

PREVENTION TRIAD CASE STUDY

LESSONS FROM THE ADAPTATION OF A FAITH-BASED PREVENTION PROGRAMME IN THE DEMOCRATIC REPUBLIC OF CONGO

FOCUS OF THIS BRIEF

What happened when a faith-based, gender-transformative violence prevention programme was adapted for a new setting in the same country?

Results from the evaluations of Transforming Masculinities and its adaptation, called Masculinité, Famille et Foi, illustrate how the programmes worked differently in their respective settings despite their similarities. Using the Prevention Triad, this brief examines what we know about the two programmes, their context, and their implementation to understand factors that may explain their different results.



INTRODUCTION

Faith and faith leaders are important influences in defining appropriate or desirable behaviours, including around gender relations and violence. Approaches that engage with faith leaders and religious doctrine thus hold promise to reduce sexual and gender-based violence (SGBV) and promote gender equality. The Transforming Masculinities¹ (TM) programme engaged with faith systems and religious leaders and included messaging and discussion of faith and violence prevention in its programme strategies. TM was implemented in Ituri Province, a rural area of the eastern Democratic Republic of Congo (DRC), between 2015 and 2018. The project was titled '*Engaging with Faith Groups to Prevent Violence against Women and Girls in Conflict-Affected Communities*'. In 2016, the TM approach was adapted for implementation in Kinshasa, DRC's capital, with an additional focus on family planning and named Masculinité, Famille et Foi (MFF)².

Both programmes adapted the approach to the local context and population, focused on social norms change for gender equality and violence prevention, and examined gender roles and power dynamics between men and women.

TM and MFF were evaluated using different study designs, tools, and outcome measures and are, therefore, not directly comparable. Overall, TM seems to have had an impact on intimate partner violence (IPV), while MFF did not. A study analysing TM's pre-post household surveys found a 57% decline in women's experience of past-year IPV and a 66% decline in men's perpetration of past-year IPV³. The

study also showed more equitable gender attitudes and fewer attitudes that stigmatise SGBV survivors at endline. For MFF, baseline and endline cross-sectional surveys in intervention and comparison congregations found no significant change in women's IPV experience. Apart from significant reductions in men reporting punching their partner and using physical violence to discourage family planning, men's IPV perpetration did not change. However, their approval of IPV did decrease. There were significant increases in the voluntary use of modern contraception, along with attitudes, norms, and self-efficacy for modern family planning, another key area of focus for MFF⁴.

While TM and MFF were implemented at the same time in the same country, their focus and the geographic, cultural, and social dynamics in each location differed. Using the Prevention Triad as a framework, this brief examines what we know about the two programmes, their context, and their implementation to understand why they may have had different results.

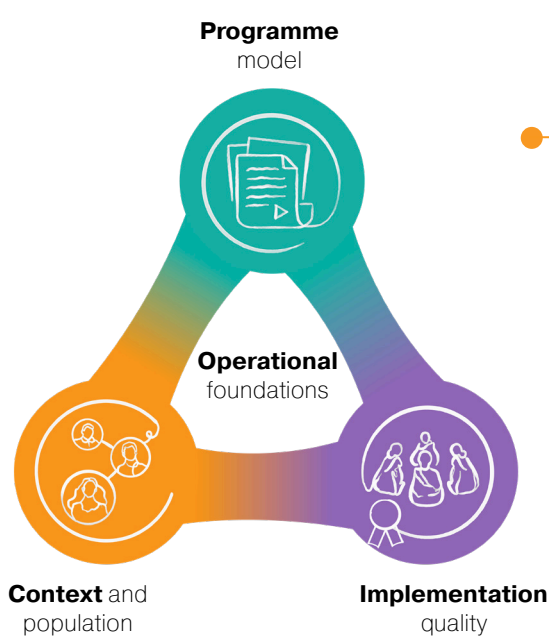


Figure 1. Prevention Triad

THE PREVENTION TRIAD

Developed by the Prevention Collaborative, the Triad is a simple tool to encourage a more holistic understanding of what it takes to make violence prevention programmes work. It highlights how multiple elements — programme model, implementation quality, context and population, as well as operational foundations — combine to determine the impact of a programme (see Figure 1)⁵.

Traditionally, adaptations and evaluations of violence against women and girls (VAWG) prevention programmes have focused on whether a particular programme model 'works' or not. The Prevention Triad case studies demonstrate the importance of considering all elements of the Prevention Triad when comparing programmes.

CONTEXT AND METHODS FOR THIS CASE STUDY

This case study explored how well the two programmes were adapted to their settings and examined factors that may have affected how or whether TM and MFF achieved change in their respective settings. It included:

- ▶ A review of programme manuals, training curricula, implementation guidelines, and evaluation reports to learn about programme adaptation, design, and implementation;
- ▶ Key informant interviews with programme designers and evaluators to add additional contextual and implementation information and allow for vetting of findings; and
- ▶ A matrix to document and compare data that were extracted for each programme.

THE TWO PROGRAMMES: OVERVIEW

COMMON ELEMENTS AND KEY DIFFERENCES ALONG THE PREVENTION TRIAD

TM and MFF both employed a model of transformation grounded in four common elements:

- ▶ Training faith leaders and ‘gender champions’¹⁶ (i.e., the programme change agents) leads to critical reflection and transformation for gender equity, violence prevention (and family planning, in the case of MFF);
- ▶ Faith leaders integrate training and reflection content into their ongoing activities and practices, including sermons, teachings, scripture study, and couple counselling;
- ▶ Gender champions facilitate community (for TM) and couple (for MFF) dialogues and activities for self-reflection and discussion, with session content linked to scripture; and
- ▶ Dialogue participants offer public testimonies of behaviour change to demonstrate new learning and behaviours to their congregation.

Gender champions, faith leaders, and community members acted as role models demonstrating gender-equitable behaviours. Additionally, spaces where testimonials, dialogues, and counselling took place, were designed to be respectful, which allowed community members to discuss and reflect on gender inequality within their value systems and lives. Public testimony helped reach the wider community to support norms and behaviour change.

Beyond these common elements, however, the two programmes differed in their **model, fit to context and population, and implementation**. In particular, three key differences emerged for MFF (Figure 2).



Figure 2. Key Differences in the Two Programmes Across the Prevention Triad

Table 1 summarises the differences between TM and MFF, which are discussed in the remainder of this section. Of note: This case study also looked at **implementation quality**, focusing on MFF because relevant TM data were not available for this analysis. Additionally, little information was available on either TM or MFF’s **operational foundations** by the time of this review. Thus, the comparisons between TM and MFF presented here generally relate to the programme model and fit to context and population.

Table 1. Differences Between Transforming Masculinities and Masculinité, Famille et Foi

TRANSFORMING MASCULINITIES		MASCULINITÉ, FAMILLE ET FOI
▶ Women and girls in conflict-affected communities in DRC are free from SGBV.	GOAL	▶ Improve sexual and reproductive health and well-being, including healthy timing and spacing of pregnancies and IPV prevention.
▶ Remote and rural conflict-affected villages in Ituri Province.	LOCATION	▶ Urban and peri-urban congregations in Kinshasa.
▶ Adults aged 18 to 75.	POPULATION GROUP	▶ Newly married couples or first-time parents; eligible women were aged 18 to 35.
▶ 15 villages in the Rethy area of Ituri Province, covering a population of about 216,000.	REACH	▶ Eight Protestant congregations in the intervention group, covering a population of about 4,500.
▶ Christian and Muslim faith leaders offered sermons, facilitated faith activities (prayer groups, counselling, etc.) and acted as role models.	FAITH LEADER ACTIVITIES	▶ Protestant faith leaders offered sermons, facilitated faith activities (prayer groups, counselling, etc.), and acted as role models.
▶ 75 faith leaders trained over five sessions of two to three days each using a faith-based curriculum that included scriptural reflection, faith reflections, and language adapted to tailor relevant concepts to the local context.	FAITH LEADER TRAINING & SUPPORT	▶ 42 faith leaders trained, including at the national, provincial, and congregational level, in a curriculum adapted from the TM faith-based curriculum.
▶ 15 men and 15 women trained over three sessions of five days each to engage men and women in community dialogues.	GENDER CHAMPIONS	▶ 20 men and 20 women trained as gender champions.
▶ With weekly meetings over a six-week period, gender champions facilitated discussions and activities on various aspects of SGBV. Participants could join community dialogue rounds more than once.	COMMUNITY DIALOGUES	▶ The programme held seven cycles of couples' dialogues with 458 couples in eight congregations, with each cycle involving nine weekly meetings. Gender champions facilitated discussion and activities on the original six SGBV sessions and three new sessions focused on family planning, parenting, and health care. Participants joined one round of dialogue.
▶ Community action groups: Engaged 225 community members; following training, community leaders held public discussions on SGBV and helped survivors access services. ▶ A 'Healing of Memories' workshop with 24 survivors and nine community members was held at baseline, which supported survivors in processing and healing from SGBV experiences through sharing life stories and building mutual understanding. ▶ Faith leaders trained in psychosocial support, counselling, and mediation for survivors of SGBV. ▶ Additional funding sourced to provide medical services to SGBV survivors within their communities.	COMMUNITY LEVEL EFFORTS	▶ Training of health care providers to provide quality SRHR services to young people. ▶ Referrals for free consultations with trained healthcare providers. ▶ Hotline for information on IPV and family planning services. ▶ Community mobilisation events held at local churches by faith leaders and gender champions to engage the community. ▶ 384 supportive sermons given by faith leaders. ▶ 315 stories of change shared with congregation members by couples. ▶ 24 community mobilisation events held.
▶ 12 months of preparation, including research and training; 24 months of activities.	DURATION	▶ Three months of training faith leaders and gender champions; 18 months of community dialogue activities.

1 PROGRAMME MODEL DIFFERENCES

The core approach underpinning TM and MFF was the same as outlined in the four elements. However, three differences in the programme model may have contributed to the variation in programme effectiveness observed: **programme duration, intensity, and new components; populations of interest and programme participation; and the SGBV services and support provided.**

Programme Duration, Intensity, and New Components

TM activities were implemented over 24 months⁷, focusing on gender equality and covering multiple forms of SGBV, such as IPV and non-partner sexual assault. By contrast, MFF was implemented over 18 months, a shorter duration, despite the addition of family planning as a focus of the programme. While MFF's couples' dialogues used the same manuals as TM's community dialogues, MFF placed less emphasis on supporting survivors, and because the programme worked with young couples, its SGBV content focused primarily on IPV. Additionally, MFF added three sessions to the couples' dialogues, including family planning and reproductive health, as well as institutional connections to clinics and hotlines. This meant at the congregation level, faith leaders and gender champions had to address more norms and behaviours within a shorter period of time in a setting with more complex social networks (see 'Differences in Fit to Context and Population').

Populations of Interest and Programme Participation

The TM programme took place in remote villages where people had closely-knit social relationships. Therefore, it focused on reaching whole villages, specifically those aged 18 to 75, through participation in community dialogues. For each round of dialogue, participants were requested, but not required, to attend all six sessions; they also did not need to participate as a couple. Individuals who were interested in participating in dialogue sessions again at a later date were welcome. In this setting, faith and community leaders were considered influential groups that could encourage violence prevention and support messages in community dialogue.

In Kinshasa, MFF worked through couples' dialogues rather than community dialogues. Rather than focusing on all adults in a geographic area, MFF sought to shift the norms and behaviours of newly married couples and first-time parents within a congregation. This approach aligned with project funding and theories that people are more amenable to changing their behaviours at this life stage (i.e., newly married couples, first-time parents). MFF adapted the programme approach to the couples' specific needs, relationship dynamics, social networks, and reference groups. MFF engaged older adults and peers in the congregation in diffusion activities, such as attending sermons and witnessing testimony.

SGBV Services and Support Provided

While TM and MFF both followed the core programme approach (i.e., the four elements), each had its own community- and institutional-level supporting activities, either offering referrals or response services for SGBV survivors as a part of holistic SGBV programming (TM) or referring participants to clinic-based services for family planning and reproductive health care (MFF).

As part of this, TM used '*community action groups*' involving local leaders and respected individuals

due to the remoteness of the villages, where support services were limited and difficult to access. These groups led a public discussion to prevent stigma against SGBV survivors, and they offered another space for personal reflection and conversations outside of the church or mosque and the dialogue sessions. It is possible that TM support services for survivors of SGBV became a diffusion activity that shifted social norms and behaviours, an unintended beneficial effect. By having respected local leaders steer these efforts, including facilitating survivor connection to health services, they may have been modelling new behaviours to support survivors and reinforcing messages that survivors deserve support, not blame. Yet, as monitoring and research did not examine this activity, whether this hypothesis is true is unclear.

MFF did not include these activities, as they were not perceived to be core elements to its theory of change and survivor services were more available in Kinshasa. Instead, MFF sought to address couples' family planning and GBV-related health care needs by strengthening an existing hotline as a source of information, training health care providers, and offering quality health services and referrals for reproductive health and family planning. These activities are built on best practices for programming on sexual and reproductive health and rights (SRHR). For both MFF and TM, the use of SGBV and SRHR services and support was not closely monitored in terms of whether and how they affected SGBV and SRHR behaviours.

2 FIT TO CONTEXT AND POPULATION DIFFERENCES

Key differences in the fit to context and population may have been important to the differential impacts on IPV observed between the two programmes.

Geographic Location, Social Networks, and Social Influence

TM was implemented in rural, remote villages in eastern DRC, and programme coverage extended to the whole village. Residents were tightly networked within each of the 15 villages, meaning the social bonds and relationships in the village strongly influenced the residents' attitudes, norms, and behaviours. By contrast, MFF was implemented in the country's densely populated capital. Given Kinshasa's size, MFF focused on eight Protestant congregations located in urban and peri-urban parts of the city. These were selected in partnership with Église de Christ au Congo, which offered leadership, institutional, and congregation-level support for MFF. At the time of adaptation, formative research indicated that congregations were closely networked, with members regularly attending the same church service. The values of their faith were important to the behaviour of members, including newly married couples and first-time parents.

While faith had an important role in people's lives in both locations, its influence was more complex in urban Kinshasa. In rural villages where TM was implemented, adults identified faith leaders as the only referent group whose approval would affect their use or agreement with SGBV and their support for survivors of SGBV. In Kinshasa, the congregation was a place for people of shared religion to meet and discuss their lives. However, unlike rural areas, its members might not have interacted frequently outside of their weekly church attendance and might have considered other relationships as (also) influential. For example, in Kinshasa, women considered first their spouses/partners, then mothers,

then mothers-in-law, and only then their faith leader as influencing their couple's relationship. Men first listed their faith leaders, then parents, and then parents-in-law as influential, followed by spouses/partners and friends. In addition, some travelled long distances to attend a service and, therefore, had different social networks nearer to their homes than their church.

Differences in Norms around Violence

While both TM and MFF focused on shifting social norms to prevent GBV, the evaluations showed that the scope for change in attitudes and norms differed greatly in the two project sites. Some 51% of men and 42% of women in TM agreed there were times a woman deserved to be beaten compared to fewer than 20% of men and women in MFF. Fewer men (5%) and women (4%) in MFF reported acceptance of violence for any reason than in TM (between 14% and 65%). Norms in Kinshasa largely showed that men and women did not think it was typical or appropriate for men to use physical or sexual IPV (>94%). However, gender attitudes, masculinity norms, and rape myth norms in rural eastern DRC allowed for greater acceptance of SGBV. Interestingly, reported use and experience of IPV was consistent, about two-thirds of participants in both sites. It may be that different or additional strategies are needed to prevent violence in contexts where greater proportions of the population already disfavour violence.

Complexity of Norms as a Driver of GBV

As with social networks and reference groups, norms were a more complex driver of behaviour in Kinshasa. For example, 60% of men and 45% of women agreed that Scripture gives men the right to physically abuse their wives. However, almost all reported that their faith leader (96%) and congregation (95%) thought IPV was inappropriate. This reveals the complexity of how faith-based norms relate to IPV, relationships, and gender equality. Similar data were not available for TM, so it is unclear if there was a similar complexity among norms, attitudes, and behaviours.

People can hold and express conflicting ideas on concepts like violence, especially when norms are changing, and their behaviour may (not) align with these ideas. As norms change, behaviours may shift to accommodate the norm (e.g., the behaviour is hidden or violence that is perceived as less harmful becomes more common) without fundamentally preventing the behaviour and its harm. Given the complex relationships among norms, reference groups, attitudes, and behaviours in Kinshasa, it is possible that strategies need more layering, with repeat exposure to activities, population groups, and messaging, for success in GBV prevention.

3 IMPLEMENTATION QUALITY DIFFERENCES

This brief's implementation quality analysis focused on MFF because TM monitoring data, reports, and supervisory assessments for quality and fidelity were not available for this analysis.

Change Agent Transformation and Extent of GBV Messaging

The MFF adaptation maintained TM's focus on GBV — and in particular, IPV — and added an outcome on family planning. To achieve this, MFF added three dialogue sessions to the couples' dialogues and the associated training programme without changing the original GBV content. Yet, MFF trained faith leaders and gender champions for the same amount of time as TM did, meaning MFF participants

had to learn and transform more behaviours without more time allocated. A review of monitoring data revealed that faith leaders in MFF offered public sermons and messaging on family planning (55% of total public messages) and gender roles and healthy relationships (37%) more frequently than GBV (8%). Community mobilisation activities inadvertently focused on family planning and healthy relationships over GBV.

Faith Leader Fidelity to Intended Messaging

A midline ethnography in MFF revealed that faith leaders offered sermons related to the project, but their messages did not consistently advance gender equality. Some faith leaders were observed to emphasise the distinct but complementary roles of men and women in their relationships, with less emphasis on equality and power sharing, while others did speak of equality between husbands and wives. Some faith leaders reinforced messaging about maintaining harmony as a couple, at times implying that women were responsible for keeping their husbands happy or blaming external evil forces for episodes of violence in a relationship. These explanations could have reinforced or created beliefs that IPV was normal, unpreventable, or largely the woman's fault. Inequitable messaging emerged around family planning as well.

In response, MFF staff offered additional training and support to faith leaders after the midline to address this. However, learning reports did not discuss whether these strategies effectively changed faith leaders' messaging. As a result, couples may have been left to reconcile the conflicting faith leaders' messages in sermons and church activities with their discussions in the couples' dialogue sessions and input from their social network.

TM monitoring data, including fidelity and quality supervision, were unavailable during this analysis. Therefore, it is unclear if the programme implemented dialogues with fidelity to the participatory approach of facilitating self and group reflection and dialogue versus teaching ideas to participants. It is also uncertain how many people participated in the community dialogues more than once. Still, supervision in TM was known to be challenging given the villages' remote location, the few supervisors relative to the number of villages covered, and staff turnover. Supervisors had to travel long distances to the villages to observe activities and support gender champions and faith leaders. This meant that they could not provide support and guidance in the programme's day-to-day activities or observe whether the dialogues and sermons incorporated refresher training or supervisory feedback, especially when faith leaders were observed offering messages and guidance that were not as gender-transformative as the ones that leaders offered in MFF.

Curriculum Materials and Language

For TM, the community dialogue curriculum materials and the training materials were translated into French, with some contextual adaptations for communities in the Rethy area of Ituri. Yet, the material was not translated into local languages due to resource limitations. Training with supervisors, faith leaders, and gender champions was held in French or Swahili with translation into local languages that are used more widely in the communities. This posed a few operational challenges, as not everyone was fluent in spoken or written French and available reference materials were not accessible during implementation or between refresher training. In addition, gaps in understanding might have gone undetected as the material was translated across languages. Whether and how this affected the fidelity

or quality of implementation is unknown. On the other hand, MFF developed materials in French, which is widely spoken and read in Kinshasa. Therefore, materials were accessible between refresher training and during implementation.

OPERATIONAL FOUNDATIONS

Unfortunately, by the time this review was conducted, there was little information available from either programme on operational foundations. While these central elements of the Triad are important for programme effectiveness, we do not have sufficient documented information for comparison between TM and MFF.

CONCLUSION

This case study reveals the complexity of implementing and adapting violence prevention programmes in different communities and contexts. While the two programmes we compared had common elements, they also had important differences in the programme model and fit to context.

The analysis points to several key considerations for future adaptation and implementation of violence prevention programmes. First, from an implementation perspective, **our analysis reaffirms that the selection and transformation of change agents and faith leaders needs to be a careful and intentional process.** These individuals may hold commonly accepted inequitable ideas on gender, gender equity, and violence. Transforming these deeply held beliefs takes time. Regular supportive supervision, monitoring, and refresher learning activities can ensure fidelity to the programme principles and key messages. These elements are essential to the theorised mechanisms of change.

Second, **responsiveness to new learning, whether formative research, participatory consultation, learning sessions, or research data, should guide the continued adaptation of programmes during implementation.** Pilot testing of programmes in their setting prior to full evaluation continues to hold value to ensure that the theorised mechanisms of change resonate in the implementation.

Developing this case study several years post-implementation meant we were able to unpack two areas of the Prevention Triad. This helped us understand how the programme worked in different settings, with different outcomes and adapted approaches. Implementation quality and the underlying operational foundations, key aspects for understanding programme adaptation and effectiveness, were under-examined in this analysis due to a lack of available documentation. As programmes are adapted to new settings, the Prevention Triad offers a helpful framework to guide documentation and learning throughout adaptation and implementation. This framework also provides more clarity on how the programme has operated in a new setting when looking at programme effectiveness.

Acknowledgements: This case study was written by Anjalee Kohli, with input from Ruti Levto, Lori Heise, Lyndsay McLean, Francesca Quirke, and Uwezo Baghuma Lele. It was edited by Oluwatobiloba Ayodele and Jill Merriman, reviewed by Tania Ghosh and designed by Ana Lucia Nustes.

REFERENCES

1. The Transforming Masculinities approach was developed by Tearfund and first implemented in Ituri Province as a partnership by the South African Medical Research Council (SAMRC), Tearfund UK, and HEAL Africa, with funding from UK AID's What Works to Prevent Violence against Women and Girls Programme, in a project called 'Engaging with Faith Groups to Prevent Violence against Women and Girls in Conflict-Affected Communities'. We refer to the implementation in Ituri as 'Transforming Masculinities' (TM) as a shorthand.
2. Masculinité, Famille et Foi was adapted by Tearfund and implemented in Kinshasa as a partnership between Tearfund and Georgetown University's Institute for Reproductive Health, with funding from the United States Agency for International Development (USAID) through the global Passages Project.
3. Le Roux, Elisabet, Julianne Corboz, Nigel Scott, Maggie Sandilands, Uwezo Baghuma Lele, Elena Bezzolato, and Rachel Jewkes. "Engaging with Faith Groups to Prevent VAWG in Conflict-Affected Communities: Results from Two Community Surveys in the DRC." BMC International Health and Human Rights 20, no. 27 (2020). doi.org/10.1186/s12914-020-00246-8.
4. "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).
5. For more information on the Prevention Triad, please refer to the [Prevention Triad explainer brief](#).
6. Gender champions were selected by faith leaders according to shared criteria from the programme — an equal number of men and women, not known as perpetrators of violence, respected in the community, and having some aptitude for teaching/facilitating.
7. The first year of the three-year project focused on research and training, followed by two years of activities in the communities.

