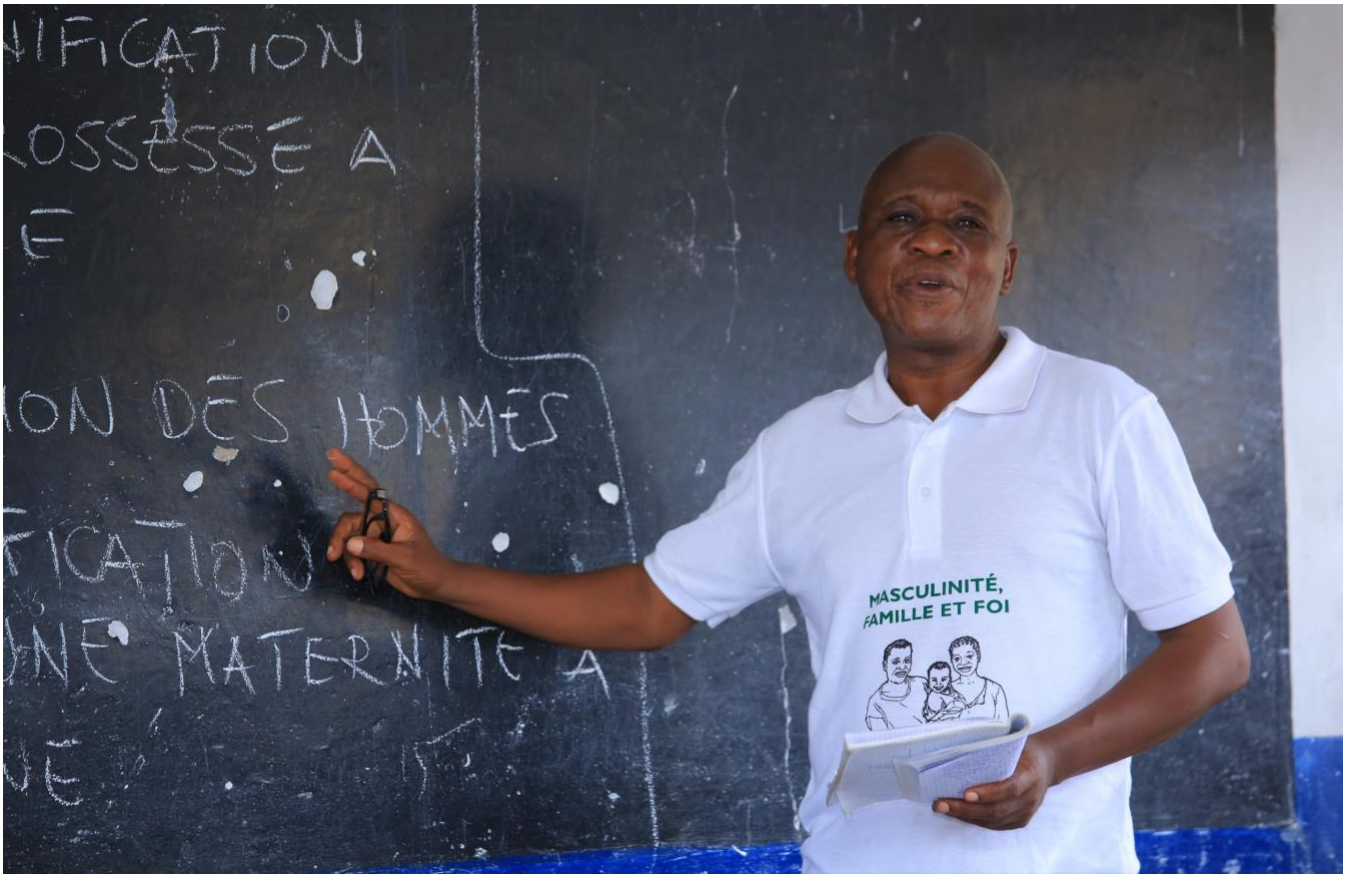
PASSAGES PROJECT

Lessons from Adapting the Transforming Masculinities SGBV Behavior Change Approach to Address Family Planning in the Democratic Republic of Congo



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LIST OF ACRONYMS AND KEY PHRASES

ASF	Association de Santé Familiale
DRC	Democratic Republic of the Congo
ECC	Eglise du Christ au Congo
IPV	Intimate partner violence
SGBV	Sexual and gender-based violence
USAID	United States Agency for International Development

Section 1
INTRODUCTION

Approximately one in every three women and girls experience physical and/or sexual violence in their lifetime[1]. Sexual and gender-based violence (SGBV) happens in every sphere and strata of society and includes, for example, sexual harassment, intimate partner violence (IPV) and non-partner sexual assault. Ending SGBV is a global priority to restore the health, safety, and well-being of women and girls. Most often, perpetrators of SGBV are men and boys, and frequently include individuals that are known to women and girls[2]. Aside from sexual harassment, IPV is the most common form of SGBV across contexts[3]; as such, women and girls often experience abuse from men closest to them. Effective SGBV prevention involves identifying and addressing the multi-level factors that allow for such violence, including the social and gender norms that promote hypermasculinity, view men's use of violence as normal and acceptable, and sanction women and girls for experiencing and reporting violence.

Social norms are the informal rules, both spoken and unspoken, that people absorb, accept, and follow. They are enacted and reinforced in relationships, communities, and across systems and structures, including legal institutions, government policy, and faith-based institutions. Social norms are defined as what people think others do (descriptive norms) or approve of (injunctive norms), and, among a host of reasons, may be held in place by rewards or sanctions[4]. Social norms which sustain SGBV are rooted in and reinforce gender inequality, including men's dominance over women and girls, the occurrence of violence including IPV, whether violence is reported, and the consequences, if any, for committing violence. As with SGBV, gender inequality affects reproductive health and family planning by, for example, influencing whether and how couples communicate and make decisions about family planning. Social norms influence approval and use of family planning[5], including whether it is acceptable to use family planning and at what point couples can use it. In the Democratic Republic of Congo (DRC), men are considered the heads of the household guiding decisions, such as when and how many children to have[6]. IPV and family planning are sometimes linked, for example, when women transgress gender roles and use family planning without their partner's consent, with IPV threatened or employed to sanction and control women's behavior[7].

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[1] Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., Watts, C. H., & WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team (2006). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. Lancet (London, England), 368(9543), 1260–1269. https://doi.org/10.1016/S0140-6736(06)69523-8.

[2] Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf; Stark, L., Asghar, K., Yu, G., Bora, C., Baysa, A. A., & Falb, K. L. (2017). Prevalence and associated risk factors of violence against conflict-affected female adolescents: A multi-country, cross-sectional study. Journal of global health, 7(1), 010416. https://doi.org/10.7189/jogh.07.010416.

[3] World Health Organization. (2013). Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence: World Health Organization. https://www.who.int/publications/i/item/9789241564625

[4] Cislaghi, B., & Heise, L. (2018). Four avenues of normative influence: A research agenda for health promotion in low and mid-income countries. Health Psychol, 37(6), 562-573. doi:10.1037/hea0000618.

[5] Schuler, S., Rottach, E., & Peninah, M. (2009). Gender norms and family planning decision-making in Tanzania: A qualitative study. Washington, DC: C-Change. Available from https://www.fhi360.org/sites/default/files/media/documents/Gender%20Norms%20%26%20Family%20Planning%20Decision-making%20in%20Tanzania.pdf.

[6] Tilahun, T., Coene, G., Temmerman, M., & Degomme, O. (2014). Spousal discordance on fertility preference and its effect on contraceptive practice among married couples in Jimma zone, Ethiopia. Reprod Health 11, 27. https://doi.org/10.1186/1742-4755-11-27; Lusey, H., San Sebastian, M., Christianson, M., & Edin, K.E. (2018). Prevalence and correlates of gender inequitable norms among young, church-going women and men in Kinshasa, Democratic Republic of Congo. BMC Public Health 18, 887. https://doi.org/10.1186/s12889-018-5742-9.

[7] Hatcher, A.M., Romito, P., Odero, M., Bukusi, E.A., Onono, M., & Turan, J.M. (2013). Social context and drivers of intimate partner violence in rural Kenya: implications for the health of pregnant women. Culture, Health & Sexuality, 15(4):404-419. doi: 10.1080/13691058.2012.760205

A significant majority of the global population is affiliated with a religious or faith tradition[8]. Faith has an important role in people's lives, including in their values, the types of relationships they form, and the behaviors they consider acceptable and unacceptable. In some settings, faith interpretation of religious teachings may sustain gender inequality through the expectations set on men, women's roles and responsibilities, and faith leader or church member sanctions for deviations from these expectations. Interpretations of scripture may also be used to justify SGBV and shame survivors. Faith leaders can be gatekeepers that directly influence the beliefs and behavior of followers: faith leaders can promote stigma against vulnerable groups or foster inclusion and support. The congregation is a social and community space which influences individual behavior, with group cohesion created and maintained through shared beliefs and values. In the DRC, faith institutions set rules of moral behavior for congregation members and deliver essential services such as health care, education, and marriage counseling. After successfully working with faith leaders to counteract harmful messaging related to HIV/AIDS, Tearfund sought to build a faith-based approach to address SGBV, and then family planning. This report explores learnings from adapting the SGBV approach, called Transforming Masculinities, to address family planning in the DRC.

This report first provides an overview of the main objectives of the analysis and the Transforming Masculinities approach, including key results from the evaluation. Following this, the report introduces adaptations made *a priori* to create Masculinite, Famille, et Foi (the adapted approach that addresses family planning) and key results from the randomized controlled trial evaluation. Focusing on adaptation learnings, the report then explores program design, implementation approaches, and contextual differences that help understand the program adaptation and distill learnings for future project adaptations. The adaptation learnings may provide support for or explain differences in social norms and project outcomes between Transforming Masculinities and the Masculinite, Famille, et Foi adaptation, including those related to SGBV outcomes. The report closes with recommendations for developing and adapting programming which seeks to include social norms change as a key strategy to prevent and reduce SGBV and family planning. The tables presented throughout the report compare the original approach (Transforming Masculinities) and the adaptation (Masculinite, Famille, et Foi) on program design, outcomes and mechanisms of change, key program activities, and coverage.

ADAPTATION LEARNINGS: AN OVERVIEW

From 2014-2015, Tearfund developed the Transforming Masculinities approach to work with faith communities and congregations to prevent SGBV. The approach was initially called the "Engaging with Faith Groups to Prevent Violence Against Women and Girls" program, and was piloted in rural communities in eastern DRC (2015-2018). The program sought to prevent SGBV, including IPV, by shifting norms that sustain SGBV and providing support to survivors of SGBV in partnership with faith institutions and local community leaders. The Transforming Masculinities approach was adapted to focus on

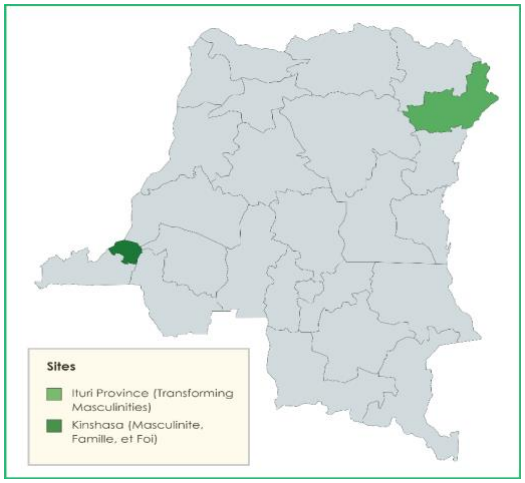

Figure 1 | Transforming Masculinities and Masculinité, Famille et Foi Intervention Sites

[8] Pew Research Center. (2015). The future of world religions: Population growth projections, 2010-2050. https://assets.pewresearch.org/wp-content/uploads/sites/11/2015/03/PF_15.04.02_ProjectionsFullReport.pdf

family planning and IPV prevention, and implemented as Masculinite, Famille, et Foi in Kinshasa, DRC (2016-2018). Understanding how programs can be adapted to suit different project outcomes and settings is important to guide future SGBV prevention programming. The adaptation of the Transforming Masculinities approach provides an opportunity to retrospectively explore questions related to fidelity to the original approach, core elements which must be retained to achieve intended outcomes, and contextual factors which must be accounted for in program design and implementation. It also offers an opportunity to explore programmatic and contextual factors which may have contributed to differences in preventing SGBV between the original approach and adaptation. Specifically, Transforming Masculinities produced significant reductions in IPV[9]; while the Masculinite, Famille et Foi adaptation resulted in positive changes in use of family planning, it did not reduce IPV[10]. This adaptation analysis seeks to contribute to a growing literature and demand to understand which interventions work for whom, in which settings, and the need for guidance on how intervention adaptation can maintain program successes across populations and geography.

The purpose of this short report is to retrospectively explore key program adaptation areas from the pilot Transforming Masculinities to its adaptation, Masculinite, Famille, et Foi. The analysis addressed the following learning questions:

1. What were the key similarities and differences in program design and implementation for the Transforming Masculinities intervention and the Masculinite, Famille, et Foi adaptation? and;
2. What can we learn about contextual factors and adaptations made to Masculinite, Famille, et Foi which may have influenced change on SGBV program outcomes?

The analysis drew from project resources, research reports, and from discussions with project teams; see **Box 1** for an overview of the methods used. A detailed examination of the project evaluation design, approaches, and findings is not included in this adaptation analysis (see **Box 1** and **Box 2** for an overview of each project's evaluation).

BOX 1. OVERVIEW OF THE ANALYSIS APPROACH

This analysis started with introductory calls with the Transforming Masculinities and Masculinite, Famille, et Foi project teams to learn about the intervention, evaluation approaches, and key learning, and to collect relevant program documents such as curricula, implementation guidelines, and evaluation reports. Data were extracted and analyzed using a matrix-approach, where key learning questions and their information areas (e.g., program objectives, theory of change, mechanisms of change, intervention context, reference groups, social norms, diffusion activities, evaluation design, and key findings) were compiled and then compared. Extraction started with each intervention separately, followed by a review across information areas to identify areas of similarity, difference, and adaptation. The analysis originally included a focus on program outcomes; however, while both programs included impact evaluations, the study designs, methods, and measurement of key outcomes were not consistent across the evaluations. Given variation in evaluation design, objectives, and tools, this adaptation analysis focused on program design and implementation, and contextual differences revealed through formative and evaluation research. The document review was supplemented with discussions with project teams.

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[9] Le Roux, E., Corboz, J., Scott, N., Sandilands, M., Lele, U.B., Bezzolato, E., & Jewkes, R. (2020). Engaging with faith groups to prevent VAWG in conflict-affected communities: Results from two community surveys in the DRC. BMC Int Health Hum Rights, 20, 27. https://doi.org/10.1186/s12914-020-00246-8.

[10] Masculinite, Famille, et Foi: End of Project Report. April 2021. Washington, D.C.: Institute for Reproductive Health, Georgetown University for the U.S. Agency for International Development (USAID). Available from https://irh.org/resource-library/masculinite-famille-et-foi-end-of-project-report/

Section 2
THE TRANSFORMING MASCULINITIES APPROACH

Transforming Masculinities was implemented as a partnership between the South African Medical Research Council (SAMRC), Tearfund UK, and Congolese partner HEAL Africa, with funding from UK-AID's What Works to Prevent Violence Against Women and Girls Programme. Transforming Masculinities applied a gender transformative, faith-based approach to transform social norms that underpin SGBV and gender equality. At its core, the approach was developed to step beyond challenging gender-ascribed roles to explore and question the values underpinning them, and the values, power, and status assigned based on perceptions of people's gender identities. Transforming Masculinities sought to generate a community-level shift from a social norm that underlies gender inequality, male superiority, towards a new norm that recognizes men and women as equal. The approach was grounded in four key principles: promotion of gender equitable role models for both men and women aged 18 and older, the restoration of positive roles of men in their families and communities, engagement of community leadership in preventing and addressing SGBV, and intervention at multiple levels of the social ecology within villages to promote gender equality (see **Table 1** for information on goals and program design from both projects and **Table 2** for a description of project outcomes and mechanisms of change for both projects. In **Table 2**, adaptations specific to Masculinite, Famille, et Foi are listed in green font).

BOX 2. A QUICK PRIMER ON THE EVALUATION

Transforming Masculinities was implemented and evaluated as part of the UK-AID funded What Works to Prevent Violence against Women and Girls Programme. The What Works evaluation of Transforming Masculinities in eastern DRC examined community-level change in SGBV of the core approach along with additional components, such as the Community Action Groups and their work on service linkages. Among men and women who had been in a relationship in the previous year, there was a 57% decline in women's experience of IPV and 66% decline in men's perpetration of IPV.

The Masculinite, Famille, et Foi evaluation examined the impact of just the core approach on IPV and family planning use, using a randomized control study design with cross-sectional samples from intervention and control group villages at baseline and endline. Among men and women who participated in Community Dialogue groups, there was a 33% increase in voluntary use of modern contraception in intervention congregations, but no significant changes in men's use or women's experience of IPV.

Since the evaluation of the intervention and its adaptation were not designed to measure the same components of the intervention, and the study design and methodologies differed significantly, this analysis does not present an exploration of differences in evaluation findings between the two projects. More detailed analyses of the impact of each intervention, such as findings on gender norms and attitudes, are presented elsewhere.[ix,x]

TABLE 1. Program Design: Key Aspects of Transforming Masculinities and Masculinite, Famille et Foi

	TRANSFORMING MASCULINITIES	MASCULINITE, FAMILLE ET FOI
Goal	Women and girls in conflict-affected communities in DRC are free from SGBV	Improve sexual and reproductive health and well-being, including healthy timing and spacing of pregnancies and prevent IPV
Setting	Remote, rural, conflict-affected eastern DRC	Urban and peri-urban Kinshasa, DRC
Coverage	15 villages in the Rethy area of Ituri Province, covering a population of about 216,000	17 Eglise du Christ au Congo (ECC) Protestant congregations (8 intervention, 9 comparison), covering a population of about 4,500 in intervention congregations
Target Population	Adults aged 18-75 years who attend religious services (Christian or Muslim)	Newly married women or first-time-parents (first pregnancy or oldest child <3 years) aged 18-35 years, and their male partners of any age
Definition of Community for Diffusion	All adults living in 15 selected villages	Adults attending church services within 8 ECC congregations
Intervention Duration	24 months of activities	18 months of activities

TABLE 2. Key Outcomes, Social Norms and Mechanisms of Change for Transforming Masculinities and Masculinite, Famille et Foi

	TRANSFORMING MASCULINITIES	MASCULINITE, FAMILLE ET FOI
Outcomes of Interest	• More progressive social norms related to gender inequality, masculinities, and SGBV (*not measured in evaluation*) • Decreased acceptance of SGBV in target communities • Reductions in SGBV • Increase in equitable relationships • Reduced stigma against survivors of SGBV • Increased access to support services	• More progressive social norms related to gender-equality, masculinities, IPV, and family planning • Reductions in IPV, including use of IPV to prevent family planning use • Increased voluntary use of modern contraception
Social Norms	• A man is superior to a woman • New norms of positive masculinity, using Jesus as a model	• God created men as superior to women • It is acceptable for a man to use violence to correct his wife's behavior or discipline a child • As household decision-makers, a man can dictate a woman's ability to seek and use family planning
Mechanisms of Change and Related Activities	Transforming Masculinities sought to promote gender-equitable norms and behavior and support survivors of violence, as a means of reducing SGBV. 1) Create new, positive norms on SGBV and gender equality through sermons delivered by trained faith leaders, who have critically reflected on their own beliefs and who use scripture to support the development of equitable beliefs in their community 2) Shift individual beliefs and behaviors on SGBV and gender equality by implementing Community Dialogue groups with adult men and women living in a village. Groups are facilitated by trained Gender Champions, who have critically reflected on their own beliefs on SGBV and gender equality 3) Address SGBV stigma and support SGBV survivors by training members of a Community Action Group to provide support to survivors (including linking survivors to services) and conduct community discussions about SGBV 4) Diffuse positive norms on SGBV and gender equality into the community through public testimonials from Community Dialogue group participants and public discussions about SGBV led by Community Action Group leaders	Masculinite, Famille, et Foi sought to improve relationship equality*, couples' communication, and shared decision-making, and reduce IPV, in order to improve voluntary family planning uptake and healthy timing and spacing of pregnancies. 1) Create new, positive norms on IPV, gender equality, and family planning through sermons delivered by trained faith leaders, who have critically reflected on their own beliefs and who use scripture to support the development of equitable beliefs and family planning uptake in their congregation 2) Shift individual beliefs and behaviors on IPV, gender equality, and family planning by implementing Community Dialogue groups with newly married couples and first-time parents. Groups are facilitated by trained Gender Champions, who have critically reflected on their own beliefs on IPV, gender equality, and family planning. 3) Create an enabling service environment by providing training on GBV and family planning to hotline staff, sharing hotline information with Community Dialogue participants, and providing referrals to health clinics with young adult friendly family planning/reproductive health services. 4) Diffuse positive norms on IPV, gender equality, and family planning into the congregation through sermons, public testimonials from Community Dialogue group participants, and community mobilization events

Adaptations from the original Transforming Masculinities intervention are in green font.

***Masculinite, Famille, et Foi focused on gender-equitable norms within the context of an intimate partner relationship.**

In order to shift social norms underpinning SGBV and promote equitable relationships between men and women, Transforming Masculinities used a model of cascading transformation, where selected Gender Champions and Faith Leaders (i.e., change agents) first underwent their own process of training, critical reflection, and transformation before leading efforts to facilitate the reflection and transformation of other members of their communities (see **Table 3** for information on program activities from both projects). This reflection and transformation process was important to the approach because change agents needed to believe in the desired changes in order to model gender-equitable behavior and to be facilitators of norms and behavior change in the community. Refresher trainings over the duration of the intervention provided additional opportunities for reflection. The approach included three key resources: 1) a manual for training Faith Leaders and Gender Champions, 2) a Hand-in-Hand Bible studies guide for Faith Leaders for sermons, testimonies, and couples' counseling, and 3) a manual for facilitating Community Dialogue groups. To achieve personal transformation for men and women, Transforming Masculinities provided safe spaces for critical reflection by community members to jointly discuss and reflect on gender inequality within their own value systems. To achieve community-level impact on SGBV norms and behaviors, Transforming Masculinities used opportunities for sharing messages with wider audiences, such as congregation and community members, to spread new norms across the entire village and to support the needs of survivors of violence.

TABLE 3. Key Program Activities: Transforming Masculinities and Masculinite, Famille et Foi			
PROGRAM AREA	**ACTIVITIES**	**TRANSFORMING MASCULINITIES**	**MASCULINITE, FAMILLE ET FOI**
Training	Change Agent Training	Cascading training with change agents (Gender Champions, Faith Leaders) and Community Action Group members	Cascading training with change agents (Faith Leaders, Gender Champions) and health service providers
	Health service provider training	N/A	Clinic health providers trained to provide family planning services and engage in discussion with target group
	Psychosocial Support Training	3-day psychosocial support training and a 3-day counseling and mediation training for Faith Leaders	N/A
Faith Leader Sermons		SGBV and gender equality focused	Family planning, IPV and gender equality focused
Community Dialogue Groups	Community Dialogue Groups	Facilitated Community Dialogue to foster critical reflection in both single sex and combined sex groups. Any community members aged 18-75 could participate in dialogue.	Facilitated Community Dialogue to foster critical reflection in single sex and combined sex groups. Groups were open to newly married couples and first-time parents.
	Length of Community Dialogue	Six weeks of dialogue with a 2 to 4-week gap between cycles	Nine weeks of dialogue with a 2 to 4-week gap between cycles
	Family Planning Health Talk	N/A	Family planning session/module added to the Community Dialogue manual/groups
Health Service Linkages	Clinic Linkages	Link SGBV survivors within villages to nearby medical services (funded by a separate grant)	Local clinics providing family planning services identified and linked to the program for service provision; Participants in dialogue given referral cards to access services
	Hotlines	N/A	Existing hotline service linked to program to provide information and guidance on IPV and family planning services
Public Testimonials		Community members share their behavior changes during public program gatherings	Community members share their behavior changes in congregations
Community Mobilization	Community Action Groups	Groups of community members organized to guide response to SGBV	N/A
	Mobilization Events	N/A	Events to create awareness and support for family planning and violence prevention
SGBV Survivor Support		Healing of Memories support circles for survivors of SGBV to process experiences and support each other	N/A

For Transforming Masculinities, trained Faith Leaders delivered gender equitable sermons rooted in scripture. They identified one male and one female Gender Champion from within their congregation to facilitate Community Dialogues in each village (see **Table 4** for information on selection, structure, and content of Community Dialogue groups for both projects). In addition to role modeling gender-equitable behavior, gender champions spoke with community members and facilitated Community Dialogue sessions each week for two hours. Community Dialogues included small groups of men and women aged 18 or older, who met once a week over a six-week period using a gender-synchronized approach[11]. Multiple rounds of the 6-week Community Dialogue session took place during the intervention period. If interested, residents of a community were able to participate in multiple cycles of the Community Dialogue groups. During Community Dialogue, Gender Champions facilitated discussion, activities, and self-reflection using questions contained in their manual; Gender Champions linked conversations to scripture. After each session, participants were given homework to reflect on avenues for changing their own behavior. The sixth session, with both men and women together, discussed how to create a community free of SGBV. At the end of a cycle, group members could choose to give testimonials in their congregation about knowledge and behavior change they or their partner experienced as a result of the Community Dialogue group. Altogether, the cascading model of critical reflection, transformation, and information dissemination, from Faith Leaders and Gender Champions, to men and women participants in the dialogues, to the congregation, formed the core of the Transforming Masculinities approach (**Figure 2**).

[11] In the curriculum approach, men and women met separately to discuss similar and mutually reinforcing content, and then met altogether. For further resources on gender-synchronized approaches, see the Interagency Gender Working Group concept paper, Synchronizing Gender Strategies: A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations, available from https://www.igwg.org/wp-content/uploads/2017/06/synchronizing-gender-strategies.pdf.

TABLE 4. Community Dialogues: Facilitators and Participant Selection, Structure and Content Overview for Transforming Masculinities and Masculinite, Famille et Foi

	TRANSFORMING MASCULINITIES	MASCULINITE, FAMILLE ET FOI
Gender Champions	Men and women aged at least 18 years old who live in intervention villages. They publicly value gender equality, model non-violent attitudes, and understand women's rights. They commit to facilitating weekly dialogue sessions.	Men and women aged at least 18 years who were members of intervention congregations. They publicly value gender equality, model non-violent attitudes, and understand women's rights. They commit to facilitating weekly dialogue sessions.
Participants in Community Dialogues	Men and women aged at least 18 years who were interested in SGBV and committed to 6 weeks of participation in Community Dialogues. They should not be known SGBV perpetrators. They express a willingness to be held accountable, commit to the process of personal transformation, and are willing to engage in SBGV prevention and response activities in their communities. They commit to maintaining the safety and confidentiality of participants in dialogues. They could attend more than one cycle of Community Dialogues, if desired.	Women aged 18-35 and their male partners who were newly married or first-time parents and were interested in SGBV and reproductive health. They committed to 8 weeks of participation in Community Dialogues. They should not be known perpetrators of SGBV. They express a willingness to be held accountable, commit to the process of personal transformation, and are willing to engage in SBGV prevention and response activities in their communities. They commit to maintaining the safety and confidentiality of participants in dialogues. Participants could only attend one dialogue group cycle.
Approach to Dialogues	A gender-synchronized approach with 5 sex separate sessions, followed by 1 mixed-sex session	A gender-synchronized approach with 5 sex separate sessions, followed by 4 mixed-sex sessions
Topics Covered in Community Dialogue Sessions	The six sessions covered: • The root causes of SGBV; • Gender roles and norms in daily life; • Power, status, and SGBV; • Faith and SGBV; • Reflections/moving forward; and • Strategies for creating a community free of SGBV.	The six Transforming Masculinities sessions were included (see left-side column). An additional 3 modules covered: • Child spacing and healthy relationships; • Men's involvement in positive parenting; and • An end-of-cycle celebration. One session would also include a structured health talk with representatives from local health clinics.
Approach to Community Dialogue Sessions	The sessions included guided questions for self-reflection, small-group discussions and activities, and discussion of scripture related to the topics covered (sessions 1 and 5). After each session, participants were given homework to reflect on avenues for changing their own behavior.	The Transforming Masculinities approach was used. In addition, sessions 7 and 8 included 'calls to action' which encouraged participants to reflect on what messages they wanted to share with others related intervention content.

In addition to this core approach, recognizing the high levels of stigma against SGBV survivors, Transforming Masculinities added two program activities in each village to the core intervention approach: Community Action Groups and Healing of Memories. Community Action Groups were comprised of local leaders, including church leaders, community workers, nurses, and police. Community Action Group members completed a two-day training that covered content similar to the Faith Leader and Gender Champion training. They hosted public discussions in their spheres of influence focused on SGBV (for example, the sphere of influence for nurses was health clinics), and met regularly to plan mobilization activities. They also committed to helping SGBV survivors access services, for example, by providing direct transport to health facilities. Finally, a Healing of Memories workshop was conducted with survivors of SGBV and influential community members engaged in support provision. The Healing of Memories component was developed by the Healing of Memories Institute in South Africa[12] and adapted for use in other contexts, including with SGBV survivors. Tearfund used an adapted version of the Healing of Memories workshop in Transforming Masculinities to support survivors in processing and healing from experiences of SGBV, using an experiential format, which included sharing life stories in small groups to break stigma, start healing, and build trust and mutual understanding between participants. In sharing life stories, participants could share SGBV experiences which affected their lives.

Figure 2 | The Transforming Masculinities Approach to Preventing SGBV1

Finally, before starting the intervention, the Transforming Masculinities partners identified two unexpected findings through formative research: (1) levels of IPV were unexpectedly high and (2) the closest medical facility to participating villages was two hours away from intervention villages, making it practically inaccessible. Therefore, two additional components were added to the core program to increase local capacity to provide psychosocial support to survivors of SBGV: a 3-day psychosocial support training and a 3-day counseling and mediation training for Faith Leaders. To increase survivors' access to health care directly in their community, Tearfund obtained additional grant funding to provide medical services to survivors of SGBV within the villages engaged in the intervention.

Monitoring data from the Transforming Masculinities approach provides an overview of project reach and the extent of activities over the 24-month period (see **Table 5**) for coverage of both projects. The What Works evaluation assessed the community-level impact of the core Transforming Masculinities approach, Community Action Groups, and the additional SGBV activities altogether. The evaluation included cross-sectional surveys at baseline and endline of men and women aged 18 and older residing in randomly selected

[12] For more information on Healing of Memories workshops, visit https://www.healing-memories.org/.

households in the intervention villages. The evaluation compared findings among those with higher and lower levels of exposure to the intervention to understand program effect. Among those men and women in a relationship in the past year, reports of women experiencing and men perpetrating any form of IPV declined by 57% and 66% at endline, respectively; perpetration (men) or experience (women) of IPV at endline did not differ by attendance at counselling services, participation in community discussion groups or public discussions. Women also reported a significant decline in non-partner sexual violence; findings were not presented on exposure to non-partner sexual violence by level of engagement in the intervention. The study measured individual attitudes but did not measure descriptive or injunctive social or gender norms. At endline, men and women reported significantly more progressive attitudes towards gender and reduced stigma towards SGBV survivors[13]. Only men reported significant decreases in acceptance of beliefs that women are to blame for rape, and fewer men held attitudes in favor of physical IPV at endline. Both men and women held attitudes at endline that were less supportive of sexual IPV as normal and more supportive for helping others who experience IPV. Men and women reported significant decreases in agreement with statements that justified sexual IPV and prioritized family privacy over responding to IPV (for example, less agreement that women should tolerate violence to keep the family together). Participating in community discussion groups or public discussions was associated with more equitable attitudes towards gender, masculinities, rape myths, and stigma on average at endline, and participating in counseling sessions was associated with more equitable attitudes for all domains, aside from rape myths.

[13] Le Roux et al. (2020). Engaging with faith groups.

TABLE 5. Coverage of Transforming Masculinities and Masculinite, Famille et Foi			
PROGRAM AREA	**ACTIVITIES**	**TRANSFORMING MASCULINITIES**	**MASCULINITE, FAMILLE ET FOI**
Training	Number of trainings and refresher trainings	9 (including Community Action Group members)	12 (including health service providers)
	Number of Faith Leaders trained	75 (5 Faith Leaders per village)	42 (12 national, 14 provincial, and 16 congregational Faith Leaders, with 2 Faith Leaders per intervention congregation)
	Number of Gender Champions Trained	30 (2 per village)	40 (4-6 per congregation)
	Number of Clinics Trained	N/A	17
	Number of Health Service provider Trainings	N/A	2 trainings completed
Faith Leader Sermons		Number not recorded	385 (family planning, IPV, and gender equality focused)
Community Dialogue Groups	Number of Community Dialogue group cycles completed	18 cycles	7 cycles (6th and 7th cycles ran concurrently)
	Community Dialogue groups	270 groups completed	56 groups completed
	Family Planning Health Talk	4432 (2328 men, 2104 women)	916 (458 men, 458 women)
Health Service Linkages	Referral to clinics	Number not recorded	2,086 people linked to services through referral cards in intervention congregations
	Hotline calls	N/A	1,699 calls made to hotline over intervention period
	Family Planning Health Talk	N/A	119 talks completed (56 in intervention sites, 63 in control sites)
Public Testimonials		Number not recorded	320 testimonials given
Community Mobilization	Community Action Groups	15 groups formed, with 15 community members per group	N/A
	Number of Community Action Group members trained	225 (15 per community)	N/A
	Community Action Group mobilization events	1080 events	N/A
	Community mobilization events	N/A	24 events
SGBV Survivor Support	Healing of Memories for Survivors of SGBV	1 workshop	N/A
	Number of Healing of Memories participants	33 (24 SGBV survivors and 9 family members and/or Faith Leaders)	N/A

Section 3
THE ADAPTED INTERVENTION: MASCULINITE, FAMILLE ET FOI

In 2016, the Institute for Reproductive Health at Georgetown University and Tearfund, with funding from the United States Agency for International Development (USAID) through the global Passages Project, adapted the Transforming Masculinities approach to create Masculinite, Famille, et Foi. The adaptation included additional focus on reproductive health and family planning; a change in geographic focus from small, rural communities in eastern DRC to urban and peri-urban Kinshasa (with the congregation as the area of coverage), and explicit efforts to identify and assess social norms at intervention outset to guide program adjustments and evaluation. Transforming Masculinities was selected for adaptation by Tearfund and the Institute for Reproductive Health due to potential for improving reproductive health outcomes in addition to hypothesized SGBV outcomes. The adaptation and implementation of Masculinite, Famille, et Foi was conducted while implementation and evaluation of the Transforming Masculinities approach was ongoing, and before evaluation findings were available.

Masculinite, Famille, et Foi sought to improve healthy timing and spacing of pregnancies and prevent IPV among young women aged 18-35 years, and their male partners of any age, who were newly married or first-time parents. A life course approach to reproductive health informed the decision to focus on young adults rather than adults of all ages, as marriage and having a first child are key life transitions where men and women engage with gender and social norms and adopt new behaviors related to family formation, relationships, and parenting. Life transition periods are considered a time when norms and behavior may more readily shift, with the right supports, because individuals are in transition in their roles and responsibilities. While the goal of the Transforming Masculinities intervention was to prevent SGBV (both IPV and non-partner sexual violence), Masculinite, Famille, et Foi focused on preventing IPV, and conceptualized IPV prevention as a step on the pathway to achieving the goal of healthy timing and spacing of pregnancies within these young couples. Since Masculinite, Famille, et Foi focused on couples' sexual and reproductive behaviors, the intervention targeted prevention of IPV, rather than SGBV more broadly. Both interventions targeted gender equitable norms as a pathway to these key outcomes.

In bringing the project from rural, eastern DRC to urban and peri-urban Kinshasa, Masculinite, Famille, et Foi focused on collaboration and implementation of the project in partnership with the Eglise de Christ au Congo (ECC). The population coverage area was adjusted to support implementation of the project within ECC church communities, and because the congregation was thought to be close knit and influential among young adults and couples. The intervention was designed to be brought to scale, and engagement with the ECC congregational network allowed for scale-up in Kinshasa. Kinshasa was chosen for its relatively large population of young adults in comparison to rural communities. Drawing from a growing body of literature on social norms theory and health outcomes, Masculinite, Famille, et Foi began with a social norms exploration[14] to identify norms and reference groups relevant to newly married men and women or first-time parents who attended church services. The social norms exploration assessed norms related to key program

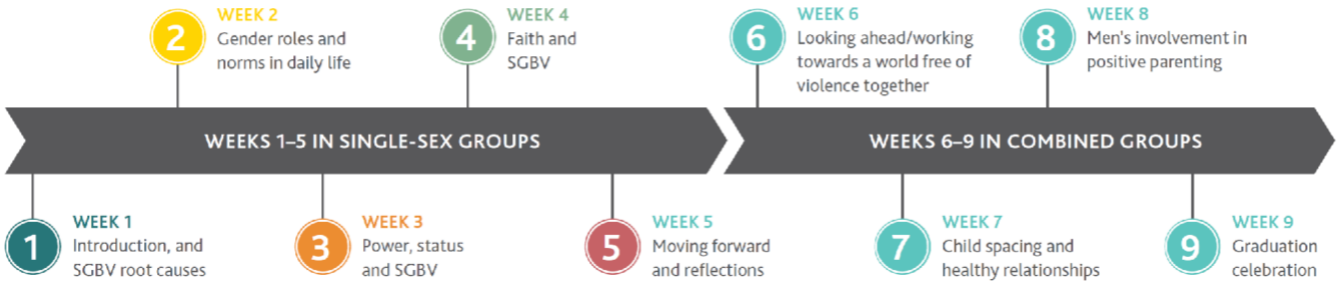
[14] The Learning Collaborative to Advance Social Norms Change & Institute for Reproductive Health. (2020). Social Norms Exploration Tool. Washington D.C.: Institute for Reproductive Health, Georgetown University. Available from https://www.alignplatform.org/resources/social-norms-exploration-tool-snet.

behaviors, including gender equality, IPV, and family planning. In addition to shifting the social norms underlying the Transforming Masculinities project (that men are superior to women), Masculinite, Famille, et Foi addressed two additional norms related to men's use of violence and control over family planning decision-making: 1) 'It is acceptable for a man to use violence to correct his wife's behavior or discipline a child' and 2) 'As household decision-makers, a man can dictate a woman's ability to seek and use family planning.'

Masculinite, Famille, et Foi built upon the core Transforming Masculinities gender-transformative principles and added strategies to integrate voluntary family planning in the project. This adaptation used the same model of cascading transformation where Faith Leaders and Gender Champions were trained, engaged in reflection and personal transformation, and then led messaging and facilitated dialogues with congregation members. In addition to the original content from the Transforming Masculinities intervention, the training and transformation process included content and reflections on reproductive health and family planning. As with Transforming Masculinities, Faith Leaders were expected to deliver sermons that drew from scripture to talk about gender equality and challenge IPV. They were also asked to speak about family planning, challenging taboos on discussing family planning in public, and perceptions of Faith Leaders as disapproving of family planning.

Gender Champions facilitated Community Dialogue groups among congregation members, engaging men and women who attended religious services as couples and parents in dialogue, reflection, and transformation. The Community Dialogues discussion guide was adapted to include additional sessions on family planning and joint decision-making, which was also covered in the Faith Leader workshops and Gender Champion trainings. The Community Dialogue curriculum was expanded from six to nine sessions: sessions 1-6 contained the same content and approach as Transforming Masculinities, with five sex-separate sessions followed by one mixed-sex session. Sessions 7-9 remained in mixed-sex groups with centered discussions on family planning, and included a health talk facilitated by trained local health workers (see **Figure 2**). Sessions 7 and 8 included 'calls to action', which encouraged participants to reflect on what messages they wanted to share with others in their congregation. In contrast to Transforming Masculinities, congregation members were only eligible to participate in one cycle of the Masculinite, Famille, et Foi Community Dialogue groups over time. In participating congregations, over 90% of eligible couples participated in the Masculinite, Famille, et Foi Community Dialogues during the 18-month intervention period. Similarly, 82.9% of endline household survey respondents had participated in Transforming Masculinities Community Dialogue groups and/or public talks/discussions[15].

[15] Le Roux et al. (2020). Engaging with faith groups.



Sessions 1-6 were implemented in both Transforming Masculinities and Masculinite, Famille, et Foi; Sessions 7-9 were added to the original Transforming Masculinities curriculum to address family planning in the Masculinite, Famille, et Foi adaptation.

Figure 3 | Community Dialogue session topics

In addition to focusing on newly married couples and first-time-parents, Masculinite, Famille, et Foi sought to create an enabling environment for family planning and IPV-related behavior change through organized diffusion of new norms within the broader congregation. The concept of organized diffusion is based on diffusion of innovation theory, where people share information that they learn with others in their networks. In programs, practitioners can build on this by encouraging project participants to share knowledge learned from interventions with others in their community[16]. Faith Leaders were encouraged to share ideas about gender equality, IPV, and family planning through their sermons and in discussion with congregation members. At the end of the nine-week dialogue cycle, couples were encouraged to use public testimonials in front of their congregation during weekly church services to share their learning and changed behaviors. The public testimonials were planned to role model new behaviors and demonstrate acceptability of nonviolence and family planning. Faith Leaders and Gender Champions also organized community mobilization events at participating churches.

To strengthen linkages to health services, Masculinite, Famille et Foi trained health hotline operators from Association de Santé Familiale (ASF) to provide information and support to young adults with family planning and IPV-related questions. Each congregation was linked to a specific health clinic, and Community Dialogue group members received referral cards in the last session with health clinic information to access a free health consultation, including family planning services and hotline information. In the urban context, where health services were readily available and health care workers had received training in youth-friendly health service provision, a hotline with referral cards and an awareness session during Community Dialogues with a local health worker connected to the clinic was hypothesized to be a sufficient linkage for family planning and IPV services. Masculinite, Famille, et Foi did not include a focus on addressing IPV-related stigma or service provision for IPV survivors. As a result, some Transforming Masculinities activities were not included in this adaptation, including the Community Action Groups, Healing of Memories, and counseling.

Monitoring data from the project provides information on the different activities and coverage of the project within intervention congregations. The Masculinite, Famille et Foi evaluation applied a randomized control trial design with the congregation as the unit of randomization. The study intended to assess individual-level

[16] Cislaghi, B., Denny, E. K., Cissé, M., Gueye, P., Shrestha, B., Shrestha, P. N., Ferguson, G., Hughes, C., & Clark, C. J. (2019). Changing social norms: The importance of "organized diffusion" for scaling up community health promotion and women empowerment interventions. Prevention Science, 20(6), 936–946. https://doi.org/10.1007/s11121-019-00998-3

changes in key outcomes, however, losses to follow-up related to participant migration between baseline and endline studies led to a two-group pre-posttest design, which compared cross-sectional samples of intervention and comparison congregations at baseline and endline[17]. Women and their male partners who were eligible to participate in the Community Dialogues were interviewed in the selected congregations. To assess diffusion of knowledge, norms, attitudes, and behaviors among the broader congregation, a diffusion survey was conducted with adult congregation members who were not newly married or first-time parents, aged 18-35.

Evaluation results showed that Masculinite, Famille, et Foi yielded key successes for family planning: Community Dialogue group participants in intervention congregations reported a 33% increase in use of modern contraception and greater intention to use modern contraception, as compared to members of congregations in the comparison group. While there were no significant changes in individual attitudes or perceptions of others' use of family planning (descriptive norm), newly married couples and first-time parents reported an increase in perceptions that others approved of modern contraception use by newly married couples and first-time parents (injunctive norm). There was also some evidence that new norms on family planning diffused through the congregation, as the diffusion survey found greater perceptions that couples used family planning (descriptive norm) and perceptions that others approved of family planning (injunctive norm).

The evaluation painted a complex picture of norms and behaviors related to gender equality and IPV. For participants in the Community Dialogues, reported perpetration (men) or experience (women) of any form of IPV did not change at endline, with the exception of men reporting less use and women less experience, of men yelling at their partner. Attitudes also did not change at endline. Participants were less likely to report that their partners approved sexual IPV and that others who were important were less likely to approve any form of IPV. However, participants reported increase in perceptions that IPV was typical (descriptive norm) in both intervention and comparison congregations, though fewer (not significant) reported that IPV was acceptable (injunctive norms). In contrast to the positive findings on diffusion of family planning, the diffusion survey did not reveal changes in behaviors or norms related to IPV among the wider congregation. The couples' survey found that Community Dialogue group participants reported greater agreement that men and women are created equal than the comparison group, but did not find changes in other individual-level attitudes related to gender equality. Dialogue group participants were also more likely to report that most husbands shared child care responsibilities (descriptive norms) and that the congregation approved of role-sharing, than the comparison group.

[17] Transforming Masculinities/Masculinité, Famille, et Foi Intervention; Endline Quantitative Research Report. September 2020. Washington, D.C.: Institute for Reproductive Health (IRH) and Center for Child and Human Development, Georgetown University with the United States Agency for International Development (USAID).

Section 4

ADAPTATION LEARNINGS: PROGRAM DESIGN, IMPLEMENTATION, AND CONTEXTUAL FACTORS SHAPING TRANSFORMING MASCULINITIES AND MASCULINITE, FAMILLE ET FOI

The What Works evaluation of Transforming Masculinities in eastern DRC and the evaluation of the Masculinite, Famille, et Foi adaptation employ different evaluation approaches and methodologies, with a focus on changes in different components of the intervention: Transforming Masculinities evaluated the impact of the core intervention and additional components, such as Community Action Groups and linkages to survivor support services, and Masculinite, Famille, et Foi evaluated only the impact of the core intervention. As such, this section focuses on learnings from the program adaptation with a look at factors which may have reasonably contributed to the difference in findings between the implementation of Transforming Masculinities in eastern DRC and its adaptation Masculinite, Famille, et Foi in Kinshasa on SGBV outcomes. Three key areas are the focus of this exploration: program design, program implementation, and contextual factors. These information areas were revealed during the matrices analysis as critical aspects of the adaptation and program success, and presented in the earlier tables. These adaptation learnings, presented by key area, unpack the information for each intervention and describe their importance as considerations for future program adaptation processes.

PROGRAM DESIGN

An examination of program design revealed four key areas which may have been barriers to seeing change on IPV in the adaptation: definition of community, target population for Community Dialogue groups, identification and engagement of reference groups, and diffusion activities.

Definition of Community

The large difference in population size between a village in eastern DRC and the capital city of DRC was reflected in how each program defined a community as its sphere of influence. Transforming Masculinities was implemented in smaller, densely networked[18] rural villages in eastern DRC; the total target population comprised about 216,000 people across fifteen villages in eastern DRC. Masculinite, Famille, et Foi was implemented in eight Protestant congregations in the densely populated capital city of DRC, Kinshasa. Though the Protestant population in Kinshasa is large (3.7 million people), Masculinite, Famille, et Foi sought to reach the 4,500 members of the selected eight congregations with the goal of scale up to additional congregations after project evaluation. This definition of community guided how each project defined criteria for Community Dialogues and designed diffusion activities.

[18] A densely connected social network is one where individuals within the network are connected to many other individuals; in other words, a high proportion of people in the community know each other and are connected to each other in some way.

For Transforming Masculinities, all adult men and women in the village were eligible to participate in Community Dialogues, and other activities supported change across the village and adult population as a whole. A whole-community approach is feasible in relatively small, well-networked, rural communities where saturation of intervention activities is a realistic objective. In contrast, reaching 3.7 million people in an urban context is more challenging. To explore implementation and scale up through existing church structures that had a wide reach and strong support for the project, Masculinite, Famille, et Foi applied a social definition of community, the congregation, as the primary location of influence for norms, and behavior change related to family planning and IPV. Faith leaders and congregation members, in addition to important others (e.g., family members, spouse), were identified as important to IPV and family planning in the social norms exploration that guided the program adaptation.

Yet, in an urban context, individuals move through multiple spheres of influence with different communities and people, and potentially less overlap between those spheres of influence. The social norms exploration was implemented through congregations. It is possible that in Kinshasa, a congregation serves as a meeting place for heterogenous networks of individuals linked by religion and church selection, but not as closely connected to each other when not attending the congregation. How norms and reference groups operate in urban settings where networks are more dispersed and individuals move through different communities/networks is not well understood and may affect norms and behavior change programming.

Target Population for Community Dialogue Groups

In eastern DRC, Transforming Masculinities engaged adults of all ages in community dialogue. In Kinshasa, Masculinite, Famille et Foi took a life course approach to reproductive health, recognizing the opportunity to shift norms and behaviors among newly married couples and first-time parents before they are internalized and normalized. However, formative research revealed that in Kinshasa, newly married couples and first-time parents encompass a relatively broad age range in which other life transitions may be occurring (for example, transition from secondary or higher education to employment), and the baseline evaluation also indicated that a substantial proportion of couples were not formally married, which may affect dynamics within the couple. Focusing on this point of life stage transition in an urban context may have captured subgroups of people across several cohorts within a broader period of life change. At the same time, a narrow focus on life transition may have resulted in missed opportunities to engage congregation members in older age groups in the more intensive personal reflection and transformation process provided by the dialogue groups. It is possible, though not clear, that if older individuals in the congregation are important reference groups for young couples, their inclusion in Community Dialogues or in select sessions would have facilitated a greater shift in norms for young people.

Identification and Engagement of Reference Groups

Reference groups for IPV were considerably more complex in urban Kinshasa than for SGBV in rural villages in eastern DRC. For Kinshasa, women and men reported different referent groups for IPV: women were most likely to consider their spouse/partner, mothers and mothers-in-law, and *then* Faith Leaders as important referent groups. Men, on the other hand, were most likely to list Faith Leaders, mothers and mothers-in-law, fathers and fathers-in-law, and *then* spouse/partners and friends. They also reported different reference groups for family planning: women were most likely to list their partner/spouse and mother and mother-in-law as referent groups, while men were most likely to list Faith Leaders and then their partner/spouse. In the more rural context of eastern DRC, the baseline evaluation affirmed that Faith Leaders were the *only* referent group whose approval would positively motivate both men and women to comply with behaviors related to using physical violence against a partner, forced sex, and support for

survivors of violence. This important difference in the number, type, and influence of reference groups in urban compared to rural settings introduces complexity that is challenging to tackle in an intervention. Both Transforming Masculinities and Masculinite, Famille, et Foi worked with Faith Leaders through training, reflection, and transformation exercises to achieve change. Yet, for Masculinite, Famille, et Foi, there were key groups who were influential to men and women and by specific behaviors, such as parents and in-laws, who were not explicitly targeted by the intervention, though the project hoped that participants would share information with these individuals in casual conversation and through testimonials.

Diffusion Activities

Both the original intervention and the adaptation utilized the core Transforming Masculinities approach of Faith Leader sermons, testimonials from Community Dialogue participants, and community events to diffuse new norms and behaviors. While not originally designed as a diffusion activity, the activities used to prevent stigma and provide services for SGBV survivors in Transforming Masculinities may have also diffused new norms around SGBV acceptability. These activities were structured into the program on a regular basis and, therefore, may have been both more intensive and had broader reach than diffusion activities in Kinshasa. For example, in the eastern DRC, Community Action Groups were added to the core approach to address stigma against survivors of SGBV. Community Action Groups hosted public discussions monthly. These discussions offered village residents more frequent opportunities for personal reflection, and brought conversations about SGBV to spaces outside of the church or mosque. Direct engagement of community leaders in providing support may have more publicly modeled willingness to take action to support survivors of SGBV and reinforced messaging that survivors of SGBV deserve support rather than blame. Masculinite, Famille, et Foi did not include similar survivor support and stigma reduction activities, or activities that reached the wider congregation or community outside of the congregation.

PROGRAM IMPLEMENTATION

The analysis identified three program implementation factors which may have influenced program outcomes: fidelity to intended messaging on gender equality, topical focus on key outcomes of interest, and program duration.

Fidelity to Intended Messaging on Gender Equality

To achieve shifts in gender equality, Transforming Masculinities and the adaptation hypothesized that engaging in dialogue and reflection, and affirmation of gender equality from faith leadership, would shift norms and practices related to roles and responsibilities for men and women. Transforming Masculinities did not include learning reports or a midline evaluation. As a result, information on how the intervention took place, key accomplishments and challenges, adjustments to the approach, and whether messaging was consistent across activities is not available. Further, we could not conclude whether the messaging and its internalization were taking place as intended.

Masculinite, Famille et Foi took a learning approach to the intervention, and included a midline ethnography and learning studies focused on deeper analysis of monitoring data. While the ethnography reaffirmed the importance of working on IPV and family planning within faith communities in Kinshasa, researchers observed that Faith Leaders did not consistently preach towards gender equality[19]. In fact, when discussing gender roles in the home, several Faith Leaders emphasized that men and women had distinct but

[19] Transforming Masculinities and Promoting Family Planning in Faith-based Communities: Midline Ethnography Report. April, 2019. Washington, D.C.: Institute for Reproductive Health, Georgetown University for the U.S. Agency for International Development (USAID).

complementary roles, with men as providers and women as caretakers. When it came to norms supporting IPV, MFF ethnographers found that some Faith Leaders used messaging that reinforced shared responsibility for harmony in the home, thereby rationalizing the use of IPV as normal, and placing responsibility for such violence on women or external forces (i.e., evil forces) and not on husbands. Some emphasized that women should practice forgiveness in response to IPV rather than accountability. Though identified at midline and discussed within the project, it was not clear from study reports whether these Faith Leaders changed their messages in response to supports from the project staff.

Topical Focus on Key Outcomes of Interest

For the Masculinite, Famille, et Foi adaptation, family planning content was added to the core Transforming Masculinities approach. The training program and Community Dialogue guides retained the same amount of content on SGBV and gender equality as had been included in Transforming Masculinities. In other words, the Community Dialogues expanded their focus without diluting content on SGBV and gender equality. Training with Faith Leaders and Gender Champions covered additional content, while maintaining the original training program. Yet, Masculinite, Famille, et Foi monitoring data revealed that, in practice, Faith Leaders shared messaging on family planning far more frequently than on SGBV. As noted above, when sharing information on SGBV in their sermons, the content was not consistently gender transformative, and sometimes reinforced harmful norms. Over the duration of Masculinite, Famille, et Foi Faith Leaders gave 385 sermons on family planning, gender roles and healthy relationships, and SGBV. About 55% of these sermons addressed family planning, 37% were on gender roles and healthy relationships, and only 8% directly addressed SGBV. Community mobilization activities also tended to focus on family planning and healthy relationships rather than SGBV. In contrast, Transforming Masculinities consistently messaged on SGBV prevention and response.

Project Duration

Transforming Masculinities was implemented over 24 months, with a focus on gender equality and SGBV. Masculinite, Famille, et Foi sought change on family planning in addition to gender equality and IPV, and was implemented over 18 months. In practice, this meant that Faith Leaders were trying to address *more* norms in the adaptation, but with *less* time to do so relative to the original intervention. In all intervention congregations, all eligible newly married couples and first-time parents participated in the Community Dialogues. Yet, fewer months of implementation would reasonably result in fewer opportunities to engage in diffusion activities, which encouraged reflection and transformation within the space of the congregation.

CONTEXTUAL FACTORS

Since Transforming Masculinities was intentionally adapted for use in a large urban setting, this section presents contextual differences between the project settings that became evident during program implementation and evaluation as important to the program design. These contextual factors, as with the project design and project implementation sections, may have affected whether Masculinite, Famille, et Foi could achieve shifts in IPV norms and outcomes. These include: boundedness of the network, scope for norms change, and complexity of norms as a driver of behavior change.

Boundedness of the Network

One way that social norms are enforced and reproduced is through the use of rewards and sanctions. Boundedness is a concept that describes how stable, or consistent, membership is within a community: for

example, whether people enter or leave in fairly short periods of time, or the same people remain in that community over time. The boundedness of a community may affect how norms influence behavior, how reference groups influence behavior, how norms spread through the community, and motivation to comply with norms. In this case, Masculinite, Famille, et Foi considered a congregation—its Faith Leaders and members—as important to shifting norms and behaviors related to family planning, IPV, and gender equality.

The Transforming Masculinities intervention considered the whole village as a sphere of influence on norms and behaviors related to SGBV prevention and response and gender equality. Villages in eastern DRC may have been more bounded than congregations in Kinshasa, which would affect the relative influence of norms change on behavior[20]. In a more bounded network (like rural eastern DRC), social norms may have a stronger effect on behavior than in a more porous network (like Kinshasa). This is because the values of the social sphere may be more homogenous, and because when a dominant or influential subgroup adopts a new norm, it more easily diffuses throughout the network[21]. Transforming Masculinities' ability to reach saturation in a village indicates that the network may have been more closed, and thus the potential to reward more positive behaviors and sanction negative behaviors may have been stronger. In Kinshasa, participants in faith congregations relocated to other parts of the city within the span of two years, as shown in the loss to follow up at endline. This indicates that the faith network in Kinshasa may be more porous. The norms of a more porous network may not be as salient or may operate differently than they do in rural areas. This does not necessarily mean that norms shifting interventions are unlikely to work in urban congregations, but perhaps such interventions need to include additional components that address this complexity.

Scope for Norms Change

At the start of Transforming Masculinities, men and women in rural eastern DRC reported greater acceptance of violence against women than in Kinshasa. For example, 51.1% of men and 41.6% of women in eastern DRC believed that there were times that a woman deserves to be beaten; in contrast, in Kinshasa, only 5.4% of men and 4.1% of women agreed or strongly agreed that it was appropriate for a husband to beat his wife sometimes. Other attitudes related to gender equality and violence confirmed this difference in the prevalence of attitudes favoring violence and gender inequality between the two projects. In other words, the scope to affect change in attitudes and social norms in Kinshasa was more challenging to both achieve and measure than in eastern DRC. Small changes in attitudes and norms in Kinshasa would have required large sample sizes to detect. In contrast, the difference between exposure to IPV was similar across the two project sites: 68% in eastern DRC and between 65-67% in Kinshasa.

Complexity of Norms as a Driver of Behavior

Men and women in Kinshasa reported a complex relationship between their faith and its values, and their own beliefs regarding IPV. While over half of women and men at baseline believed that according to scripture, a husband is supposed to discipline his wife, only about 5% believed, themselves, that it was appropriate for a husband to beat his wife at times. This meant that, at the outset of Masculinite, Famille, et Foi, a fair share of participants did not agree with physically hitting their wives, but believed that their religion did condone physical abuse. Similarly, there was a potential conflict between injunctive norms (perceived approval of IPV) and descriptive norms (perceived presence of IPV) in the congregations

[20] Kincaid, D.L. (2004). From innovation to social norm: Bounded normative influence. Journal of Health Communication, 9:S1, 37-57, DOI: 10.1080/10810730490271511.

[21] Ibid.

surveyed. For example, 5% or fewer women and men agreed that that their congregation's Faith Leaders thought it was appropriate for a husband to beat or force sex on his wife at baseline, and 5% or fewer women and men agreed that that members of their congregation thought it was appropriate for a husband to beat or force sex on his wife at baseline. In contrast, almost one-quarter of women and men believed that many or most husbands in the congregation did, in reality, beat their wives, and force their wives to have sex. These differences between personal beliefs and norms revealed a shared perception of the religious community as less progressive than individuals within that community believe themselves to be.

These findings, along with previously mentioned data on reference groups, indicate that faith institutions have potential for influencing shifts in norms and behaviors related to IPV and family planning. Yet, how these norms influence behavior, how well faith-based norms communicate the expectations and values of the members of a congregation, and how much people adopt faith-based norms in their private behaviors versus public behaviors will affect the intervention's ability to instill new norms and behaviors. Similar information is not available from eastern DRC. Finally, interventions of longer duration and increased layering may be needed in an urban environment to address these varying spheres of influence and reference groups.

Section 5
RECOMMENDATIONS FOR ADAPTING NORMS-SHIFTING PROGRAMMING

This analysis explored the differences between the pilot Transforming Masculinities and adaptation Masculinite, Famille, et Foi to learn about intervention adaptation in the context of scaling an approach to new sites with different social networks, target populations, and outcomes of interest. Through program review and staff interviews, we sought to highlight several points of similarity and variation between these interventions, emphasizing program design, implementation, and contextual factors, which are important to consider when adapting and evaluating norms and behavior change interventions. A few key findings are summarized below.

Program design

- **Multiple opportunities to engage in critical reflection may improve uptake of new norms and behaviors.** Transforming Masculinities offered repeated opportunities to engage in reflection, both within and outside the physical space of the church or mosque, which may have reinforced messages and offered multiple avenues for community members to reflect upon personal beliefs and behaviors.
- **Interventions with more visible rewards or sanctions for positive behavior may improve uptake of positive behaviors and reduce negative behaviors.** In Transforming Masculinities, the visible and tangible forms of support for survivors provided by Community Action Groups may have complemented messaging by Faith Leaders within the congregations to demonstrate not just through words, but through action that community leaders care about supporting survivors and do not condone SGBV.
- **SGBV interventions which are adapted to include family planning as an outcome may need to be accompanied by longer duration of program implementation and evaluation, to allow for sufficient time to enact change on *both* SGBV and family planning.** Since Masculinite, Famille, et Foi was seeking to generate change on family planning in addition to IPV, a longer program duration than the 2.5 years used in the Transforming Masculinities approach may have been needed to see change on IPV outcomes.

Program implementation

- **Interventions seeking to address both SGBV and family planning should ensure that content on SGBV and family planning are complementary and mutually reinforcing**. Developing a curriculum which is tailored to address both throughout, and which draws linkages between SGBV and family planning, may enhance opportunities to reflect upon and change values and behaviors related to violence and unhealthy timing and spacing of pregnancies.
- **Active program monitoring, learning, and regular supports to change agents to correct incorrect messaging is important throughout the intervention duration.** Investing in real-

time monitoring and creating opportunities for course-correction could improve fidelity to intended messaging.

Contextual considerations

- **A porous (or unbounded) social network may be a barrier to uptake of new norms and behaviors**. Especially in urban contexts, practitioners and researchers alike should check assumptions on boundedness of the network, and consider how intervention design and implementation may need to be adapted when populations may relocate frequently within an urban area. Interventions may need to be designed to engage heterogeneous parts of a social network or community, and formative research using methods such as social network analysis may help identify which networks to engage to maximize opportunities for change.
- **In urban contexts, there may be a range of influential actors who need to be engaged in an intervention to see normative change, and the range of actors may differ for women and men.** For example, this analysis found that Faith Leaders may have greater influence in rural than urban contexts, and that parents and parents-in-law were influential reference groups for men and women in urban Kinshasa. Interventions seeking to address family planning may benefit from including family members beyond women's partners/husbands. Finally, norms and reference groups are complex for any given behavior, considering how they operate within a couple's relationship to influence behaviors adds an additional layer of complexity and nuance to program design.

Section 6
CONCLUSION

The Transforming Masculinities approach holds promise in shifting behaviors and preventing SGBV in rural settings. While the Masculinite, Famille, et Foi adaptation did not achieve similar results in SGBV in an urban setting, it improved voluntary family planning uptake. Even with careful efforts to understand social norms and intentional focus on institutional-level and individual-level changes with influential actors, a range of program design, implementation, and contextual factors can influence program impact. In addition to measuring impact, investments in adaptation and monitoring may ensure that positive findings can be replicated and identify barriers to change. For adaptation of programming seeking to shift social norms on SGBV, a thorough understanding of social norms and networks which goes beyond naming specific norms towards identifying which networks are influential, how densely connected networks are, how people are networked, and how social norms and reference groups influence behaviors, can lead to improved project design.