

JANUARY 2016

GREAT Project Endline Report

Institute for Reproductive
Health, Georgetown
University

4301 Connecticut
Avenue, NW Suite 3
Washington, DC 20008



Photo Credit: Sophie Savage, Institute for Reproductive Health, Georgetown University



GENDER ROLES, EQUALITY AND TRANSFORMATIONS PROJECT
INSTITUTE FOR REPRODUCTIVE HEALTH GEORGETOWN UNIVERSITY
PATHFINDER INTERNATIONAL
SAVE THE CHILDREN

This publication was made possible through support provided by the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement No. AID-OAA-10-00073. The contents of this document do not necessarily reflect the views or policies of USAID or Georgetown University.

Written by Institute for Reproductive Health, Georgetown University for distribution and use by all partners on the Gender Roles, Equality and Transformations (GREAT) Project.

Gender Roles, Equality and Transformations Project

The mission of the GREAT Project is to develop and test life-stage specific strategies to promote gender-equitable attitudes and behaviors among youth and their communities with the goal of reducing gender-based violence and improving sexual and reproductive health outcomes in post-conflict communities in Northern Uganda.

Georgetown University's Institute for Reproductive Health
Pathfinder International
Save the Children

Institute for Reproductive Health | Georgetown University
4301 Connecticut Avenue, N.W., Suite 310
Washington, DC 20008 USA

Email: irhinfo@georgetown.edu

Website: www.tinyurl.com/projectgreat

TABLE OF CONTENTS

TABLE OF CONTENTS.....	2
ACKNOWLEDGEMENTS.....	3
LIST OF ACROMYNS & KEY PHRASES.....	3
BACKGROUND.....	3
METHODOLOGY.....	5
RESULTS.....	6
Background characteristics	6
Coverage And Diffusion: Who Did We Reach?	6
Gender norms and equality	8
Sexual and reproductive health	9
CONCLUSIONS & RECOMMENDATIONS.....	11

ACKNOWLEDGEMENTS

This report was prepared by Nana Dagadu on behalf of the Gender Roles Equality and Transformation (GREAT) project with support from the IRH team of Rebecka Lundgren, Victoria Steven, Danielle McCadden, and Sophie Savage. This research would not have been possible without the thorough data collection and analysis by NaNa Development Consultants Limited, the excellence of the 30 local research assistants/interviewers, and the commitment and diligence of Gratian Masendi and Thomas Odong (IRH Uganda) who supervised field activities. The research also benefited from the contributions of the GREAT Project Consortium members – especially Brad Kerner, Pauline Kabagenyi, and Benon Orach of Save the Children, and Callie Simon, Gwyn Hainsworth, Lucy Shillingi, Susan Oregede, and Geoffrey Opyet of Pathfinder International – in planning, developing the study protocol and survey tools, and providing input on the analysis and conclusions. Most importantly, we thank the young people and community members of the Amuru and Lira districts who generously shared their time and experiences with the research team, in hopes of improving the future of their communities.

LIST OF ACROMYNS & KEY PHRASES

CAG	Community Action Group
FP	Family Planning
GBV	Gender-Based Violence
GEM	Gender-Equitable Men scale
GREAT	Gender Roles, Equality and Transformation
IRH	Georgetown University's Institute for Reproductive Health
NM/NP	Newly Married/Newly Parenting
OA	Older Adolescent(s)
SPSS	Statistical Package for the Social Sciences
SRH	Sexual and Reproductive Health
VHT	Village Health Team
VYA	Very Young Adolescent(s)

BACKGROUND

The Gender Roles, Equality, and Transformations (GREAT) project is a six and a half-year project funded by USAID and implemented by Georgetown University's Institute for Reproductive Health (IRH), in partnership with Save the Children International and Pathfinder International and their respective implementing partners, Straight Talk Foundation and Concerned Parents Association. The GREAT Project aims to develop and test life-stage specific strategies to promote gender-equitable attitudes and behaviors among youth and their communities with the goal of reducing gender-based violence (GBV) and improving sexual and reproductive health (SRH) outcomes in post-conflict communities in Northern

Uganda. The GREAT project piloted the community-based interventions from July 2012 to September 2014 with the goal of creating an enabling environment for SRH and family planning (FP) use. At the core of the effort is an intervention package, consisting of four components (Figure 1) and simple tools to bring about behavior change among various cohorts within the target populations. The intervention package was designed with scale in mind i.e. to be scaled up with the resources likely to be available outside a pilot setting.

Figure 1. GREAT Intervention Components



GREAT explored whether less intensive inputs (low cost and minimal staff time) could foster the desired changes in social norms and behavior related to gender, SRH, and GBV. Therefore, implementation was planned to cover four sub-counties with the Community Action Cycle implemented by nine Community Action Groups (CAG) per parish; the radio drama aired twice a week in all communities via at least one station; 60 Village Health Team members (VHT) per district participating in gender reflections and adolescent-friendly SRH service orientations; and at least three community or school-based groups per village. Two sub-counties were selected as control sites for comparison.

After a baseline study in 2012 and 22 months of implementation from August 2012 to September 2014, an endline study was conducted by a local research firm, NaNa Development Consultants Limited, to determine whether or not to expand the GREAT interventions after the pilot phase, and what modifications may be needed to increase its effectiveness. Specifically the endline study was intended to measure whether the intervention resulted in:

- 1) Increased gender-equitable values, attitudes, and behaviors among adolescents age 10-19 and adults;
- 2) Improved SRH knowledge, attitudes, and access to services among adolescents 10-19; and
- 3) Decreased tolerance of GBV among adolescents and significant others.

Due to broad radio coverage to both intervention and control sites, propensity score analysis was used to compare the results of those exposed to GREAT with a simulated matched control group, taking into account socio-demographic differences. This report presents the findings of the endline survey and makes reference to results from the baseline survey (also conducted by NaNa Consultants).

METHODOLOGY

Data Collection

The endline survey was conducted in October 2014 in GREAT Project intervention and control sub-counties in Lira and Amuru districts. Survey respondents were classified into four life stages:

- 1) Very young adolescents (VYA): boys and girls 10-14 years old, attending school
- 2) Older adolescents (OA): boys and girls 15-19 years old, unmarried, without children
- 3) Newly married/parenting (NM/NP): boys and girls 15-19 years old, married/cohabitating with or without children
- 4) Adults: men and women over the age of 19

The endline sample size was matched to the baseline sample calculated as 2,000 adolescents and adults in order to allow for a design effect of 2, 10% non-response rate, 5% non-completion rate, and measurement of changes in knowledge, attitudes, and behavior of at least 10%. Additionally, sample sizes of individual life stages (See Table 1 for details) were established to allow within group comparisons. Respondents were selected using a stratified, two-stage cluster sample of primary and secondary schools (VYA) and households (all other life stages). The same 20 villages in Amuru and 26 villages in Lira and 28 schools (14 in each district) sampled at baseline were also sampled at endline.

Interviews were conducted in a place of convenience for each respondent – school, home, or community location – using questionnaires developed by IRH in consultation with GREAT partners and local experts. While the instruments for the three older life stages followed a structured format with multiple choice agree/disagree options, the VYA instrument included participatory elements to engage children and decrease potential sensitivity of questions. A modified Gender-Equitable Men (GEM) scale was used to measure gender norms. All questionnaires were approved by Ugandan and Georgetown University Institutional Review Boards as well as by USAID/Washington.

Table 1: Detail of Achieved Sample Size by Life Stages

Life Stage	Age	Description	Sample Size (females; males)	Baseline sample size comparison (females; males)
VYA	10-14	Boys and girls; attending school	450 (225; 225)	450 (227; 223)
OA	15-19	Boys and girls; unmarried, without children	1,107 (556; 551)	1,094 (549; 545)
NM/NP	15-19	Boys and girls; married/cohabitating with or without children	507 (307; 200)	506 (202; 304)
Adults	19+	Men and women; community members	401 (194; 207)	398 (216; 182)
TOTAL			2,465 (1,282; 1,183)	2,448 (1,194; 1,254)

Data Analysis

Data analysis was facilitated by the use of Excel and Statistical Package for the Social Sciences (SPSS) software, Version 20. All secondary schools were excluded from the Lira sample as no interventions were implemented in Lira secondary schools. Among the 24 intervention villages, six (four in Lira and two in Amuru) were excluded from the sample due to no toolkit and community action cycle activities implemented there during the course of the project. Statistical analyses took into account sampling weights, clustering and stratifications. Due to broad coverage of the radio drama even in control areas, effect sizes for the GREAT project interventions were obtained as difference-in-difference estimates from models using propensity score matching. Linear regression was used to obtain the effect sizes. Counterfactual outcomes (*what would have been expected in absence of exposure*) were generated for the exposed and compared to actual observed outcomes.

RESULTS

BACKGROUND CHARACTERISTICS

Across all life stages, most respondents were Catholic, predominantly ethnic Acholi in Amuru district and ethnic Lango in Lira district, and stated having a trusted adult with whom to speak about difficult issues. Among adult men, approximately 60% had completed primary school and 37% had completed secondary school. About three quarters of adult male respondents (76%) were married, 80% were employed, with a mean of 3.4 children. Among adult women, the majority (68%) had completed primary school, 9% had completed secondary school, 75% were married, 63% were employed, and they had a mean number of 3.8 children. The majority of newly married and parenting males had a primary education (80%) and were employed (77%). For the newly married and parenting females, however, while most (62%) were educated through primary school, only about one third (35%) were employed. Among OA, most were educated through primary school (over 80%), almost three quarters (72%) were living with a sibling of the opposite sex in households headed by one of their parents, and one quarter (23%) were in a romantic relationship. Results were similar for male and female OAs. The majority of VYA (80%) were also living with at least one of their parents and a sibling of the opposite sex, but all were attending primary school. Results were similar in the intervention and control areas and between baseline and endline.

COVERAGE AND DIFFUSION: WHO DID WE REACH?

Exposure to the GREAT components was measured at endline to determine the coverage of the intervention. Among all age groups, radio listenership was high with at least 90% of both sexes in each cohort listening to the radio at least once a week and about 93% of all respondents having heard gender equality, SRH, and GBV discussed on the radio. Listenership of the Oteka radio drama was high as well (Table 2) and concentrated among males. Participation in activities using the toolkit, however, was low, particularly for OA who were less likely to belong to an organized group (only 3.4% reported having participated in such activities more than twice a month as compared to over 70% in each of the older cohorts). Among VYA, exposure to toolkit activities was very high because activities took place in

school-based clubs¹. Finally, across cohorts, there were low rates of interaction with VHTs (17%) and CAG members (15%)².

Table 2: Coverage (%) of GREAT intervention components by life stage

Life Stage	Radio Drama	VHT Service Linkages	Community Action Cycle	Community Groups & Clubs Using Toolkit
VYA	78	12	8	40
OA	59	9	5	3
NM/NP	58	22	7	5
Adults	62	25	10	2
TOTAL	60	17	7.5	12.5

In addition to exposure, we wanted to assess diffusion throughout the community. We discovered that 42% of the respondents who ever listened to the Oteka radio program or participated in toolkit activities shared the information with others; rates of sharing information were higher among men than women and among adults. At least 55% of adult respondents were involved in at least one discussion with an adolescent to shape that young person's attitudes and practices.

In sum, 40% of the respondents had no access to any of the GREAT interventions. Among the 60% of respondents who were exposed to GREAT, 94% were exposed through the Oteka radio program only, 5% through radio and toolkit activities, and about 1% through toolkit activities only. All respondents who ever participated in CAC activities had also listened to Oteka.

¹ VYAs were sampled only from school clubs, thus out-of-school youth are not included in this analysis.

² low levels of exposure to VHTs and CAGs could be due to the variety in individual SRH needs and challenges during the interviews identifying CAG members among various community organizing structures.

GENDER NORMS AND EQUALITY

Information regarding gender norms and equality was collected from respondents of all life-stages using



an agree/ disagree format with statements such as *A woman should obey her husband in all things*, *A man should have the final word about decisions in the home*, *Giving a bath and feeding kids are the mother's responsibility*, and *It is more important for boys to get an education than girls*. Indicators were analyzed independently and also consolidated into indices including: gender norms, rights and privileges of men, household role sharing, boys' education inequality, and SRH.

Significant improvements ($p < 0.05$) were observed in equitable partner-decision-making, household role sharing, and couple communication scores among NM/NP with specific increases in: women's involvement in decision-making, male involvement in sharing of household roles, and male involvement in at least two childcare tasks (see Table 3 for effect sizes and confidence intervals).

OAs increased advocacy for sister's education to parents ($p < 0.05$) and male VYAs also increased sharing of household chores ($p < 0.05$). Across life stages, there were also significant ($p < 0.05$) reductions in attitudes supporting boys having more free time or women obeying husbands unconditionally. Overall, males of all age groups generally showed more improvement than females.

Table 3: Effect Sizes and Confidence Intervals for Statistically Significant ($p < 0.05$) Gender Norms Indicators

Item (cohort)	Effect Size (%)	Confidence Interval
Equitable partner-decision-making score (NM/NP)	9	(2.4, 14.7)
Household role sharing score (NM/NP)	7	(-10.8, -2.2)
Couple communication score (NM/NP)	12	(2.4, 21.1)
Men's involvement in sharing of household roles (NM/NP)	17	(0.1, 34.6)
Men involvement in at least two childcare tasks (NM/NP)	10	(0.9, 19.7)
Male advocacy for sister's education to parents (OA)	16	(6.2, 26.2)
Sharing of household chores (VYA)	21	(4.1, 44.7)

SEXUAL AND REPRODUCTIVE HEALTH

10% MORE

NEWLY MARRIED AND
PARENTING
RESPONDENTS WERE
**CURRENTLY
USING FAMILY
PLANNING** AS A
RESULT OF GREAT
INTERVENTIONS

Adults, NM/NP, and OA were asked about SRH, and VYA were surveyed about puberty. Overall, respondents who participated in GREAT expressed improved SRH attitudes and behaviors. There were several significant ($p < 0.05$) improvements observed among newly married and parenting adolescents: increased communication with partner about FP use; increased FP seeking behavior³; increased FP use^{4,5}; and increased intention to use FP in the future (see Table 4 for effect sizes and confidence intervals). There were significant improvements in SRH attitudes and behaviors: increased contraceptive self-efficacy⁶ (effect size: 10%); increased belief that contraceptives are safe for adolescent girls (effect size: 13%); communication about timing of next child (effect size: 11%); and partner support of FP use (effect size: 11%). Among NM/NPs, results showed that individuals who believe that their partners would support their decision to use contraceptives, where couple communication score is high, and who know the location of FP services were more likely to be using contraceptives while those who believe that an ideal couple should have a child in their first year of marriage were least likely to be using contraceptives.

Among older adolescents, significant ($p < 0.05$) improvements were found in decreased offense at wife requesting condom use; decrease in perception of childbearing as sign of real womanhood; and increased intention to use FP in the future (see Table 4 for effect sizes and confidence intervals). There were also improvements in SRH attitudes and behaviors: increased contraceptive self-efficacy⁷ (effect size: 28%); partner support of FP use (effect size: 25%); and current FP use (effect size: 10%).

With the exception of current FP use among newly married or parenting females, males often expressed more improvement than their female counterparts in the older cohorts. Additionally, the observed upward trend in the uptake of contraceptives among the adolescents could be attributed to improved attitudes about FP and contraceptives. Other positive trends in attitudes and beliefs were noted, including fewer respondents with the view that girls who carry condoms are promiscuous and that an ideal married couple will produce a child the first year of marriage.

Although very young adolescents of both sexes had limited detailed knowledge of the menstrual cycle and the associated risk of pregnancy, the majority viewed the physical and social changes associated with puberty positively, agreeing that *It is normal for boys and girls to experience changes in their body at different rates* and *It is normal that boys and girls begin to have romantic feelings once their bodies*

³ FP seeking behavior defined as having sought FP services from health worker/VHT in past 6 months before survey

⁴ Top reasons for using condoms: HIV prevention, other/unknown, pregnancy prevention

⁵ Top reasons for not using contraceptives: no partner/opportunity, desire a pregnancy, and no knowledge of the methods

⁶ During the survey, respondents were asked about their (a) confidence to use contraceptives correctly all the time; (b) knowledge of the location of FP services; and (c) ability to easily reach the location of FP services.

⁷ During the survey, respondents were asked about their (a) confidence to use contraceptives correctly all the time; (b) knowledge of the location of FP services; and (c) ability to easily reach the location of FP services.

begin to develop. Limited significant changes between exposed and unexposed VYAs may be due to already-high values at baseline.

Table 4: Effect sizes and Confidence Intervals for Statistically Significant (p<0.05) SRH Indicators

Item (cohort)	Effect Size (%)	Confidence Interval
Communication with partner about FP use in last 3 months (NM/NP)	12	(0.1, 22.9)
FP seeking behavior (NM/NP)	16	(7.0, 25.1)
Current FP use (NM/NP)	10	(1.1, 19.6)
Intention to use FP in the future (NM/NP)	10	(2.3, 18.5)
Offense at wife requesting condom use (OA)	11	(-16.9, -5.7)
Decrease in perception of childbearing as sign of real womanhood (OA)	12	(-17.3, -5.9)
increased intention to use FP in the future (OA)	16	(9.5, 22.2)

Gender-based violence

Adults, NM/NP, and OA were surveyed about GBV issues including corporal punishment, intimate partner violence, and alcohol consumption. Statements related to this topic included: *there are times when a woman deserves to be beaten*; and *a woman should tolerate violence to keep her family together*. Though some indicators in this category improved, the majority of changes were not statistically significant.

However, significant (p<0.05) changes were observed in reduction of violent response to partner conflict among NM/NPs and inappropriate touching reported by male OAs. Overall, GBV-accepting attitudes, as measured by the GBV score, reduced significantly (p<0.05) among both NM/NPs and OAs and of particular note was the significant increase in OAs' self-efficacy to seek help for inappropriate touching. OAs and VYAs also expressed decreased (7% and 9% respectively) association between alcohol and a man's physical strength, endurance, and prowess.



Table 5: Effect sizes and Confidence Intervals for Statistically Significant (p<0.05) GBV Indicators

Item (cohort)	Effect Size (%)	Confidence Interval
violent response to partner conflict (NM/NP)	16	(-27.1, -4.4)
inappropriate touching reported by males (OA)	8	(-13.1, -2.3)
self-efficacy to seek help for inappropriate touching (OA)	9	(3.2, 13.8)

CONCLUSIONS & RECOMMENDATIONS

GREAT led to significant improvements in attitudes and behaviors among exposed individuals. Adolescents and adults who heard the radio program or participated in reflection activities reported positive changes in gender equality, partner communication, FP use and attitudes towards GBV. The greater change observed among males and NM/NPs across all outcomes points to the opportunities for norm change around key life transitions of marriage and parenting as well as considerations of power underlying male access to interventions and media sources.

However, participation of one group each of VYAs, older adolescents and newly married or parenting adolescents in each community was insufficient to diffuse change beyond those exposed to GREAT to the broader community. Possibly, as evidenced by low coverage for the non-radio components, too few adolescents were engaged in reflection activities in intervention areas to achieve community-wide effect. Additionally, in spite of the premise that engaging community leaders would catalyze and support changes promoted by GREAT, few respondents stated that they participated in community mobilization activities. However, this may have been under-reported because survey respondents did not recognize that activities were led by GREAT. Alternatively, because these activities were conducted at the parish rather than village level, their impact at community level may have been insufficient.

These findings on coverage, gender equality, SRH, and GBV have several implications for the scale-up of GREAT interventions and for the design and implementation of social norms interventions in general. First, the scale-up phase could benefit from a few adaptations to the intervention package such as: 1) adjust the radio drama air time to increase listenership among young women and VYA/OA; 2) expand the use of the toolkit to secondary schools to reach older adolescents; and 3) train 2 VHTs per village and link to partners that provide services. Additionally, a scale-up model that increases breadth and depth of intervention, facilitates institutionalization in district government, and promotes multi-sectorial linkages will help catalyze widespread sustainable movements to challenge inequitable norms and support positive health outcomes at the individual and community levels.

Results from GREAT's qualitative research and scale-up experience will add further to the global evidence base of approaches to reaching a "tipping point" of community change by documenting the pathways that ultimately contribute to changes in attitudes and behaviors.