 men and 12 women). At the second time-point, we will conduct 20 IDIs with listeners (10 men and 10 women). Listeners will be recruited from SASA! Together listener groups and will be purposively selected to represent different levels of listenership. Interviewers will conduct IDIs at the first time-point remotely, by telephone, rather than face-to-face (due to an Ebola outbreak affecting Western and Central Uganda, as detailed in the Protocol amendment section below). At the second time-point, interviews may be conducted by telephone or in person.

Potential participants will be identified by Community Activists operating in Kisinga subcounty. Community Activists will, with their consent, take the phone number of potential participants. These phone numbers will be shared with UGANET, who will share them with Research World International for the purpose of recruiting participants. Interviewers will telephone potential participants to explain the study and request their consent to participate in an IDI. If the potential participant chooses to participate, the interviewer will either conduct the IDI then or will arrange a future time and date to conduct the IDI. The interviewer will conduct the consenting process directly before conducting the IDI.

IDIs with community members will explore motivations/facilitators for listening to the Booster (Objective 1d) and barriers to listening (Objective 1e); community members' perceptions of the Booster's influence (Objectives 3a-e); the extent to which the Booster increases engagement with SASA! Together activities (Objective 2a) and reinforces *SASA! Together* messaging (Objective 2b); and safety issues around listening/radio content (Objective 2d).

*Key informant interviews*

KIIs will be held with Community Activists and staff from UGANET/ Raising Voices/ PVI. Key informants will be selected purposively to include those with extensive involvement and varied roles in intervention implementation and/or design.

Each Community Activist will be interviewed at two time-points – approximately 19 weeks after the Radio Booster begins airing, and shortly after Radio programming finishes (approximately 37 weeks). We will conduct 15 IDIs with Community Activists at the first time-point and 12 IDIs with Community Activists at the second time-point.

Community Activists who have extensive experience in *SASA! Together* programming ("model Community Activists") will be identified by UGANET, and recruited into the study by researchers from Research World International. As there are only 2 model Community Activists operating in Kisinga subcounty, we will recruit model Community Activists from across Kasese district.

Interviewers will conduct KIIs with Community Activists at the first time-point remotely, by telephone, rather than face-to-face. At the second time-point, interviews may be conducted by telephone or in person.

During the process of identifying participants, members of staff from UGANET will obtain potential participants' phone numbers. These phone numbers will be shared with Research World International for the recruitment process. Interviewers will telephone potential participants to explain the study and request their consent to participate in an IDI. If the potential participant chooses to participate, the interviewer will either conduct the IDI then or will arrange a future time and date to conduct the IDI. The interviewer will conduct the consenting process directly before conducting the IDI.

6 KIIs with UGANET/ Raising Voices/ PVI staff will take place at one time-point only (approximately 37 weeks), in order to gain overall experiences of and reflections on Radio Booster implementation and its role within broader *SASA! Together* programming.

To mitigate the power dynamics which can exist between staff members in all research interactions, we will purposively select KII participants jointly across the full team of UGANET, Raising Voices and PVI staff. Staff will be selected based on their role in the study but their participation will be voluntary. Selection and recruitment of staff will be led by LSHTM researchers with input from staff at UGANET, Raising Voices and PVI. LSHTM staff will conduct all KIIs with staff members as LSHTM does not employ staff from any of these organisations. LSHTM has an equal partnership with Raising Voices, rather than an employer-employee relationship. UGANET and PVI are sub-contracted to work for Raising Voices, but are not employed by them.

KIIs with UGANET/ Raising Voices/ PVI staff and Community Activists will explore staff and community activists' experiences of implementing the radio drama intervention (Objective 1h); the extent to which the Booster increases engagement with *SASA! Together* community activities (Objective 2a); the role of 'listener groups' in promoting critical thinking about Radio Booster content/facilitating links with *SASA! Together* ideas (Objective 2c); and ethical issues arising from implementation (Objective 2d).

*Focus-group discussions*

FGDs will take place with

- 2 'listener groups' (1 female group, 1 male group)
- 2 groups of *SASA! Together* Community Activists (1 female group, 1 male group)

- 1 group of community leaders (cultural/religious/local government)

Each 'listener group' and group of Community Activists will take part in two FGDs, at approximately 6 weeks and 37 weeks after the Radio Booster begins airing. Repeated focus groups will allow assessment of how reception of and responses to the Booster change over time. The FGD with community leaders will take place at one time point (approximately 37 weeks) to allow reflection on the entire period of Radio Booster implementation.

Listener groups will be identified and selected with the help of *SASA! Together* Community Activists who have been involved in setting up and facilitating these groups. Activists to be interviewed will be purposively selected by UGANET to represent a range of ages, duration of involvement with the intervention and community characteristics. UGANET will also help identify community leaders (cultural, religious and local government) with whom they have had involvement during implementation of *SASA! Together* programming. Recruitment of all of these individuals into relevant focus groups will be conducted by Research World International in order to maintain the independence of the research process.

FGDs with listener groups will explore the acceptability and enjoyment of the Radio Booster content (Objectives 1d, 1e, 3a), the role of listener groups in promoting critical thinking about radio booster content/facilitating links with SASA! Together ideas (Objective 2c), and perceptions of the Radio Booster's influence within the community (Objectives 3c-3e).

FGDs with Community Activists will explore the same themes as those explored in the KIIs with programme implementers and CAs.

The FGD with community leaders will explore the acceptability of the Radio Booster content to religious, cultural and local government institutions, as well as its reception among and influence on the local community and institutional practices (Objective 3f).

*Listener group recordings*

We will conduct up to 8 audio recordings of listener group meetings held between week 19 and week 33 of the intervention. Each listener group will engage in no more than 6 recordings. During the listener group, the facilitator will play a radio episode and then facilitate a discussion about its content. We will record the discussion of the radio drama episode, including anything said by both facilitators and participants. Each discussion is expected to last no more than 40 minutes, including the consenting procedure.

*Informed consent and interview procedure*

*For in-person data collection*

As with the community-member survey, individual written informed consent will be obtained for all individuals participating in in-person IDIs, KIIs, FGDs and recorded listener groups. An information sheet about the study will be read aloud to all participants by data collection staff. In cases where the participant is unable to read or write, an impartial witness must be present during the consent procedures and must print and sign their name, with the date, on the consent form on behalf of the potential participant. Participants who are unable to write will use thumbprints in place of signatures to sign the consent form.

In the case of recorded listener groups, both listener group participants and facilitators will be considered study participants, and as such will all be required to give consent to be recorded.

IDIs and KIIs will be conducted in a private place of the respondents choosing, and conducted by interviewers that are the same sex as the respondent. Locations of FGDs will be selected by the field coordinator with the help of Community Activists, to ensure privacy and the safety of participants. As with the quantitative survey, the IDIs, KIIs and FGDs will be conducted in accordance with international guidelines for the collection of data on violence against women(19).

*For remote data collection (by telephone)*

Individual verbal informed consent will be obtained for all individuals participating in IDIs and KIIs conducted remotely by telephone. An information sheet about the study will be read aloud to all participants by the interviewer over the phone. The interviewer will discuss the information sheet with the participant and seek verbal consent for their participation. If the participant gives verbal consent, the interviewer will attest to this by writing the name of the participant on a paper copy of the consent form and signing and dating their own name on the same form.

*Qualitative data management and analysis*

All IDIs, KIIs, FGDs and recorded listener groups will be audio recorded with the participants' consent. Audio recordings and hand-written notes are transcribed verbatim and translated from Lukonzo into English. A sample of the transcripts are checked for quality of transcription and translation. Data will be uploaded onto NVivo and analysed following a qualitative thematic analysis approach where notes will be disaggregated by gender and age, and analysed thematically in order to answer the objectives of the study.

Personal identifying information will be collected from all IDI, KII and FGD participants due to the longitudinal nature of this research and the need to contact participants to arrange second and third phases of data collection. Only staff from Research World International, Raising Voices, LSHTM and the local Research Ethics Committee and Uganda National Council for Science and Technology (UNCST) will have access to private information that identifies participants by name. Personal identifying information of staff members from Raising Voices, UGANET or PVI who participate in KIIs will not be shared with Raising Voices or other partners who they work with directly. One list containing personal identifying data of qualitative participants will be encrypted and stored in a separate password-protected server location to the transcripts. This document will be destroyed within 12 months of all publications and reports having been published.

Consent forms will be stored securely in locked filing cabinets in secure locations arranged by Research World International. These will be transferred to locked filing cabinets in Raising Voices' offices upon completion of each survey round. All data will be anonymised and will only be shared with study staff from Research World International, Raising Voices and LSHTM. They may also be shared with potential research degree students or collaborators interested in contributing to the analysis or conducting secondary analysis of anonymised data.

**Ethics and safety**

Ethical clearance will be sought from Institutional Review Boards at the London School of Hygiene and Tropical Medicine, Mildmay Uganda and the Uganda National Council for Science and Technology.

Approval to work in the study sites will be sought from the Chief Administrative Officer at the District level and the Local Council (LC) V Chairperson of the study District. Study information will be further shared with the Resident District Commissioner, LC3 and LC1 Chairpersons. Permission will

also be sought from local leaders at Parish- and Zone-level before any intervention implementation or data collection takes place. Communities will receive ongoing feedback throughout the study.

Individual written informed consent will be obtained for all community members participating in in-person surveys, IDIs, KIIs, FGDs and listener groups. In this process, an information sheet about the study will be read aloud to all participants by data collection staff. In cases where the participant is unable to read or write, an impartial witness must be present during the consent procedures and must print and sign their name, with the date, on the consent form on behalf of the potential participant. Participants who are unable to write will use thumbprints in place of signatures to sign the consent form.

Individual verbal informed consent will be obtained for all individuals participating in IDIs and KIIs conducted remotely by telephone. An information sheet about the study will be read aloud to all participants by the interviewer over the phone. The interviewer will discuss the information sheet with participants and seek verbal consent for their participation. If the participant gives verbal consent, the interviewer will attest to this by writing the name of the participant on a paper copy of the consent form and signing and dating their own name on the same form.

Of additional ethical concern is the sensitivity of the questions in the community survey. Although we will not ask directly about experiences of violence, the intervention content and the nature of the questions in the survey may evoke experiences that cause distress to respondents. Additional risks may be posed by the partner of a respondent finding out the nature of the interview. To minimise risk of harm to both respondents and interviewers, the study will adhere to the WHO recommendations for conducting research on domestic violence(19). Actions include the careful wording of questions to ensure that they are non-judgmental, providing interviewers with intensive training on how to respond if someone discloses violence or requests assistance, providing all participants with information about potential sources of support, and ensuring that follow-up support can be made available if requested.

Enumerators will receive at least three weeks of training on the ethical and methodological issues surrounding the conduct of a survey relating to IPV, as well as ongoing support during the course of the survey. Interviewers will all be fluent in the local language (Lukonzo), and interview respondents of the same sex as themselves. Confidentiality will be maintained at all times.

Furthermore, when conducting IDIs and KIIs remotely, interviewers cannot be certain that participants are in a safe and private location. To enhance the safety of participants, interviewers will establish a “safe word” with the participant before the IDI or KII. This will be a word that the participant can use if, during the course of the interview, their safety is compromised. In this instance, the interview will be paused and postponed until a time when the participant can take part safely and privately.

UGANET and Raising Voices will create and update a referral list that includes formal and informal psycho-social-legal services for women experiencing VAW, including resources provided by UGANET (a helpline and shelter based in Kampala). This list is provided to all study participants irrespective of whether or not they have experienced VAW. If participants are taking part in remote IDIs or KIIs, they will be given the option to have the referral list shared with them by SMS. UGANET and Raising Voices will train research staff and programme facilitators on the use of the referral list. UGANET will have a dedicated staff member who will respond to new cases as they emerge. Programme activities will be monitored carefully for any signs of backlash.

Participants in study data collection who disclose any personal exposure to severe physical violence or sexual violence in the past year, or who report feeling unsafe and at risk of imminent violence, will be referred appropriately through UGANET established referral network including health, psychosocial, legal aid, shelter and other services.

**Compensation**

In line with the procedures of local ethics boards, as each session will take longer than 45 minutes, all participants in the study will be compensated with a token of appreciation for their time of the value of 10,000 Ugandan shillings (approximately 3 USD). All surveys participants will be offered a bar of a soap. FGD, IDI and KII participants will be offered 10,000 Ugandan shillings. In addition, FGD participants will be offered refreshments and, if they incur costs to travel to the site of the discussion, they will be reimbursed up to 10,000 Ugandan shillings.

As participation in listener groups is part of the implementation programme, we will not compensate participants in recorded listener groups.

For participants in IDIs and KIIs conducted remotely, compensation will be transferred to the participants in the form of mobile money. Participants will be reimbursed 11,000 Ugandan shillings to cover the mobile money withdrawal fee of 1,000 Ugandan shillings.

**Protocol amendments**

Several amendments have been made to the protocol since the study inception:

- Seven of the 22 villages in the original survey sampling frame were more remote than anticipated (3-4 hours walk from the next nearest village). For logistical purposes therefore, we decided to drop four of the less accessible villages from the sampling frame, while still retaining three of them in order to be able to estimate intervention reach to these more remote locations. The survey will now take place in a total of 18 villages.

Furthermore, an Ebola outbreak in the Western and Central regions of Uganda (September 2022 – January 2023) led to the following changes to the protocol:

- Cancellation of a planned midline survey of community members. Initially we planned three surveys (baseline, midline and endline), but this has now been changed to two surveys (baseline and endline).
- Larger sample size for the community-member survey at endline. Resources originally intended for the midline survey will be diverted towards the endline survey. We originally planned to survey 650 people at each of the three planned time-points. With cancellation of the midline, our endline target sample size has now been increased to 980.
- Change to remote data collection for first round of IDIs and KIIs (conducted approximately 19 weeks into Radio Booster programming). Originally these were intended to be conducted face-to-face, but will now be conducted over the telephone.
- Cancellation of middle round of FGDs with listener groups and CAs. Originally three rounds of FGDs were planned, but the round planned for 19 weeks into programming has now been cancelled.
- Listener group recordings (not originally planned) will now be instigated in lieu of the cancelled round of FGDs with listeners.

**Dissemination strategy**

The study findings will be disseminated through both formal and informal networks, with the aim that the evidence we generate contributes to strengthening and expanding existing VAW prevention programming as well as honing new prevention strategies. Community meetings/events will be held in the study community and wider region in which the Booster is aired, to share the findings and celebrate successes with Community Activists, community members and local officials and other stakeholders. Events will also be held to discuss findings and their implications with staff involved in SASA Together/Radio Booster implementation and data collection. Study findings will also be presented to key stakeholders at national and regional level, disseminated through the GBV Prevention Network and other relevant networks (including via social media), and presented at relevant national and international conferences and meetings including the Sexual Violence Research Initiative (SVRI) Forum. Reports of the study findings and areas of learning will also be prepared in various formats; for use by organisations implementing SASA! Together and those involved in VAW prevention programming more widely; for submission to peer-reviewed academic journals; and for use by policy makers and the donor community.

**Strengths and limitations**

This study builds on existing evidence on what works to prevent IPV, and seeks to evaluate whether and how the incorporation of a mass media component might expand the reach and strengthen impacts of a community mobilisation VAW prevention programme.

The study is a collaboration between partners with extensive experience variously in the design, implementation and research of VAW prevention programming, as well as the design and implementation of edutainment campaigns to shift norms and behaviours underpinning poor health and wellbeing outcomes.

There are limitations to this research in terms of scope and design. The absence of a control site precludes attribution of change to the Radio Booster. Furthermore, study duration is little more than six months, which is a relatively short time in which to observe community-level behavioural shifts. We instead focus on process and mechanisms through which the Radio Booster might enhance SASA! Together programming, while also charting change in desired 'outcomes' over the course of programming.

The rationale behind this approach comprises the following: In order to demonstrate incremental impacts of the Radio Booster over and above SASA! Together community programming, a large number of communities and a lengthy follow-up period would be required. The Radio Booster is in the early stages of development and it is important to understand its potential to strengthen VAW prevention initiatives before investing the level of resources that a full-scale impact evaluation would entail. Furthermore, random allocation of sites to intervention or control arms would not be feasible given the large geographic areas covered by radio stations.

Our study also has many strengths. We employ mixed methods to quantify and *understand processes of* intervention uptake and diffusion, synergies between intervention components, and attitudinal and behavioural change among community members. The quantitative survey is conducted among a quasi-random sample of community members. While a true random sample is not feasible given the absence of up-to-date household lists, the quasi random sampling strategy should minimise selection bias and ensure that the sample is representative of the wider study community. Selection bias can also occur through non-response. Response rates in this study will be maximised in a number of ways: at least three repeat visits will be made to households where

respondents are not available at the time of the first visit; interviewers will be trained on how to introduce the study and build rapport with respondents in order to minimise the number of refusals; the cross-sectional design precludes the problem of loss to follow-up between survey rounds. Repeated community surveys allow us to assess how listenership and outcomes change over time.

The inclusion of non-listeners as well as listeners in our sample allows us to examine barriers to listening, as well as explore whether attitudinal and behavioural outcomes differ between listeners and non-listeners. Though this type of comparison is prone to self-selection bias if underlying differences exist between listeners and non-listeners, thereby impeding causal attribution to the Radio Booster, taken together with evidence on process it adds to the plausibility assessment of the potential for this type of intervention to reduce IPV.

The IDIs, KIIs and FGDs will elicit the experiences and views of varied participants in the process of social change – ordinary community members, local leaders within the study communities, SASA! Together Community Activists, and staff involved in the design and implementation of the Radio Booster and SASA! Together community programming. Through these we can address diverse questions relating to attitudinal and behavioural change, mechanisms through which the booster may impact on IPV and relationships more broadly, and the Booster's feasibility, acceptability and potential transferability to other contexts.

The study research questions are designed to generate evidence that will help inform and strengthen future iterations of the Radio Booster and its incorporation into existing VAW community prevention programming. They will also help inform further research, including the value and (if warranted) design of future impact evaluations of the Radio Booster or similar interventions. Crucially, findings will add to the evidence base on how to scale up successful community VAW prevention programmes, and expand programme reach to populations all too often excluded from in-person programming by geographical, social, economic, conflict- and health-related barriers.

**References**

1. World Health Organization. Violence Against Women Prevalence Estimates, 2018. Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva: World Health Organization; 2021
2. Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, et al. Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. PLoS Med. 2013;10(5):e1001439.
3. Jewkes RK, Dunkle K, Nduna M, Shai N. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. Lancet. 2010;376(9734):41-8.
4. Kouyoumdjian FG, Calzavara LM, Bondy SJ, O'Campo P, Serwadda D, Nalugoda F, et al. Intimate partner violence is associated with incident HIV infection in women in Uganda. AIDS. 2013;27(8):1331-8.
5. Wathen CN, Macmillan HL. Children's exposure to intimate partner violence: Impacts and interventions. Paediatr Child Health. 2013;18(8):419-22.
6. Jewkes R, Willan S, Heise L, Washington L, Shai N, Kerr-Wilson A, et al. Effective design and implementation elements in interventions to prevent violence against women and girls. What Works To Prevent VAWG? Pretoria: South African Research Council; 2020.
7. Kerr-Wilson A, Gibbs A, McAslan Fraser E, Ramsoomar L, Parke A, Khuwaja H, et al. A rigorous global evidence review of interventions to prevent violence against women and girls.

Pretoria, South Africa: What Works to Prevent Violence Against Women and Girls Global Programme; 2019.
8. Michau L. The SASA ! Activist Kit for Preventing Violence against Women and HIV. Kampala, Uganda: Raising Voices; 2008.
9. Uganda Bureau of Statistics (UBOS) and ICF. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF; 2018.
10. Abramsky T, Devries KM, Kiss L, Nakuti J, Kyegombe N, Starmann E, et al. Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and educe HIV risk in Kampala, Uganda. BMC Medicine. 2014;12(122).
11. Abramsky T, Devries KM, Michau L, Nakuti J, Musuya T, Kyegombe N, et al. The impact of SASA!, a community mobilisation intervention, on women's experiences of intimate partner violence: secondary findings from a cluster randomised trial in Kampala, Uganda. J Epidemiol Community Health. 2016;70(8):818-25.
12. Usdin S, Scheepers E, Goldstein S, Japhet G. Achieving social change on gender-based violence: a report on the impact evaluation of Soul City's fourth series. Soc Sci Med. 2005;61(11):2434-45.
13. Solorzano I, Bank A, Pena R, Espinoza H, Ellsberg M, Pulerwitz J. Catalyzing personal and social change around gender, sexuality, and HIV: Impact evaluation of Puntos de Encuentro's communication strategy in Nicaragua. Washington DC: Population Council, 2008.
14. Banerjee AK, La Ferrara E, Orozco V. Entertainment, Education, and Attitudes Toward Domestic Violence. AEA Papers and Proceedings. 2019(109):133-7.
15. Ellsberg M, Arango DJ, Morton M, Gennari F, Kiplesund S, Contreras M, et al. Prevention of violence against women and girls: what does the evidence say? Lancet. 2014.
16. Uganda Bureau of Statistics. The National Population and Housing Census 2014 - Area Specific Profile Series. Kampala, Uganda: UBOS; 2017.
17. BBC Media Action. Uganda Media Landscape Report. BBC Media Action; 2019.
18. The Collaboration on International ICT Policy for East and Southern Africa (CIPESA). National Information Technology Survey 2017/18 Report. Uganda: NITA Uganda; 2018.
19. Watts C, Heise L, Ellsberg M, Garcia-Moreno C. Putting women's safety first: ethical and safety recommendations for research on domestic violence against women. Geneva: World Health Organization; 1999.