PASSAGES PROJECT

Masculinite, Famille, et Foi

End of Project Report

MARCH
2021

PREPARED BY THE INSTITUTE
FOR REPRODUCTIVE HEALTH
AND TEARFUND

USAID
FROM THE AMERICAN PEOPLE

Passages

Recommended Citation:
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).

This report was prepared by IRH and Tearfund under the Passages Project. This report, its attachments, and the Passages Project are made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the under Cooperative Agreement No. AID-OAA-A-15-00042. The contents are the responsibility of IRH, Tearfund and FHI 360 and do not necessarily reflect the views of Georgetown University, USAID, or the United States Government.

Passages Project
info@passagesproject.org
www.irh.org/projects/Passages
Twitter: @Passages_Prject #PassagesProject

TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF TABLES

TABLE OF BOXES

LIST OF ACRONYMS AND KEY PHRASES

PARTNERS

IRH	Institute for Reproductive Health, Georgetown University
USAID	United States Agency for International Development

TERMS

ASF	Association de Santé Familiale
AYSRH	Adolescent and Youth Sexual and Reproductive Health
CBO(s)	Community-based Organizations(s)
CHW(s)	Community Health Worker(s)
DRC	Democratic Republic of Congo
ECC	Eglise de Christ au Congo
FBO(s)	Faith-based Organizations
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-based Violence
INGOs	International Non-governmental Organizations
IPV	Intimate Partner Violence
IRB	Institutional Review Board
KAP	Knowledge, Attitude and Practices
M&E	Monitoring and Evaluation
MFF	Masculinité, Famille, et Foi
MOH	Ministry of Health
NGOs	Non-governmental Organizations
PMP	Project Monitoring Plan
PSI	Population Services International
TM	Transforming Masculinities
WHO	World Health Organizatio

ACKNOWLEDGMENTS

This report was written by Courtney McLarnon (IRH) and Francesca Quirke (Tearfund), with input from Prabu Deepan (Tearfund) and Bryan Shaw (IRH) on behalf of the Masculinite, Famille et Foi (MFF) project within the global Passages Project. Reviews and contributions were provided by Anjalee Kohli (IRH), Rebecka Lundgren (University of California San Diego), Jamie Greenberg (IRH), Luke Martin (Tearfund), and Betsy Costenbader (FHI 360). The team is indebted to Catherine Tier (IRH) for her editorial support to this report.

In addition to the above core team, the authors would like to recognize the outstanding contributions of the many people who participated in bringing the project to fruition. Including, USAID/Washington, particularly Linda Sussman, Caitlin Thistle, Joan Kraft, Anita Dam, Kristen Rancourt, Afeefa Abdur-Rahman, and Michal Avni (now with Iris Group) and USAID/DRC in particular Thibaut Mukaba, for their support and guidance to this adapted program. Members from the Passages Project consortium – especially Betsy Costenbader, Donna McCarraher, Andres Martinez, Seth Zissette, Lara Lorenzetti, Rick Homan, and Kate LeMasters of FHI 360; Ashley Jackson, Dr. Selego Chalet, Rachel Braden, and Heather Chotvacs of Population Services International; Nana Dagadu, Oumou Cisse, Jarai Sabally, Manika Garg, Tim Shand, Kimberly Ashburn, Christina Williams, Sammie Hill, Sophie Savage, Christina Juan, and Mariam Diakite of IRH – who invested their time, passion, and expertise for over five years.

We would like to especially thank Dr. Djesse Wa Matchabo and Laetitia Okana for providing in-country leadership and support to the MFF program at start up and throughout implementation; and Dr. Charles Kalambayi for supporting final close out on behalf of IRH. We also recognize that the research conducted for this program could not have been possible without the data collection efforts from Health Focus for our baseline and endline studies, as well as a group of ethnographers led by Gauthier Musenge for the midline ethnographic study.

A special thanks and appreciation are given to Ospy Nzigire and Felix Mutingamo who, on behalf of Eglise de Christ au Congo, led the implementation in Kinshasa and are our resident experts on this program. They were supported in their efforts by Albert Ikasso, and Julie Ikasso, and by their department director, Professor Kwim. Our thanks also to Reverend Milenge, vice-president of Eglise de Christ au Congo for his oversight and championing of the project. We also recognize the commitment and support of the Tearfund DRC team with special thanks to Jackson Kambere, Sylvie Kokere, Neville Mudekereza, Yvonne Kavuo, Audry Shematsi and Helen Hollands for their project management, as well as Sabine McAllister, Edoaurd Saidi and Celestin Bizimana for their wider support. Grateful recognition also to Richard Malengule and DRC Directors David McAllister and Hebdavi Muhindo for their leadership, and technical expertise provided by Uwezo Lele Baghuma, Desmond Lesejane and Hendrew Lusey

We also would like to acknowledge the direction and expertise provided by our health service partner Association de Sante Familiale, namely, Chalet Selego, Nides Boketshu, Albert Chikuru, Alice Mushagalusa, Mireille Ntotila, and all the staff at the *Confiance* Clinics and who operated the *Ligne Verte* hotline. We additionally recognize the efforts of the MFF Technical Advisory Group who gave their time and expertise to ensure the success of the project implementation.

Most importantly, we thank the Faith Leaders, Gender Champions, young couples and community members of who participated in activities across communes in Kinshasa in Ngaliema II, Lingwala, Kintambo, Bumbu, Ngaliema I, Kasavubu, Kalamu, Matete, Mont-Ngafula, Lemba, Masina, Ndjili, Makala, Kimbaseke, and Bandalungwa. We're grateful for them sharing their time and experiences with the program and research teams, in hopes of improving the future of their communities.

EXECUTIVE SUMMARY

Masculinite, Famille et Foi, is the first adaptation of the Tearfund-developed 'Transforming Masculinities' approach, an evidence-based intervention for religious leaders and faith communities to promote positive masculinities and gender equality within a faith context to reduce sexual and gender-based violence. The Masculinite, Famille et Foi adaptation was developed to **transform harmful gender norms and reduce social acceptance of gender-based violence and other gender inequalities, which support early childbearing and high fertility rates, and prevent young couples from accessing and using modern family planning** in Kinshasa, Democratic Republic of Congo.

Masculinite, Famille et Foi was guided by a theory of change informed by normative and behavior change theories, to assess how new ideas and behaviors diffused through congregations would lead to: 1) a supportive normative environment for family planning use, the reduction of intimate partner violence, and greater gender equality, 2) improved self-efficacy, knowledge, and skills to negotiate and use family planning, and motivation to comply with new norms, and 3) improved attitudes regarding family planning use and gender equality, and rejection of intimate partner violence.

Adapted and implemented from 2015 through 2019, Masculinite, Famille et Foi was designed with scale up in mind. Together, a consortium of partners within the global Passages Project (Institute of Reproductive Health (IRH) of Georgetown University, Tearfund, Eglise de Christ au Congo, and Association de Santé Familiale) collaborated through formative research and design, baseline evaluation, implementation, monitoring and learning, and an endline evaluation.

It's design, a light and costed package of scalable activities, included:

1) **Transforming Faith Leaders** through partnership and transformative trainings to support Gender Champions and young couples to shift norms in support of family planning use, reducing intimate partner violence and improving gender equality.
2) **Building Capacity of Gender Champions** through transformative trainings to work together with Faith Leaders to support young couples to conduct Community Dialogues, support organized diffusion, and act as overall change agents in support of family planning use, reducing intimate partner violence, and improving gender equality.
3) Conducting **Community Dialogues**, facilitated by Gender Champions, for young couples (newly married or first-time parents) in a series of structured, small group discussions grounded in scripture, to reflect and take action together on issues surrounding intimate partner violence, family planning, and gender equality.
4) Supporting **Organized Diffusion** throughout congregations through story sharing, supportive sermons, couple testimonies, community mobilizing events, and more, to help facilitate the spread of new ideas and behaviors to the larger community.
5) Linking to an **Enabling Service Environment,** which was reinforced through strengthening the youth-friendly service provision protocols and in providing referrals and a hotline to the young couples for free services and information.

Through its implementation phase, over the course of 18 months, the Masculinite, Famille et Foi intervention reached 42 Faith Leaders at national, provincial, and parish levels, 40 male and female Gender Champions, and conducted 7 cycles of Community Dialogues with 458 young couples (916 individual men and women). To support diffusion of new ideas and behaviors, 384 supportive sermons were given by Faith Leaders, and 315 stories of change were shared by couples throughout their congregations, while 24 community-wide mobilizing events reached more individuals throughout the congregations. To help young couples achieve their family planning goals, 17 clinics were linked to congregations, trained in youth-friendly health provision, and referrals provided to young couples. Over 5,000 young couple members sought services during the intervention timeframe.

Masculinité, Famille et Foi included several learning opportunities. Using the Social Norms Exploration Tool, the team determined which social norms were relevant to program outcomes in order to inform program design and evaluation. The results identified the norms driving the behaviors the program sought to shift, such as acceptability of family planning use, and the reference groups (influential people) to include in intervention activities, such as faith leaders, parents, and close friends. Masculinité, Famille et Foi also conducted qualitative baseline research and midline ethnographic research. Findings generated in both research efforts helped provide deep insights into the cultural and normative context, particularly the role gender norms play. While complex, they also pointed to areas where intervention was possible, for example, in how Faith Leaders influenced the behaviors of young couples, which topics may resonate within the community better, how decisions regarding family planning are made and who influences them, and under what conditions violence in relationships is condoned or condemned.

Ongoing adaptive monitoring and learning was conducted through routine monitoring, rapid qualitative learning studies, hosting learning meetings, convening the technical advisory group, and in-depth site visits and assessments. These efforts and learnings are showcased in a program brief on adaptive management. The monitoring and learning studies and resulting 'findings' allowed the team to synthesize data and adjust the monitoring system for scale up surrounding overall acceptability of the intervention, and how feasible it was to implement. Learnings generated around the transformative trainings, mentoring, and support to couples were particularly helpful to inform adjustments for scale up. In addition to informing learnings for scale up among the team, and with new implementers, they provided opportunities for stakeholders to share insights with the program team and opened discussions for their pathway to scale.

To evaluate the intervention, quantitative couple and community surveys were conducted at baseline in 2017, and again at endline in 2019 after 18 months of intervention. The surveys explored changes in social norms, followed by changes in attitudes, and ultimately by changes in behavior, as per the program's theory of change. The results suggest that the intervention was effective at shifting many of the social norms, attitudes, and behaviors for family planning in intervention congregations—most notably for first-time parents. First-time parents in intervention congregations were more likely to: 1) hold supportive attitudes; 2) discuss family planning with their partner; 3) be confident that they could obtain and use family planning; 4) perceive that their reference group members approve of family planning use among first-time parents; and, ultimately, 5) were more likely to currently use and to intend to use modern contraception in the future, compared to first-time parents in comparison congregations. The quantitative endline presents a more mixed picture, though, in relation to norms, attitudes, and behaviors surrounding gender equality and intimate partner violence. We hypothesized at outset that changes in norms would support changes in behavior; with the hoped-for outcome a tipping point, or a sufficient mass of people adopting new attitudes and behaviors to create momentum in shifts of social norms. The reality was more complex. First, large majorities in both intervention and comparison congregations reported personal disapproval of intimate partner violence and perceived that others in their community would not support intimate partner violence, making it difficult to detect differences. Further, it is also possible that social desirability or improved awareness of intimate partner violence could have biased those results. A qualitative endline study is planned to take place in Kinshasa in Spring 2021 to further elucidate these findings.

With USAID support, Masculinité, Famille et Foi is being scaled up in the Democratic Republic of Congo and Rwanda, and the lessons from this adaptation are being shared to inform other Transforming Masculinities adaptations. Opportunities to share the experience, evidence and lessons learned from Masculinité, Famille et Foi in Kinshasa continue to be explored.

This report serves as a comprehensive summary of the culmination of efforts from the consortium of partners engaged in Masculinité, Famille et Foi for over five years. Those interested in learning more

about norms-shifting interventions, social and behavior change, gender transformative programming, or working with faith communities may be interested in Passages Project resources on these topics. Resources referenced are hyperlinked at the end of the report, and are available on: https://irh.org/projects/passages/

Section 1
Background and Significance

Faith communities as catalysts for social change

Social norms, "unwritten rules governing behavior shared by members of a given group or society," matter because of the powerful influence they have in our lives. There is increasing evidence of connections between religion and social norms in Central Africa (Tearfund UK, 2004), indicating a role for religious institutions in shaping reproductive health (RH) normative environments. Literature on faith-based responses to HIV/AIDS has mainly focused on issues of sexual behaviors, where religion has been identified as an institution acting in support of prevention or behavior change, or one whose messages can result in risky behaviors related to health outcomes (Haakenstad et al., 2015). Promoting behavior change within faith communities often begins by identifying religious leaders who have the capacity and legitimacy to motivate and mobilize communities. Thus, where faith leaders are adequately engaged and equipped, they can be vital catalysts within communities for addressing social norms to improve health outcomes (Tearfund UK, 2004). In Sub-Saharan Africa, **faith-based organizations (FBOs)** stand out due to their societal role and influence. These organizations put religious leaders in key positions that can influence critical choices around sexual practices (Lipsky, 2011). For this reason, it is important to understand the potential roles that FBOs can play in improving health outcomes.

A number of studies have noted the distinctive characteristics of FBOs that make them viable partners for development interventions in Africa, including (Levin, 2014):

- *Reach and Access:* FBOs have unique reach; play an integral part of life and society in most parts of Africa; have a large audience of people/followers; and are among the first responders to community needs.
- *Networks*: FBOs have well-developed networks, ranging from international to grassroots communities.
- *Motivation and Sustainability:* Faith-based motivation means that workers (both paid and volunteers) persevere, despite few resources and difficult circumstances; scriptural teaching on service and compassion contribute to care and support; and FBOs are seen to be reliable and trustworthy.

The role of FBOs within health programming is well documented; however, there is limited research on the role of religion in promoting issues of gender equality (Lusey, 2016). Conservative voices continue to use arguments, often couched in cultural, economic, or religious terms, to justify discrimination against women and gender minorities, while upholding the traditional foundations of male privilege (Gupta et al., 2019). However, there is also evidence that religion can be an important influence in the development of masculinities in relation to rates of violence and acceptability of violence (Lusey, 2016). Faith leaders should be supported by FBOs to convey these health-affirming messages, rather than those perpetuating harmful gender or cultural norms (Duff & Buckingham, 2015). Additionally, FBOs can improve their delivery of accurate health messaging through access to evidence-based, behavior-change communication materials, which should be developed consultatively and made easily adaptable (Duff & Buckingham, 2015).

The link between social norms, family planning and gender-based violence

Social norms, those unwritten rules, "tell us which behaviors are appropriate or typical within a given group" (IRH, 2019). Gender norms are generally conceptualized as a

subset of social norms that underpin gendered roles in society and can create or sustain gender inequalities. There is growing evidence of early socialization and its connection to inequitable gender roles, as harmful gender norms can encourage risky behaviors among young men and women who are impressionable, and has links to increased risks of **gender-based violence (GBV)** (Pulerwitz et al., 2006). One form of GBV in particular, **intimate partner violence (IPV),** has been shown to adversely affect women's ability to access FP (Hindin et al., 2014). Thus, addressing gender norms is increasingly recognized as a key strategy to promote not only more equitable gender roles, but also reduced violence and better RH outcomes, particularly among young people (Schuler et al., 2011; Adams et al., 2013). Increasingly, the FP community recognizes that men as well as women have gender-related vulnerabilities, and that programs must address underlying social norms in order to achieve widespread, lasting change for whole communities (WHO, 2007). Moreover, recent research suggests that gender norm change works as a "gateway factor" for improving a broad range of outcomes (WHO, 2007).

In 2007, the World Health Organization (WHO) published a systematic review, defining **gender transformative programs** as programs that "seek to transform gender roles and promote more gender-equitable relationships [as they] critically reflect about, question, or change institutional practices and broader social norms that create and reinforce gender inequality and vulnerability" (WHO, 2007). Because these programs oftentimes address deeply entrenched norms, they are inherently complex, often requiring robust, context-specific, multi-level interventions that may take time to implement, and do not unfold in a linear manner (Hillenbrand et al., 2015).

Further evidence suggests that male involvement in programs can improve spousal communication, gender-equitable attitudes, and FP use (Hardee et al., 2016). Research also shows that programs working with boys and men can impact the social norms that underlie behaviors related to RH, such as IPV (WHO, 2007). International initiatives to achieve RH outcomes, like reducing unintended pregnancy, stopping the spread of HIV/AIDS, and improving maternal health, are increasingly recognizing that these outcomes are affected by gender (WHO, 2007).

One systematic review highlighted the success of interventions that target the societal and structural elements of restrictive gender norms, when compared to efforts focused on individual, or even interpersonal power (Barker et al., 2010). This underscores how health outcomes may be difficult to change without a more holistic, systems approach (Barker et al., 2010). When supporting uptake of voluntary FP and RH services, it is crucial for programs to build an enabling environment, with the aim of transforming prevailing social and gender norms that may inhibit them. Furthermore, when implementing this kind of gender transformative intervention, it is necessary to collaborate with the power holders, reference groups, and social networks that influence behaviors and maintain norms within that specific community.

Good **RH, and FP** in particular, allow individuals and couples the information and means to decide freely and intentionally the number, spacing, and timing of their children (WHO, 2020). Poor RH, often resulting from lack of access and poor uptake of FP, accounts for an estimated one third of the global burden of illness, and is a leading cause of early death among women of reproductive age (UNFPA, 2011). Although there has been a global increase of FP and contraception use, unmet need still remains high (Kaneda & Greenbaum, 2019). In 2014, more than four in ten women of reproductive age (15–49) in Sub-Saharan Africa wanted to avoid a pregnancy (UNFPA, 2014). However, more than half of these women— 55 million—were not using an effective contraceptive method (UNFPA, 2014). These women account for a disproportionate 93% of unintended pregnancies (UNFPA, 2014).

Women and couples may face a wide range of barriers to regulating their own fertility, including limitation of choice regarding method, financial cost, lack of knowledge, misinformation, health concerns, provider biases, and constraints on women's decision-making abilities (Sedgh et al., 2016). All of these barriers can lead women and couples to a lack of control over their own RH (Williamson

et al., 2009). These constraints can also be perpetuated by male partners if they determine the terms of sex, and may or may not be willing to use condoms (Lusey, 2016). Furthermore, men may play crucial 'gatekeeper' roles for FP access in their capacity as parliamentarians, government officials, religious leaders, traditional and community leaders, and family members, within which they often perpetuate and reinforce patterns of gender discrimination (Voices 4 Change, 2014).

IPV has been shown to have a significant impact on women's RH and autonomy. A systematic review of IPV prevalence found that 30% of women globally have experienced physical and/or sexual violence at the hands of an intimate partner (WHO et al., 2013). Moreover, it is women of reproductive age, and frequently those who are young or poor, who are most likely to experience IPV (Hasstedt & Rowan, 2016). FP programs should consider women's experiences of IPV, reproductive control, and the underlying norms that constrain women's agency (Maxwell et al., 2015). For example, programs that appeal to men's involvement in FP because of their role as decision-makers may reinforce harmful norms. Therefore, it is important to engage men in FP through transformative approaches, which can eventually lead to better couple communication, joint decision-making, and reduce unmet need for FP (IRH, 2014).

Transforming Masculinities: the founding rationale

In the Democratic Republic of Congo (DRC), the majority of the population identify as belonging to a religion, and religious leaders remain influential leaders of opinion within communities (ECC, 2021). FBOs are also active in responding to material need, providing between 50%-70% of health care in the DRC (MPSMRM/Congo et al., 2014). In the face of political and economic crisis and instability, FBOs have continued to play a long-term and recognized role in healthcare at a national level in the DRC.

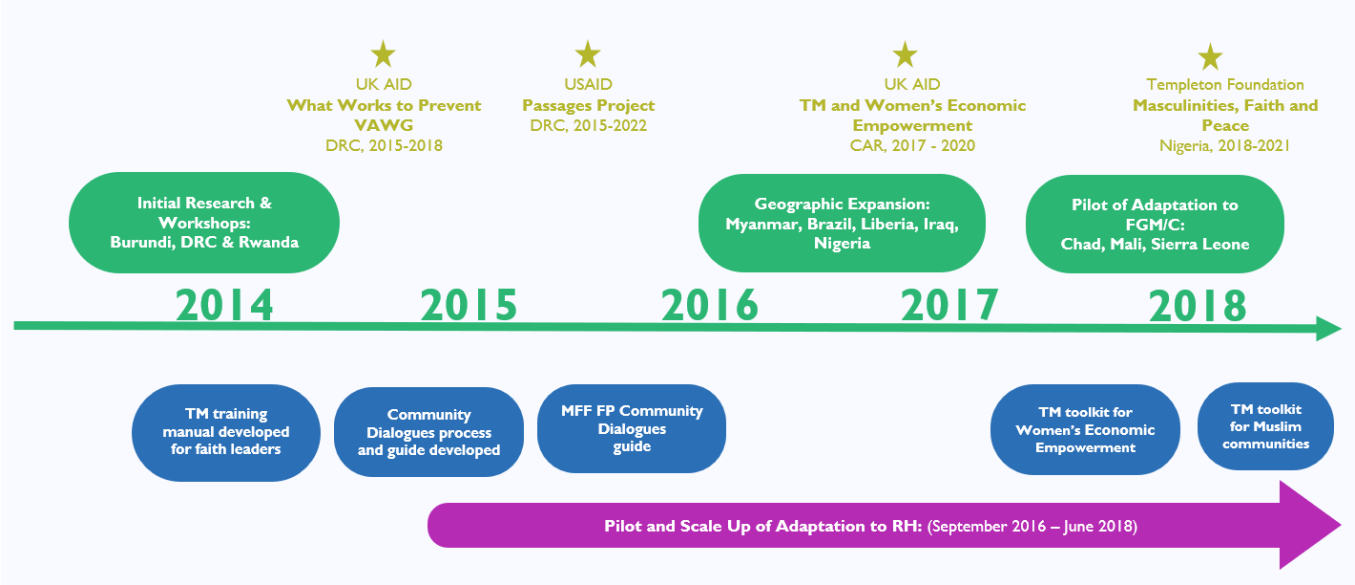
As a response to sexual and gender-based violence (SGBV) and expressed need from survivors in multiple contexts, Tearfund commissioned a series of formative research studies in 2013 and 2014 in the DRC to develop a faith-based intervention to address harmful gender norms and harmful expressions of masculinities, and to promote gender equality. Based on respondents' interest and desire to explore these topics further, a combination of workshops, dialogues, and reflection series were subsequently piloted in Rwanda, Burundi, and the DRC. These were packaged as an intervention to respond to SGBV within a faith context, working with faith leaders and communities, and to increase evidence in programming, working with faith leaders and communities on addressing SGBV. Tearfund's resulting Transforming Masculinities (TM) approach is an evidence-based intervention for religious leaders and faith communities to promote positive masculinities and gender equality within a faith context, and in doing so, reduce SGBV. The intervention uses a process of participatory scriptural reflection and dialogue with faith leaders and congregants to identify, create, and embrace new, positive masculine identities, and to take action. TM focuses on addressing gender inequality and unequal power relations as the root cause of IPV, and SGBV more broadly. The approach engages men as well as women in transformative discussions and activities, and places these concepts within an acceptable faith framework to enable faith communities to embrace more equitable norms.

Section 2
Adapting Transforming Masculinities & Designing Masculinite, Famille, et Foi

'Transforming Masculinities' original innovation in Eastern Congo

Tearfund's TM intervention approach was developed and refined over the course of several years through an iterative process of research, design, piloting, and fine-tuning. As shown in **Figure 1,** the first step was programmatic formative research conducted in 2014 in Rwanda, Burundi, and the DRC, which highlighted the importance of faith leaders and faith communities, faith practices, and sacred texts in influencing and reinforcing behaviors and norms. Starting with a small number of workshops, specifically targeting faith leaders from Protestant churches, the formation of this approach began in mid-2014, in all three of these countries.

Figure 1. A visual guide to the evolution of the Transforming Masculinities intervention approach



The initial workshops focused on unpacking the concepts of SGBV, with an emphasis on gender inequality as its root cause, using scriptural reflections on the creation of men and women as equal partners. The workshops encouraged reflection on harmful practices and promotion of gender equality within a faith framework.

The positive responses and openness to these initial workshops were very encouraging, and led to further development of the TM process, including wider engagement with men and women in their communities alongside the faith leader workshops. In early 2015, based on exposure to other program models in the sector, the Gender Champion-facilitated Community Dialogues were integrated into this approach. This stemmed from the recognized need for dialogue between men and women, as well as the need for champions who would facilitate the dialogues. The Community Dialogue format and process was developed to mirror existing volunteer-led discussion groups typically run in Protestant congregations, thus making integration easier to sustain after the project

timeframes. An improved curriculum was developed with integrated activities, reflections, and sessions, and a topical focus on power and status, with related sacred texts. The importance of addressing gender inequalities was also emphasized, with linkages between power imbalance and violence. This newly packaged TM process was first rolled out in the eastern DRC through the Department for International Development-funded What Works to Prevent Violence against Women and Girls program (2015 - 2018) in 15 remote, rural, conflict-affected communities in Ituri Province.

Figure 2 displays the key groups engaged in the original conception of TM as well as the resources for implementation. The core components of the TM intervention are:

- Gender transformative workshops for national, provincial, and congregational-level faith leaders using the *Transforming Masculinities Training Manual*. Faith Leaders are also given Bible study and sermon resources to address SGBV.
- Gender transformative trainings for men and women in the community to fulfill the role of Gender Champions using the *Transforming Masculinities Training Manual*.
- Reflective group discussions, called 'Community Dialogues,' facilitated by trained Gender Champions for men and women in their communities using the *Community Dialogue Facilitators' Guide*. Community Dialogues run for cycles of 6 weeks at a time, with multiple cycles and new members per calendar year (see **Figure 3** for topics covered).

Figure 2. Transforming Masculinities core activities, resources, and topics

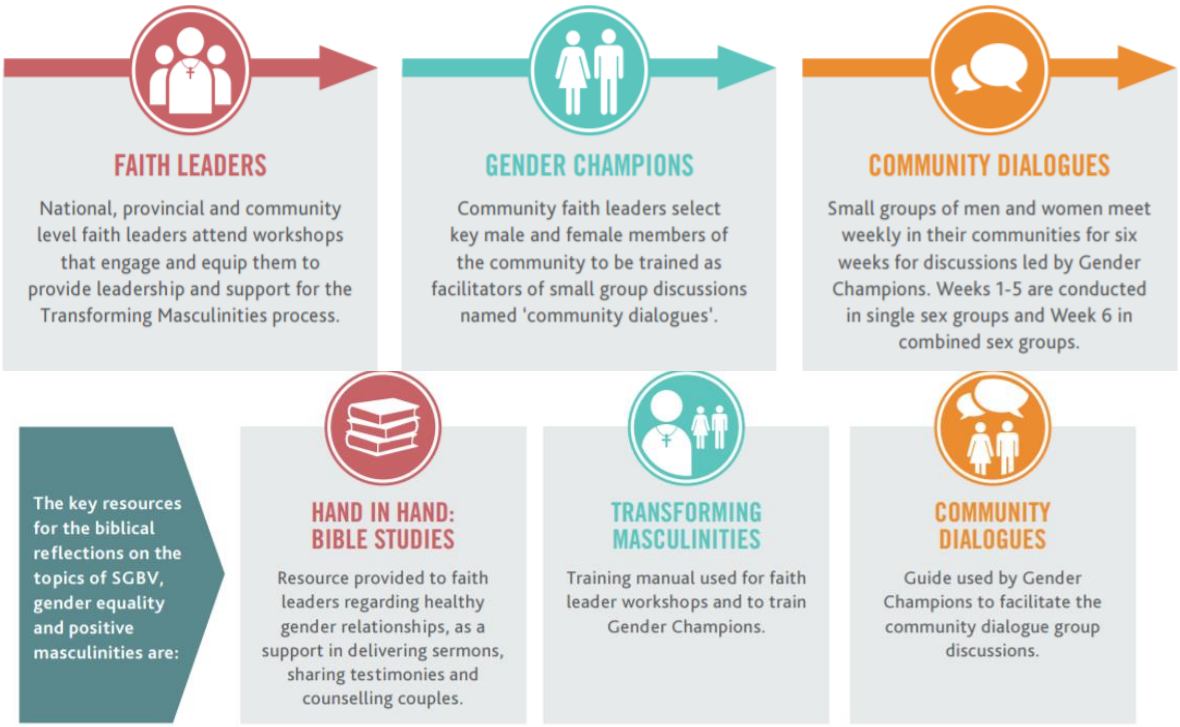
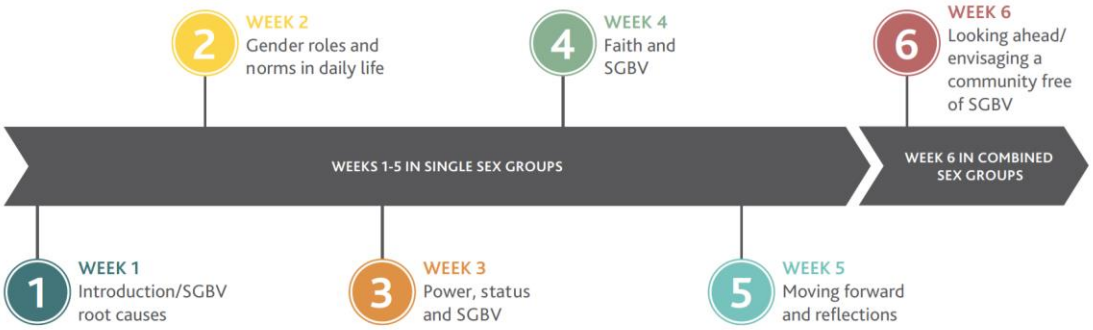


Figure 3. A visual guide to the standard Transforming Masculinities Weekly Sessions



Adaptation under Passages: Focus on social norms at scale to improve reproductive health

Emerging evidence of positive gender norms shifts from the TM pilot in eastern DRC provided the rationale for adaptation under the global Passages Project in 2015 (**Box 1**), due to the interplay of gender and social norms in FP decisions, and the need to meaningfully engage men in FP. Given the critical role men play in FP decisions, gender norms that influence and shape masculine norms, and the influence of religious texts on gender norms and FP, the adaptation focused on addressing the intersections of these. An understanding of how gender norms impact FP decisions resulted in a refined focus on **newly married couples and first-time parents** for the core intervention activities.

In light of this, from 2015-2016, the Institute for Reproductive Health, Georgetown University (IRH), Tearfund, and Population Services International (PSI) together adapted the original TM model to the urban setting of Kinshasa, keeping the core faith engagement focus, and adding components on RH/FP. The model also sought to strengthen the enabling service environment through linkages to available PSI *Confiance* clinics.

The goal of this revised TM approach, renamed as **Masculinité, Famille, et Foi, or "MFF",** was to transform harmful gender norms and reduce social acceptance of GBV and other gender inequalities, which support early childbearing and high fertility rates and prevent women and men from accessing and using modern FP.

Experiences from implementing TM in eastern DRC had highlighted the importance of building diffusion activities into the intervention design rather than treating them as a key outcome of the intervention. As such, the adapted approach expanded the organized diffusion component to include additional activities to strengthen diffusion of messaging and modeling of changed behaviors to reinforce the direct intervention activities and address prevalent social norms.

Box 1.
Passages Project and Rationale for Adapting Transforming Masculinities

The Passages project is an implementation research project that aims to address a broad range of social norms, at scale, to achieve sustained improvements in violence prevention, gender equality, FP, and reproductive health. The project uses norms-shifting approaches to build the evidence base and contribute to the capacity of the global community to understand and shift norms to strengthen reproductive health environments. Passages capitalizes formative life course transitions – very young adolescents, newly married youth, and first-time parents - to test and scale up interventions that promote collective change and foster an enabling environment for voluntary FP, especially healthy timing and spacing of pregnancies.

At inception, the TM approach was included for adaptation and testing under Passages to assess whether faith-based settings, within which norms are formed, can be effective for shifting norms and sustaining behavior change.

Forming partnerships

Formal discussions with IRH and Tearfund began in November 2014, to discuss adapting the TM approach for Passages. L'Eglise de Christ au Congo (ECC) was proposed by Tearfund DRC as the implementing partner, given the longstanding partnership between ECC and Tearfund, their existing work on health and FP, as well as ECC's reach and influence in Kinshasa and throughout the DRC. The significant size of ECC's network of congregations (300,000+ parishes countrywide and 20 million members) was also key to Passages' focus on planning for scale up from the beginning, as well as long-term sustainability through institutionalization. The M intervention pilot was rolled out as a partnership between IRH, Tearfund, ECC, and PSI's DRC affiliate, l'Association de Sante Familiale (ASF). Through several coordination meetings between partners at the global level and across country teams, coordination processes and mechanisms were established to ensure a unified approach across ASF's and Tearfund/ECC's work on the MFF intervention. See **Box 2**.

Box 2.
Tearfund, ASF, IRH, and FHI 360 Roles

Tearfund: Implemented the intervention in partnership with **ECC** in their congregations. Responsible for capacity building of partners, trainings, monitoring and evaluation (M&E).

l'Eglise du Christ au Congo (I) : Implemented the intervention in 17 congregations in Kinshasa. Conducted monitoring activities and supported ongoing evaluations.

ASF: Enabled the service environment in catchment areas (clinics, referrals, hotline, GBV referrals, and support system). Provided community health worker (CHW)-led Health Talks in intervention sites.

IRH: Consortium and partner lead, linkage to global Passages project. Led the evaluation research study to evaluate the extent that MFF achieves set outcomes. Conducted formative research and capacity building, support for M&E.

FHI 360: Provided technical support to data analysis and synthesis for research and evaluation activities.

Theory of change development

As part of the study protocol development, the MFF theory of change (ToC) (**Figure 4**) was created by global and in-country partners. It outlines the intervention components, the pathway of norms shifting, the diffusion of ideation, the intermediate outcomes, the behavioral outcomes, and the overall impact we seek to achieve. Based on emerging social norms theory, the MFF ToC hypothesizes that a faith-based approach provides a specific community within which norms shifts can be effective for behavior change. Further, it hypothesizes the ability of organized diffusion to support new gender transformative attitudes and norms due to the social connections, the influence of the scriptures in informing behaviors, and the role of influencers will allow for an enabling environment for sustained change.

The ToC details the components of the MFF adaptation, including the gender transformative training of faith leaders and Gender Champions, a provision of participatory reflection Community Dialogue sessions with newly married couples and first-time parents, and diffusion activities reaching the wider congregation population. Together, the components of the MFF intervention package are theorized to diffuse new ideas and behaviors through congregation members, leading to the intermediate outcomes of:

- A supportive normative environment within reference groups (including Protestant congregation members, couples/spouses, faith leaders, close friends, and parents) for: 1) FP use; 2) reducing IPV; 3) shifting perceived social norms around masculinities, IPV, and FP use (example norms targeted shown in **Box 3**);
- Self-efficacy and outcome expectations: 1)FP knowledge; 2) Skills for negotiating FP use; 3)

Box 3.
Social norms targeted by MFF

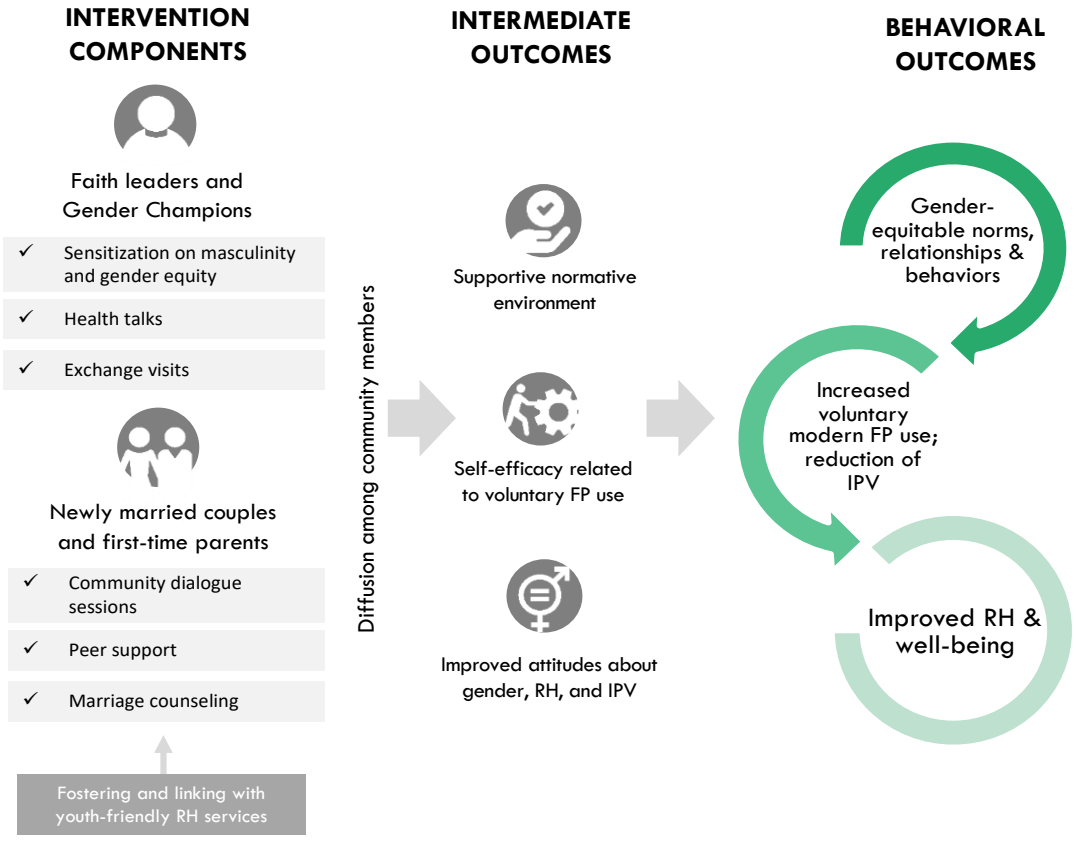
1. In this community, people believe God created men as superior to women.
2. It is acceptable for a man to use violence to correct his wife's behavior or discipline a child.
3. As household decision-makers, a man can dictate a woman's ability to seek and use FP

Ability to use FP; 4) Ability to negotiate FP use with partner and; 5) Motivation to comply with FP norms.

- Positive changes in attitudes regarding FP use, gender equality, and a rejection of IPV.

MFF's behavioral outcomes and impact on the right side of the ToC refer to the core behavior change intended to result from intervention activities in the middle column. These include supporting a strengthened service environment, leading to improved relationship quality, increased couple communication and shared decision-making, and reduced IPV that will in turn lead to increased modern FP use among newly married couples and first-time parents. These behavioral outcomes are expected to lead to improved RH and wellbeing, including healthy timing and spacing of pregnancies.

Figure 4. Simplified Theory of Change for Masculinite, Famille et Foi



Formative assessments and norms diagnosis

As part of the Passages Project adaptation process, a Congregational Readiness Assessment was conducted to better understand the current landscape of the proposed ECC congregations in order to select the congregations in which to implement the intervention. This activity was complemented by a health service mapping to identify linkages between congregation sites and ASF clinics. Additionally, a rapid assessment using the Social Norms Exploration Tool (SNET), was conducted to identify and diagnose the key social norms and related reference groups for the project's targeted behaviors amongst newly married couples and first-time parents.

Congregational Readiness Assessments

Tearfund, with ECC, IRH and ASF, conducted the Congregational Readiness Assessment (CRA) in the initially proposed 30 ECC congregations, to ensure that the number of available couples and congregational information aligned with the planned MFF intervention and evaluation.

The purpose was to gather key information on the proposed congregations to facilitate selection of the engaged congregations, based on the number of eligible couples per congregation available to participate in the planned Community Dialogues, as well as respond to the baseline and endline research studies, and ensure a representative selection of congregations across size, denomination and location in the randomization of control and intervention sites. The assessment also guided implementation planning for the number of Community Dialogues required to be run to align with the identified number of couples in each congregation and, therefore, the number of Gender Champions to be trained as facilitators

Following the Congressional Readiness Assessments, 17 of the initially proposed congregations were selected for having sufficient numbers of eligible couples to participate in the research and planned intervention activities (see **Section 4**).

Health Clinic Mapping and Youth-Friendly Health Service Assessments

Based on the list of communities selected by Tearfund from the Congregational Readiness Assessments (**Table 1**), ASF made a primary selection of *Confiance* clinics eligible to participate in the project based on proximity to ECC communities, as well as existing services they offer. The 17 congregations identified by Tearfund were linked to one or more local *Confiance* clinics from ASF's primary selection. In addition, ASF worked to conduct GBV quality assurance assessments of the *Confiance* clinics, to later inform training exercises for providers and PSI's Youth-Friendly Health Services at *Confiance* clinics.

Based on both the Congregational Readiness Assessment and the Youth-friendly Health Service Mapping, the following adjustments were made to the planned MFF intervention:

- Initially, intervention and research inclusion criteria stated that participants should be members of the selected congregations. However, it was noted during the CRA that a significant proportion of regular, known, committed attendees of the congregation had not gone through a formal membership process. For example, some congregations only formally registered members once per year. It was, therefore, decided to expand the inclusion criteria to include regular attendees in the target age category who were known to the faith leaders and recruiting Gender Champions, rather than relying solely on membership records.
- The age range for Community Dialogue participants increased from 18-24 to 18- 35 for women, without an upper age limit for male partners, in recognition that couples in Kinshasa typically marry later once they have completed tertiary education and found employment.
- The definition of "newly married couples" was expanded to encompass couples in committed, monogamous relationships, including couples that might not have formalized their partnership through one of the three forms of marriage (civil, religious, and traditional), which can be economically challenging for young people in the DRC.
- The definition of a "first-time parent" was clarified to include couples who had other children co-habiting or had more than one child, as long as their first child was 3 years old or younger, as well as couples expecting their first child (at time of project start).
- Health service provision standards were assessed, and in turn, training plans to support health service linkages include a reinforced GBV response protocol and youth-friendly health service provision.

Following the Congregational Readiness Assessment, the MFF team randomly assigned 8 intervention and 9 control congregations to participate in the intervention and research activities (**Table 1**). Based on the Congregational Readiness Assessment results, ASF worked together with Tearfund and IRH to finalize selection of FP service delivery sites (*Confiance* clinics and pharmacies) in intervention and control zones. Care was taken to ensure that each target site had one corresponding *Confiance* clinic and pharmacy, in order to ensure comparative study groups.

Table 1. Finalized list of Congregations and Linked Clinics

No	Communes	Nom de la paroisse	Cliniques *Confiance* et pharmacies
	Control Sites		
1	Lingwala	Paroisse de la CEM/NEST	Pédiatrie Kalembelembe + Pharmacie
2	Matete	Aumonerie Universitaire Protestante de l'UNIKIN, Matete	Centre Médical Magnificat + Pharmacie
3	Mont-Ngafula	Paroisse de l'Eglise du Rocher de la CEAC	Centre de Santé Mawagali + Pharmacie
4	Lemba	Paroisse de Lemba-Salongo de la CPK	Centre de Santé Bon Berger de l'Intendance + Pharmacie
5	Masina	Paroisse de Masina de la CEK	Centre de Santé Elonga Pascal + Pharmacie
6	Ndjili	Paroise de Ndjili de la CEC	Centre Hospitalier Mokili Mwinda + Pharmacie
7	Makala	Paroisse de Makala de la CBCO	Centre Mère et Enfant de Bumbu + Pharmacie
8	Kimbaseke	Paroisse Chapelle de la Victoire de la CADAF	Centre de Santé et Maternité Tshimungu + Pharmacie
9	Bandalungwa	Paroisse de Bandalungwa de la CEPAC	Centre Hospitalier de Reference Libikisi + Pharmacie
	Intervention Sites		
1	Ngaliema II	Aumonerie Universitaire Protestante de l'UPN	Centre Hospitalier la Borne + Pharmacie
2	Lingwala	Paroisse Internationale Protestante de Kinshasa	Centre Maman PAMELA DELARGY + Pharmacie
3	Kitambo	Paroisse de Kimvula de la CBCO	Maternité de Kitambo + Pharmacie
4	Bumbu	Paroisse Bumbu 1 de la CBCO	Centre de Santé la Grace + Pharmacie
5	Mont-Ngafula	Paroisse de Mont-Ngafula de la CELPA	CESOMAS/Zapé + Pharmacie
6	Ngaliema I	Paroise d'Ozone de la CEAC	Centre de Santé Bolingo + Pharmacie
7	Kasavubu	Paroisse de Lisala de la CBFC	Centre de Santé de Reference de Lisala + Pharmacie
8	Kalamu	Paroisse Saint Pierre de l'EAC	Centre de Santé Bomoto + Pharmacie

Social norms formative assessment: Piloting the Social Norms Exploration Tool (SNET)

Another key facet of the formative research was use of the Passages-developed SNET (see **Box 4**). This tool was developed to help implementers with the rapid assessment of influential norms affecting behaviors of interest through participatory exercise. It was also important in helping to adjust the intervention design to better target key reference groups related to FP and IPV-related behaviors for our main population groups: newly married couples and first-time parents.

The MFF project was the first to pilot the SNET. The SNET was conducted in June 2016 in two ECC congregations that were neither MFF intervention or control congregations, due to ongoing intervention preparation activities. The objectives were to: 1) Test the utility and feasibility of the tool in identifying and defining social norms related to the MFF intervention; 2) identify which, if any, social norms influence IPV and FP use among newly married couples and first-time parents; 3) rank the relative importance of social norms on FP use and IPV prevalence; 4) define in measurable terms those social norms that influence FP use and IPV; and 5) provide information to adjust the MFF intervention design, related research, and evaluation instruments, as needed.

The process consisted of four key stages as outlined in the tool: 1) identification and definition of social norms; 2) identification of social norm reference groups (people who influence behaviors and practices of the key participants); 3) exploration of social norms; and 4) interpretation of results. The social norms exploration process generated information on both prevailing social norms and reference groups. A snapshot of the results is shown in **Table 2.**

Overall, the SNET confirmed the intervention's premise that faith leaders are social referents for both IPV and FP use, and thus strengthened the argument for the intervention design. Interestingly, the SNET indicated that faith leaders were more influential for newly married couples than for first-time parents, and that the faith community or congregation as a whole were an important reference group, alongside the individual faith leaders. The inclusion of spouses, friends, family members, and health workers as reference groups highlighted the need to engage the wider congregation in MFF, and confirmed the need to engage health workers to provide accurate FP information. Further, the SNET results informed revisions of the research tools related to reference group measurement and scale development, further described below in **Section 4**.

Box 4.
Background on the "SNET"

The SNET is a participatory, learning, and action (PLA) tool that informs social norm exploration. It is a rapid assessment tool and a team-based, qualitative process, using participatory action research to quickly develop a preliminary understanding of a situation from the perspective of a program. Through five phases, the SNET includes guidance and a set of exercises to conduct a social norms exploration, with findings that can be used to address norms in a program. The SNET proposes that, with a clearer understanding of the social norms that prevail in a given community, including who maintains (or is perceived to maintain) the norms, and of how they relate to behaviors, practitioners can design more effective projects.

As such, the SNET proposes that understanding social norms can help practitioners: 1) identify the most relevant norms that influence specific behaviors; 2) design interventions to transform harmful norms and promote positive norms; and 3) develop measures and instruments that accurately evaluate change in social norms.

Table 2. Summary of findings from SNET assessment for MFF

	Voluntary FP Use	*Gender & Masculinity*	*Intimate Partner Violence*
Social norms identified	• As household decision-makers, men dictate a woman's ability to use FP • It is appropriate for first-time parents and newly married couples to use FP	• God created men as superior to women • Disapproval of husband sharing household work and childcare responsibilities	• There are times when a woman deserves to be beaten • It is acceptable for a man to use force to correct his wife's behavior and to have sex with his wife
Reference groups identified	• For men: Intimate partners, nuclear family members, friends, pastors • For women: Intimate partners, nuclear family members, extended family members, friends, pastors	• For men: Pastors, friends • For women: Intimate partners, friends, pastors' wives	• For men: Pastors, friends, intimate partners • For women: Intimate partners, friends, pastors' wives, nuclear family members

Designing the service linkage model

To ensure a strong service environment for those residing in the intervention and control congregational communities, the MFF intervention included a strengthened service linkage model. ASF provided 1) FP health talks and referrals (referral cards) for health care in intervention and control congregations, 2) maintained and monitored quality youth-friendly health services at all *Confiance* Clinics (linked to intervention and control sites) and GBV response services, and 3) operated a youth-friendly hotline. Efforts were made to ensure equivalent quality and access to FP services in both study arms.

1. **The FP health talk** was facilitated by Community Health Workers (CHWs) in both control and intervention sites, based a standard health talk already in use and which CHWs were familiar with. In the intervention sites the FP health talk took place in the final week of the Community Dialogues, and in the control sites the talk was given to a specifically assembled group of newly married couples and first-time parents with a comparable number of couples (8-10) within the same time frame. The Health Talks covered family planning (FP) and RH, introduced the services available at the *Confiance* clinics, counseled Community Dialogue participants on different types of FP methods, and clarified misperceptions around FP side effects. **Referral cards** were distributed to each individual at the end of the health talk (2 per couple) in both intervention and control congregations, and explained how to use them to access further FP advice. Referral cards directed couples to their nearest *Confiance* clinic for a follow up FP consultation. These clinics, in turn, collected service statistics, including FP use disaggregated by age and sex as a means of tracking any impact of the intervention on service uptake.

2. **Building the capacity of CHWs** and pharmacy staff to provide youth-friendly health services and IPV referrals/response. CHWs were trained to provide youth-friendly FP counseling and services and respond appropriately to disclosures of IPV, according to established protocols. Training content included the RH needs of youth, positive attitudes toward providing FP to youth, standards of youth-friendly services (e.g., non-judgmental communication, respect for confidentiality), and ethical and confidential approaches to assisting GBV survivors. Survivors who disclose GBV experiences to *Confiance* providers receive a compassionate response, relevant health care, and linkages to the non-health care services they may need.

3. **Running a youth friendly hotline, "La Ligne Verte"** to provide information and advice to youth on FP, IPV, and other topics. "La Ligne Verte" was a free hotline provided in Kinshasa, and other locations in the DRC, mainly through the USAID-funded SIFPO and SIFPO2 projects (Support for International Family Planning Organizations, in over 15 countries). As part of social franchise network activities, the Ligne Verte was already active and had been operated by ASF since 2015, which was responsible for the ongoing training and competence of the hotline operators. The hotline number was provided to congregants in both the intervention and control sites. As part of Passages, the operators received refresher trainings and appropriate GBV referrals and responses.

Adapting the Community Dialogues Guide to include reproductive health and family planning

In order to meet the dual objectives of reduced IPV and improved RH, including FP use, the TM model and curriculum for MFF was adapted to include a version of the Community Dialogues guide which included a faith-based perspective to FP. This additional content was jointly developed by IRH, ASF, and Tearfund, with support from faith leaders and Gender Champions. The adapted guide drew on existing resources created by Christians Connections for International Health (CCIH), EngenderHealth, and the REAL Fathers project.

The purpose of the additional content was to encourage couple communication on their FP perspectives within a reflective group setting, and to encourage discussion on FP in preparation for the health talks at the end of Community Dialogues. The additional sessions were also facilitated by Gender Champions and covered in Weeks 7 and 8 of the dialogues, once the male and female participants had been brought back together with their partner (Week 6). These sessions were organized in the following way:

- **Week 7**: child spacing and healthy relationships
- **Week 8**: men's involvement in positive parenting

The final session (Week 8) of the dialogues ended with a health talk by a CHW. This session followed with a celebration event in the 9th week with couples, Gender Champions, and religious leaders. This event celebrated the graduation of the cycle by sharing stories of change and a commitment to continue reflections and action.

Designing Masculinite Famille, et Foi's 'organized diffusion'

Diffusion of MFF messages on FP, IPV, and gender equality to a wide, normative environment was central to MFF's design to create a supportive setting for intended behavior change among newly married couples and first-time parents. As the SNET highlighted, the opinions of the wider faith community (e.g. members of the congregation), family members, close friends, and health professionals were important to couples' practices and choices. In order to reach a tipping point of change and ensure that couples were supported in RH and gender equitable behaviors, MFF was designed to reach the wider congregation with consistent messaging through a number of activities.

1. **Faith leaders preaching supportive sermons:** Following the TM training, faith leaders were invited to share MFF messages on FP, IPV, and gender equality on a regular basis during congregation services. The Transforming Masculinities Manual and the Hand in Hand Bible Study Guide, described below, were used as sermon guides. Faith leader engagement in the diffusion activities also served as an indicator of their support for the intervention.

2. **Couple testimonies and story sharing:** Couples were encouraged to share their stories of change following completion of the Community Dialogues from the front of Sunday gatherings to encourage other couples to participate and to share the key messages with the wider congregation.

3. **Community mobilization and celebration events:** Each congregation held three events on one of the MFF topics, to which the wider congregation was invited. Events were held on significant dates such as Father's Day and Mother's Day, and were an opportunity to talk about couple relationships and FP with those members who were not part of the Community Dialogues. Celebration events were slightly smaller-scale events, held at the end of each cycle, with participating couples, and all present were asked and encouraged to attend.

Masculinite Famille, et Foi core materials

Finally, in supporting implementation, the program materials are described below:

- **Transforming Masculinities Training Manual** *(for Master trainers, Faith Leaders and Gender Champions):* Developed by Tearfund, this manual was used during all MFF faith leader workshops, Gender Champion trainings, and refresher sessions and workshops with National, Provincial, and Congregational-level Faith Leaders. The manual was designed to accompany participants through a personal journey of critical reflection, experiential learning, and application. It seeks to help participants understand concepts of gender, gender roles and norms, gender equality, SGBV, root causes of SGBV, and linkages to gender inequality, power, status and violence, scriptural understanding related to gender equality, and positive masculinities. This equips participants with possible strategies and use of the TM process and adaptations.

- **Community Dialogues Facilitator Guide, adapted to include reproductive health** *(for Gender Champions)***:** As described above in adaptations, this tool is used by Gender Champions in the TM approach to facilitate a series of reflections and dialogues. The themes are intended to prompt personal reflection and deepen understanding of the topics. The sessions are practical and action-oriented, so at the end of each one, the participants are given personal and relational reflections to think through during the week, with a view to sharing their thoughts at the subsequent group session. The sessions are composed of scriptural reflections and other tools to facilitate honest dialogues at the community level. The Community Dialogue Facilitator Guide was drafted and edited by Tearfund, in partnership with IRH and PSI/ASF, and was used by Gender Champions for the full eight weeks of the Community Dialogues sessions. The additional content in Week 7 covers child spacing and healthy relationships, and Week 8 is focused on men's involvement in positive parenting.

- **'Hand in Hand'***(for Faith Leaders and Gender Champions)***:** These are 12 Bible studies, contextualized to enable church leaders to break their silence on IPV, equipping them to transform their response. This tool is also used by parish pastors in their sermons to diffuse key messages, and as a Bible study guide that accompanies the Community Dialogue sessions.

- **MFF Quick Guide** *(for Faith Leaders and Gender Champions)***:** Developed by Tearfund as a graphic "quick guide" to the MFF intervention. The quick guide provides a visual explanation of the intervention components, the Community Dialogue cycle, the weekly sessions, and the tools used. This is a key part of the Gender Champions toolkit, and is shared both internally and externally.

- **GBV Response Manual** (*for CHWs):* PSI/ASF finalized and translated a GBV response manual into French for social franchise providers. The manual is based on the WHO clinical handbook, "Health care for women subjected to IPV or sexual violence," and adapted to the realities and constraints of responding to GBV through the private sector. Since private providers are not able to offer post-exposure prophylaxis and conduct forensic documentation, the manual focuses on the first-line response and referrals that link survivors with more comprehensive care in the public sector. It was shared with all 80 *Confiance* health care providers in Kinshasa.

Section 3
Implementing Masculinite, Famille, et Foi

Generated from the design and adaptation phase, in reaching young couples, the MFF intervention consists of the five intervention components below, adapted from the original TM model. Following the initial phase of adaptation and material development, trainings for MFF began in September 2016 for faith leaders and Gender Champions. Below, we share the journey of implementing MFF through transformative trainings, capacity building, Community Dialogues, organized diffusion activities, and enabled service linkages, described in **Figure 5**. We share insights from monitoring throughout, and findings from implementation learning studies at the end of this section.

Figure 5. MFF Intervention Components and Summary of Reach

Intervention Component	*Icon Key*	*Brief Description*	*Summary of Intervention Component Reach*
Transforming Faith Leaders		Gender transformative workshops for faith leaders held for National, Provincial and Congregational level. The goal is change through the denominational hierarchy. Faith leaders support Gender Champions in the recruitment and running of the Community Dialogues and provide supportive sermons to the wider congregation as part of the diffusion activities.	• 42 faith leaders trained • Of which: 12 national-level leaders, 14 provincial-level leaders, and 16 congregational-level leaders
Building Capacity of Gender Champions		Gender transformative workshops for peer role models to be trained as Gender Champions. Responsible for facilitating the Community Dialogues, supporting couples, and monitoring congregational-level activities.	• 40 Gender Champions trained • Representing 8 intervention congregations
Community Dialogues		Led by trained Gender Champions for newly married couples and first-time parents. Gender synchronized discussion groups on GBV, FP, and gender inequality. Includes an FP health talk linking couples to FP services.	• 7 cycles of Community Dialogues were held • 458 couples/916 individuals participated
Organized Diffusion		Organized diffusion activities included supportive sermons, stories of change sharing by couples completing the Community Dialogues and community mobilization events.	• 384 supportive sermons given • 315 stories of change shared by couples • 24 community mobilization events held • 120,000 contact points across 8 intervention sites

Enabling Service Environment		An enabling service environment across both control and intervention sites for young couples where they received referral cards to linked, trained, local clinics for each congregation, youth-friendly training for providers, and a RH/FP hotline for confidential questions.	• 17 linked clinics • 42 CHWs trained in youth friendly service provision • 5,506 individuals sought services: 3,420 across the 9 control and 2,086 from across the 8 intervention sites • 1,699 calls were made to hotline: 1,128 calls made by men and 571 made by women.

Transforming faith leaders

'Master' training

Ahead of commencing Gender transformative trainings for faith leaders and Gender Champions, Tearfund held a 4-day Master Trainers workshop in Kinshasa from August 15-18 2016, with 20 participants from ECC, ASF, Tearfund, IRH, and the support of the Director of Programme National de Santé de l'Adolescent, who opened the training. This training increased the number of people who could act as trainers for TM in Kinshasa within the partner organizations, provided a cohesive overview of the MFF intervention to increase understanding of key concepts, provided discussion of the intervention with ECC congregations, and clarified coordination between ASF and Tearfund.

Faith leader trainings

Training sessions for faith leaders were held at multiple levels to ensure consistency in understanding and commitment to the project, and to encourage personal transformation. The following training sessions were conducted in the beginning of the project, followed by a refresher training (see **Box 5**) after the completion of the first cycle.

- **National-Level Faith Leader Training:** From 21st – 23rd September 2016, 11 National-level Faith Leaders were engaged in scriptural reflection and other activities to unpack gender, gender equality, masculinities, IPV, and FP. The focus, as throughout the MFF intervention, was primarily to help participants unpack their own knowledge, attitudes, and practices by creating a safe space for reflection.

- **Provincial-Level Faith Leader Training:** From 28th – 30th September 2016, 14 Provincial-level (Kinshasa province) Faith Leaders from within ECC were trained. The goal and focus of the training were the same as the National-level training, as both National and Provincial-level Faith Leader engagement is critical to support the congregation-level religious leaders and ensure change within ECC.

Box 5.
MFF Refresher Trainings

Refresher training sessions and workshops were conducted with the Gender Champions and the congregational leaders from the 8 intervention sites after the completion of the first cycle, and subsequently each project year. The refresher programs reinforce the MFF concepts and process, creating further space for reflection on self-development and transformation. Additionally, these programs focus on challenges and lessons from implementation to plan for solutions. The refresher programs are for 2-3 days, maximum.

- **Congregational-Level Training:** From 20th – 22nd September 2016, 16 pastors and lay leaders from the 8 intervention congregations were trained using the TM process. Congregations were invited to send female leaders, as well the principal faith leader. The purpose of the training was to lead to personal change within the congregational leadership, explain the intervention and gain buy-in, and ask leaders to identify and invite key congregation members, male and female, to be trained as Gender Champions. These leaders were also responsible for working with Gender Champions and the research team for couple selection, and were also encouraged to diffuse messages through sermons, testimonies, Bible studies, etc., in their respective congregations.

Knowledge, Attitudes and Practice (KAP) pre- and post-tests conducted at each faith leader training showed that the most significant change was on the understanding of gender inequality being the root cause of SGBV. On average there was a 20% positive change towards strongly agreeing that addressing gender inequality was essential to addressing IPV. There was, however, limited change towards the desired agreement with the statement that men should participate in household tasks, moving 1.4% from 1.86 (37.2%) to 1.93 (38.6%) on a five-point scale.

Feedback from the faith leader workshops indicated they were interested in the topic and pleased to be engaged in the project, with an average score of 4.3/5 or 86%. According to workshop reports, participation and engagement was high in all 3 of the faith leader workshops, with leaders reflecting on their own families and upbringing and understanding the link between masculinities and violence. Faith leaders particularly appreciated the use of scriptural reflection and the discussion of Jesus Christ as a model for positive masculinity, the exercises on gender roles and power dynamics, and the presentation on FP. These workshops were excellent opportunities to solicit input from faith leaders on adapted materials and in agreeing on scriptural references for the program to use in dialogues and activities.

Building capacity of Gender Champions

Gender Champion training

Forty men and women from the 8 intervention sites were selected with support from their congregational leaders to be trained as Gender Champions from 24th – 28th October 2016. The training lasted 3 days, and included 16 participants in a cohort, in order to ensure the space remained reflective. The participants were encouraged to critically reflect on their gender and IPV-related attitudes, knowledge, and behaviors, and commit to the process of change for themselves. The training consisted of scriptural reflections and other activities to unpack gender, gender equality, masculinities, IPV, and FP. The focus, as throughout the MFF intervention, was primarily to help the participants unpack their own knowledge, attitudes, and practices by creating a safe space for reflection. The trained Gender Champions were regrouped for a one-day program focused on improving their understanding of the MFF process, recruiting and mobilizing for the Community Dialogues, and using the MFF toolkit. CHWs also conducted a FP session to sensitize Gender Champions on FP methods and the FP talks conducted during the dialogues.

KAP data indicated that the trainings resulted in a number of shifts in understanding and perspective. Similarly to the faith leaders, the most significant shift in understanding for Gender Champions was that gender inequality should be addressed as the root cause of IPV (20% increase in agreement). On a five-point scale where 1 represented strongly disagree and 5 strongly agree, disagreement with the statement that women were created as helpers for men (in the Biblical narrative) and were therefore inferior, increased 26% from an average of 3 (neutral) to 1.7 (disagree). There was a change of 1.1 (22%) points to disagree with the statement that there is no such thing as marital rape from a group average of 2.2 to 1.1. There was also a 1 point (20%) change to strongly

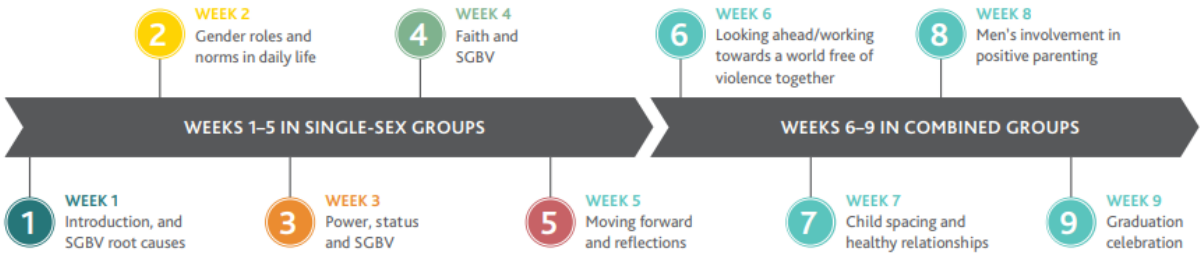
disagree with the statement that a man is the head of his household and should dominate his wife. Questions to assess changes in knowledge and attitudes regarding RH and FP were added post baseline, so comparative figures are not available.

'Community Dialogues' with newly married couples & first-time parents

Community Dialogues were facilitated discussions with 8-10 couples per congregation of newly married couples and first-time parents in 8 weekly sessions. These dialogues were facilitated by the Gender Champions, using the Community Dialogues Guide and Family Planning Reflections as a guide for the 8 weeks, finishing with a celebration event on the 9th week to mark the participants' completion of this process. The weekly sessions were structured in the following way:

Each Community Dialogue ran for a cycle of 12 weeks, which included 8 weeks of group discussion, a celebration event on Week 9, and three weeks for finalizing monitoring, reviewing the recent Community Dialogues, and recruiting for the following cycle. During the first 5 weeks, male and female couple members met separately to discuss similar but differentiated content on IPV, power, and gender equality. Couple members rejoined their partner for Weeks 6-8, which focused on moving forward together as partners and making healthy and joint FP decisions as a couple. Male Gender Champions facilitated the male sessions and female Gender Champions the female sessions, and worked together during the joint sessions (Weeks 6-8). At the end of the 8th week session, a CHW from a linked clinic would attend the session and deliver a 20-minute talk on FP methods and distribute referral cards. During the celebration event, couples made a commitment to ongoing change and putting learning into practice, as well as sharing their stories of change and any feedback on the process. Faith leaders also attended the end of cycle celebrations to support the project, congratulate the couples, and hear about the changes in couples' lives. A small amount of funding was provided for each cycle's refreshments. After each cycle, Gender Champions met with faith leaders to debrief and finalize the end of cycle reporting. Debriefs were then held by the ECC project team with Gender Champions and faith leaders to discuss feedback and makes plans for the following cycle, including recruitment of new couples.

Figure 6. MFF Community Dialogue Sessions, by week

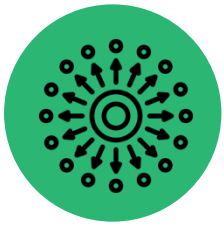


In total, 7 cycles were run during an 18-month period, reaching 458 couples. Each Community Dialogue group chose the best time to meet, typically Sunday following the main church service. If a couple was unable to attend one week for the main session, they were able to have a catch-up session with the Gender Champion. If a couple missed more than 2 weeks, they paused participation until the next cycle, as the sessions built on each other and the group dynamic was a key part of the process. Retention rates were high for the Community Dialogues across all congregations, with an overall average rate of 89%. Where there was some drop off (43 couples), this was typically because of work commitments sending couple members out of Kinshasa (72%). The next most common

reason was that the husband's work schedule conflicted with the meeting time (16%). Most of the couples were first-time parents, and there were fewer newly married couples. Faith leaders also saw the Community Dialogues as helpful for marriage preparation, as they gave key content and structure to an activity that faith leaders typically run for all couples ahead of religious marriage. Engaged and co-habiting couples were included under newly married couples due to the different forms of marriage common in Kinshasa. This interest also guided ECC's plan to integrate MFF into marriage preparation more formally in scale up.

Couple feedback indicated that they were very pleased with the content of the sessions and saw changes in their relationships. They were particularly interested in the activities on gender roles and power dynamics, as well as the FP sessions. The lowest score typically went to time management, as sessions often ran over. Gender Champion facilitation scores from ECC project team site visits varied, but improved from cycle to cycle, following refresher trainings and input from the ECC project team.

Gender Champions remained very engaged in the Community Dialogues, even with the level of commitment required. All 40 Gender Champions remained active until the end of the project (though one female Gender Champion took a break for a couple of cycles following the birth of her child).



Organized diffusion activities

Diffusion was a key component of the intervention, given the focus on addressing social and gender norms related to IPV and FP. Trained pastors from the intervention congregations were encouraged to preach **sermons** in support of FP, support for survivors of IPV, gender equality, positive masculinities, and challenging harmful practices. In addition, couples and first-time parents completing the Community Dialogues were given a platform during Sunday service to share their **testimonies** with the whole congregation. The parishes also mobilized around key events/significant days of the year to organize **community mobilization events** with the aim of disseminating and engaging the congregation on the MFF themes. These diffusion activities also supported the Gender Champions in recruiting new participants for the Community Dialogues cycles. Diffusion was assessed by using a diffusion survey and tracked through monitoring tools (see Monitoring below for further detail).

Sermons
Trained faith leaders were invited to share supportive sermons based on MFF messages, using the *Transforming Masculinities Training Manual* and the *Hand In Hand Bible Study Guide* as references. Faith leaders were free to choose how often and which topics to speak on. The topic and number of people listening to the sermon were recorded by Gender Champions on a weekly basis and submitted as part of their monthly reporting to the ECC team. The number of sermons preached also served as an indicator of faith leader engagement, with ECC project staff making sure to meet with faith leaders when sermon numbers appeared to be low. A total of 385 supportive sermons were made on MFF messages across the 8 intervention sites over the 18-month period, which is an average of 48 sermons per congregation and 2.5 per month. Out of a total of 385, 214 of these sermons (55%) were on FP and 37% were on gender roles and healthy relationships. The remaining 8% directly addressed IPV. This is perhaps surprising, considering the slightly greater focus in the faith leader training on addressing IPV compared to FP, but may be explained by high interest from the congregation, and the fact that it is less challenging to address gender inequality than violence. The topics were noted by Gender Champions rather than the sermon content. More insight into content was provided by the midline ethnographic study.

Testimonies
Couples who completed the Community Dialogues were invited to share their testimonies, or stories of change, from the front of the church to the wider congregation. This was organized by faith leaders and Gender Champions in their respective congregations. This raised awareness of MFF, helped with recruitment for subsequent cycles, and shared MFF messages more broadly. Gender Champions collected data in their monthly monitoring reports on the number of testimonies shared, and the attendance of the congregation at that occasion. Testimonies were shared 320 times over the implementation period, resulting in 15,000 contact points across the eight congregations. Contact points refer to the total number of men and women present at the diffusion events and are likely to include the same congregation members multiple times.

Community mobilization events
Community mobilization events were organized by Gender Champions and faith leaders in their respective congregations, with a small amount of project funds allocated for refreshments and materials. Events were held in the churches and open to all congregation members. Gender Champions submitted a draft outline plan prior to the event, and then a short summary report and photos afterward. Each congregation held 3 community mobilization events during the 18-month period, on an MFF theme selected by the faith leaders and Gender Champions. In total, 24 community mobilization events were held, totaling 4,000 contact points (2,500 women and 1,500 men). Five of the eight congregations chose to hold one of their mobilization events on the topic of FP, and invited a CHW to make a presentation. This was important in bringing the FP conversation into the main congregation space and showed these congregations engagement in FP. Other topics included the importance of the family (without an FP presentation), positive parenting, power and gender norms, and Jesus Christ as a model of positive masculinity.

Enabling service environment

Youth-friendly and integrated health service provision trainings

The following training sessions were led by ASF to strengthen service delivery and youth-friendly services in the *Confiance* clinics. Tearfund staff also participated in the sessions to familiarize themselves with FP and ASF's approaches, and to orient the clinic workers and related stakeholders on the MFF approach.

1. **Training of Trainers on Youth-Friendly Health Services and GBV Response**: From March 29 – April 2, 2016, ASF held a 5-day country-level training of trainers workshop in Kinshasa, DRC, to orient 25 government partners, youth representatives, ASF staff, and other Passages partners in DRC (Tearfund, IRH, and Save the Children) on best practices in youth-friendly health services and response to GBV. The workshop served multiple purposes. First, ASF staff practiced facilitating modules for ASF's provider training guide and received technical coaching from HQ staff. Second, ASF pre-tested the provider training modules adapted for the project, using feedback from the workshop to refine them.

2. **Training of Trainers at Provincial-Level:** The first training of trainers workshop at the national level secured buy-in to roll out a training of trainers at the Kinshasa provincial level, in order to gain champions for MFF. ASF conducted a similar workshop with 17 provincial-level representatives of the Ministry of Health (MOH) and Ministry of Women, Family, and Children. This second training of trainers was instrumental, as these government stakeholders were involved, alongside ASF, in training and supervising providers in the study communities.

3. **Training of *Confiance* Providers and Hotline Operators:** In May 2016, ASF trained 80 *Confiance* providers and 41 CHWs to offer youth-friendly health services and first-line response to GBV, as well as 9 hotline operators and 1 editor of a youth magazine to ensure that their work was youth-friendly.

4. **Throughout the Tearfund-led activities, ASF-trained staff (CHWs) attended** the trainings for faith leaders and Gender Champions to review the content of the health talk content and take questions from them. This enabled faith leaders to ask their own questions about FP, and to understand the specific content that would be shared with their congregants ahead of time. Further, this helped Gender Champions grasp the FP content and ask their own questions before facilitating the Community Dialogues. This helped clarify the boundaries of their role guiding conversations on FP from a faith perspective, without the expectation of being a FP expert.

Health talks and referrals

As discussed in the adaptation section, a 20-minute health talk on FP methods was developed by ASF for the final session of the Community Dialogues on Week 8, in line with what CHWs were used to and already providing in other settings. The health talk was standardized through the use of a flipchart, and presented examples of both hormonal and barrier FP methods, the advantages and disadvantages of each method, and clarified myths and concerns around the use of each method. The same talk was delivered in both control and intervention congregations, and was intended to reach the same number of eligible couples in both sites. In the intervention sites, the talk was delivered to the eligible couples who had already participated in 8 weeks of Community Dialogues. The sessions were facilitated by the Gender Champions, who then introduced the CHWs to give their talk and distribute referral cards directing participants to their closest linked and trained *Confiance* clinic. In addition, a supportive hotline called the *Ligne Verte* was available throughout the implementation period.

Couples received free, private consultations on FP methods, and paid for their selected method. The MFF-branded referral cards were collected and used to track visits and FP uptake linked to MFF activities throughout the intervention implementation period. A total of 2,086 individuals sought services at one of the eight *Confiance* clinics linked to intervention sites, while 3,420 individuals sought services at one of the nine *Confiance* clinics linked to control congregations.

In the control congregations, it was primarily faith leaders who announced the visit of the CHWs and invited 8-10 couples to attend, matching the same criteria as the intervention couples, so the health talk would be consistent for both intervention and control sites.

Detailed service-level data from the *Confiance* clinics during the first three months of implementation was lost, but, for the bulk of implementation (end of 2017 and throughout 2018), the following trends were seen:

- **New female users of FP:** 755 from intervention sites, 1005 from control sites.
- **Top five most-used FP methods:** *Jadelle* Implant, Sayana Press Injection, Depo-Provera Injection, Intrauterine Device (IUD), and Male Condom. This was similar across sites.
- **Average age range of new FP user:** 25-34 in both intervention and control sites.

Furthermore, the *Ligne Verte* hotline, available weekdays to all program participants, provided referrals and advice on RH and GBV. Of note, the *Ligne Verte* suffered a disruption to its service for 6 consecutive months within the 18-month period of the intervention. Throughout the intervention implementation period, a total of 1,699 calls were made into the hotline from participating MFF intervention and control sites. From the 1,699 calls, 1,128 calls were made by men and 571 were made by women. Unfortunately, reasons why more callers were male are unknown.

It's important to note that the service monitoring data showed several trends in comparatively greater clinic visits and calls from participants from control sites. We determined that this was potentially due to the nine control sites inviting everyone to listen to health talks in the early months of the intervention (as opposed to just comparable young couples), leading to greater distribution of referral cards, and control site members being highly motivated to engage with this aspect of the intervention that was open to them. However, there may have been other factors influencing these trends, including potential overlap with existing RH/FP programs in control site areas.

Monitoring Masculinite Famille, et Foi

The Monitoring System and Plan for MFF was jointly developed by Tearfund and IRH, and subsequently adapted for reporting by ECC, Passages, and ASF. The tools and reporting templates were developed and adapted to capture delivery of activities and outputs according to the work-plans. They were also used to collect process-related information and data to improve content, process, and delivery of the MFF intervention. **Table 3** outlines the main core implementation tools.

Table 3. Monitoring Tools for MFF

M&E TOOL	DETAILS
Attendance Sheets	*To track attendance. Used at workshops for faith leaders (national/regional/congregational), trainings for Gender Champions, during or after each workshop/training. Reported by the Project Officer within 2 weeks of completion.*
Pre/Post KAP Surveys	*Anonymous quantitative form used to track the influence of trainings on participants' perspectives on FP, IPV, and gender equality. Used at workshops for faith leaders (national/regional/congregational) and trainings for Gender Champions at the start and end of each workshop/training. Reported by the Project Officer and Tearfund ECC M&E Officer within 2 weeks of completion.*
Evaluation Forms	*Quantitative form used at workshops for faith leaders (national/regional/congregational) and trainings for Gender Champions, during or after each workshop/training, to rate multiple aspects of the training, including relevance of topics, ease of understanding, and logistics. Reported by the Project Officer and Tearfund ECC M&E Officer within 2 weeks of completion.*
Feedback Forms	*Narrative form used to gain insight into participants' experiences and reflections. Used at workshops for faith leaders (national/regional/congregational) and trainings for Gender Champions, during or after each workshop/training. Reported by the Project Officer and Tearfund ECC M&E Officer within 2 weeks of completion.*
Community Dialogue Monitoring Tool	*Attendance form filled out by Gender Champion each week of the Community Dialogues. Reported by the Gender Champion responsible in the relevant congregation 1 week after the completion of the 8-week cycle.*
Gender Champion Facilitation Form	*Score-based form used during monitoring visits. Filled out by ECC project staff in conversation with Gender Champions each visit. Used to identify areas of facilitation to strengthen and inform refresher training content.*
Community Dialogue Evaluation Form	*Score-based form filled out by participating couples at the end of each cycle. Submitted to ECC project team.*
Couples Testimony Form	*Narrative form filled out by couples at the end of each cycle to capture stories of change, most impactful sessions, and recommendations for future cycles.*
Diffusion Monitoring Tool	*Used to monitor weekly diffusion activities in the congregation, including attendance, topics shared/diffused, discussions held, and members present. Reported by the Gender Champion responsible in the relevant congregation on a monthly basis.*
Monthly Narrative Report & Abridged Project Monitoring Plan (PMP) Tool	*Monthly reporting on project indicators and narrative report on project activities, challenges, and adjustments submitted by the MFF ECC M&E Officer on the first week of the following month to Tearfund.*

Community Mobilization Event Reports	*Brief narrative summary report to record details of the community mobilization events, including theme, date, and number of participants. Reported by the MFF ECC M&E Officer within 2 weeks of completion.*
ASF Health Service Database	*Database used by ASF to collate information emerging from* Confiance *clinics on MFF intervention site health service referral system, health visits based on referral cards used, and key indicators, such as information sought, FP method obtained, if relevant, and demographics.*

Monitoring and learning process

The ECC M&E Officer collected data using intervention-specific M&E tools, as detailed above. The collected data was analyzed and compiled into monthly reports to Tearfund DRC. These monthly reports informed and shaped Tearfund's quarterly reporting and semiannual reporting to IRH. The check-in calls with the Tearfund DRC team, HQ, and ECC teams were informed by these reports, and issues related to content, process, and delivery are discussed and revised/adapted in mutual agreement.

With input from IRH and ASF finalized, ASF used service delivery utilization indicators to monitor implementation of the MFF intervention. These indicators covered the number of *Confiance* clinic and pharmacy FP clients (disaggregated by age and sex), the number of referrals cards at each of the 17 MFF sites, and the number of hotline calls through Passages during the reporting period.

Central to the monitoring and learning process were pre-established and ad-hoc meetings, workshops, and stakeholder engagement strategies to learn from emerging insights of implementers on the ground, reflect on incoming monitoring data, and factor in experiential learnings. These opportunities led to many small programmatic adjustments throughout implementation, many of which are shared in a brief on Adaptive Management approaches used in the program. This included inputs from the Technical Advisory Group (TAG) members (see **Box 6**) when visiting Community Dialogues and/or attending workshops and training. The informal mechanisms and on-going learning moments were key to strengthening delivery and improving process and content.

Box 6.
MFF's Technical Advisory Group "TAG"

Established during the program design stage in 2017, the MFF TAG provided critical technical input and guidance to the program. The TAG was comprised of 20 members from the representatives of government ministries of Health, Women, Family and Children, Youth and Sport; UNICEF; other international non-governmental organization (INGO) bodies, including Pathfinder, Promundo, and Medecins du Monde; representatives from the ECC departments of Youth, Women, and Pastors of Kinshasa, and the MFF implementers (IRH, ECC, Tearfund, and ASF).

The TAG, which had a rotating leadership structure and was convened quarterly throughout implementation, provided input on the intervention's design, implementation strategies, emerging monitoring data, and baseline findings, and often heard from on-the-ground implementation challenges and brainstormed solutions together. The TAG members also frequently conducted supportive site visits and met with participants. Finally, towards implementation wrap up, the TAG provided input into the preliminary scale up vision and strategy for the DRC.

Program learnings

Ethnography, activity-based Costing & Retrospective Learning Studies

Midline Ethnographic Results

Together with partners, IRH conducted a midline ethnographic assessment of the MFF intervention. The ethnographic assessment took place between May and September 2017, over months 5-10 of implementation. Of the 17 congregations involved in the overall evaluation, four intervention congregations were selected, based on size (small, large) and leader engagement (low or high

engagement), and two comparison congregations were purposively selected in consultation with Tearfund and ECC staff. For leader engagement, the ECC Passages team categorized faith leaders with low or high engagement based on their involvement in the workshops, their interest in the Community Dialogues, and whether the primary faith leader from each congregation attended organized MFF meetings or sent a deputy. Ethnographers were recruited from the University of Public Health in Kinshasa and trained by IRH with Tearfund and ECC's involvement.

The assessment explored the quality of implementation, community acceptance of the MFF intervention, diffusion of MFF messages, and the expression of gender-related attitudes among faith leaders, Gender Champions, newly married couples, first-time parents, and the community as a whole.

The guiding questions for the ethnographic study were:

1. How are gender, violence, and FP represented within the intervention by faith leaders, Gender Champions, and during the Community Dialogues?
2. How do newly married couples and first-time parents express gender-related attitudes? Where is there agreement and disagreement on gender roles? What perspectives do they hold regarding decision-making and roles of men and women in FP? Do they discuss FP use and its effects on couple communication and decision-making?
3. How are other people beyond newly married couples and first-time parents integrating the MFF themes?
4. What is attendance like at MFF Intervention events?
5. How do people respond to what they are hearing? How do they describe the events?

Overall, ethnographers observed that the MFF intervention was working as designed, but acceptability by men and the wider community could be enhanced by harmonizing and strengthening key messages based on observed pushback. Results showed that the norms, attitudes, and beliefs promoted in faith communities were intimately related to the outcomes of interest (gender equality, GBV/IPV, FP use), often in negative ways. Moreover, they confirm that gender equality, GBV/IPV, and attitudes which prevent healthy timing and spacing of pregnancy are serious and prevalent concerns in these communities. At midline, while the intervention appeared to be mitigating or addressing many outcomes (more equal gender roles, GBV, FP use), it was unclear whether it was successfully influencing underlying issues of male power as a root cause of these outcomes with participants. While some shifts were seen among couples, the ethnography report highlighted that transforming these deeply rooted attitudes and beliefs would be a long-term endeavor.

Box 7.
Summary of Overarching Findings from Midline Ethnography

- Gender norms are deeply rooted, and profoundly influence women's abilities to control their fertility and live free from violence.
- Intense pressure to conform to social expectations is related to violence and fertility
- Although contested and gradual, women and men report changing beliefs and norms related to gender, violence, and FP
- Christian values of forgiveness may result in women bearing the burden of violence

Findings shared during the ethnographic process enabled reflection to strengthen areas of the intervention. These included highlighting the importance of challenging male dominance and gender inequality, addressing the power imbalance, focusing on justice and equality, and countering harmful interpretations of scriptures during refresher trainings and ongoing meetings with Gender Champions and faith leaders. During trainings and regular meeting with Gender Champions and faith leaders, TM sessions were revisited to reflect on these key concepts, the importance of justice and Congolese laws on SGBV, as well as the intervention guidance on the importance of countering harmful reactions to reinforce the importance and validity of gender equality. There was also emphasis on ECC's role in establishing strong GBV referral links and monitoring for unintended negative consequences. Because the results of the study were not available until late in the

implementation process, the ability of the team to adjust was limited, but informed later scale up efforts.

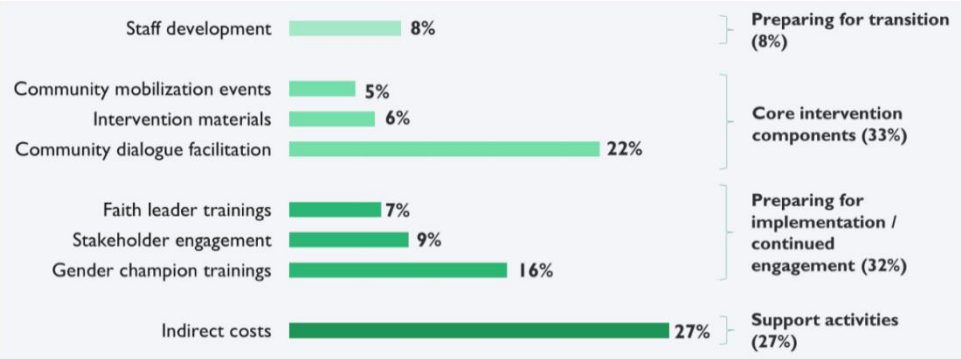
Costing Study

Throughout the planning and implementation phases of MFF, a concurrent and retrospective activity-based costing study was undertaken by Tearfund, with insight and guidance from FHI 360 and IRH, using the Costing Primer for Norms-shifting Interventions. The purpose of the activity-based costing study was to identify the resources needed to sustain the intervention through the pilot implementing partner, ECC, and to estimate what resources would be needed for other organizations to implement the program at scale. The study also aimed to determine the cost of specific intervention components to guide revisions of the package for scale up, and to evaluate potential cost savings associated with implementing the intervention through faith-based partners (i.e., based on a culture of voluntary service at the congregational level).

Year 1 costs were collected retrospectively, Year 2 costs were collected quarterly, and Year 3 costs were collected monthly. Direct costs were pulled from the monthly financial reports from Tearfund and from ECC, while labor costs were measured as a proportion of time and assigned to activities to better understand their associated time costs. In-kind or donated inputs (non-financial costs) were assigned an equivalent or 'shadow' cost - for example, meeting spaces within the congregations for workshops or larger meetings were calculated at typical hire costs, and Gender Champion time as volunteers were calculated as typical wage equivalents. All costs linked to research and headquarter support related to the research initiative (rather than program implementation) were removed in order to provide useful information on the cost of replication for a national non-governmental organization (NGO).

Overall cost of the resources used to implement the intervention over the three-year period was ~ $610,000. As seen below in **Figure 7**, just under one-third of the resources were used to prepare for intervention implementation and stakeholder engagement. Over one-third of resources were used to support the core intervention components, dominated by the ongoing Community Dialogues with young couples, men, and women. The remaining third of resources were used to prepare for the planned scale up piloting and ownership transition of the intervention by building the capacity of local staff and for indirect support (including program monitoring as well as overhead costs, such as office rent and expenses, bank fees, and audit costs).

Figure 7. MFF Component Cost, as % of Total



As anticipated, the Community Dialogues accounted for the largest share of resources. This was expected, as it includes the Gender Champion stipends (which were provided to compensate for their time reporting on their work, rather than as paid employment), refreshments, supervision visits from staff outside of any research-related visits, as well as end-of-cycle celebrations, and end-of-cycle meetings with Gender Champions and faith leaders.

Shadow costs were smaller than expected, ranging from 1.1% to 4.8% of total costs over the three years, which may have implications for scale up, as it indicates a reliance on outside resources to support the intervention.

Retrospective learnings studies

In late 2018, immediately following the completion of the MFF pilot, the team collaborated on a Learning Agenda to guide scale up efforts. This included a number of small, structured, retrospective "learning studies" to better understand the intervention and implementation experience, and provide information to guide adaptation decisions (example of one learning study described in **Box 8**). The learning studies primarily drew on monitoring and evaluation (M&E) data, together with supplementary focus group discussions (FGDs) with the implementation team and key intervention actors (e.g. faith leaders, Gender Champions, participating couples, etc.) The studies were informed by the needs of implementers and local stakeholders alike, and were intended to feed into the existing scale up plan, focusing on both the intervention impact (outcome results) and process.

Each study sought to answer questions related to 1) implementation mechanisms; 2) quality; 3) fidelity; 4) efficiency; 5) sustainability; and 6) scalability; each study focused on one of the following intervention components:

1. Faith Leader Transformation and Engagement
2. Gender Champion Transformation and Facilitation
3. Community Dialogue Implementation
4. Health Service Linkages
5. Diffusion Activity Implementation

The **Faith Leader Transformation and Engagement** learning study was designed to provide information on the effectiveness of the trainings at transforming faith leadership and their role as gatekeepers in the intervention. Their unique role in diffusion was also explored. The **Gender Champion Transformation and Facilitation** learning study centered around the role Gender Champions play as transformative agents and as facilitators and couple mentors. The focus of the third study, on the **Community Dialogue Implementation**, was core content, session management, couple attendance and participation, and how other elements impacted implementation. The fourth learning study on **Diffusion Activity Implementation** reflected on how diffusion activities were implemented, received, shared, and their potential for scalability. The final learning study on **Health Service Linkages**, as **Box 8** describes, focused on understanding FP talk content and management, referrals used, and reflections on scalability.

Box 8.
Example Retrospective Learning Study Questions and Data Sources, by Health Service Linkage component

Questions

1. Was the FP Talk content covered as planned? Was the content clear and comprehensive?
2. Did the hotline operate as planned?
3. Were people engaged during the FP Talk?
4. Were the FP Talks well-managed?
5. Was the FP Talk accepted? What changes did couples suggest, if any?
6. How scalable is this component (considering cost, complexity, and ease of implementation)?
7. Did the couples from Community Dialogues discuss the FP Talk with others?
8. Were people seeking services from the FP Talk? How so?

Data Sources

- Service Statistics (monitoring data)
- CHW reports (service data)
- Gender Champion facilitation feedback forms (monitoring data)
- TA trip reports
- Service Training and Workshop Reports
- Monthly ECC reports

The learning studies were completed by Tearfund and IRH together in 2019. As described above, it included team-based review of monitoring data and supplementary FGDs to unpack learning questions by learning study (intervention component). Below in **Table 4**, we share top-line findings and recommendations from these learning studies, by component.

Table 4. Learning Study Findings, by Component (including learnings and takeaways)

Learning Study 1: Faith Leader Transformation and Engagement	
Summary of findings	- As a result of trainings, faith leaders noted significant improvements in comfort level discussing FP, and in discussing and supporting people around IPV. - Use of the TM materials in trainings was important to engage faith leaders with biblical and scriptural reflections. This approach was seen as highly effective in gaining support from faith leaders. - Using 'social norms' framing was helpful for faith leaders to pause and reflect on how these social rules are made, followed, and enforced, and their role. - Further, reflecting on gender helped faith leaders engage women in leadership positions in the training – further including them in the intervention throughout. - Majority (13/16) of the original faith leaders were engaged throughout, with some retention issues where leaders were sent on to new parishes by ECC. - In FGDs, faith leaders mentioned improvements in their personal relationships resulting from the intervention. - All faith leaders stated that they enjoyed supporting the diffusion activities (sermons, youth meetings, couples counselling), and encouraged additional supportive/diffusion activities.
Recommendations for scale up and future implementation	1. Train faith leaders who will be present throughout implementation and multiple leaders from the same congregation in case of changes. 2. Find regular touch points for updates and refreshers to ensure ongoing engagement of faith leaders as lack of ongoing communication resulted in confusion on progress. 3. Build internal training capacity within implementing partner or faith leaders themselves to support others and co-facilitate trainings. 4. Find ways to engage faith leaders in diffusion outside of sermons, or other diffusion activities that would be acceptable within the context.

Learning Study 2: Gender Champion Transformation and Facilitation	
Summary of findings	**Transformation** - KAP analysis of the trainings showed shifts in the attitudes of participants towards gender equality and FP. - Some (not all) unmarried Gender Champions found it hard to discuss topics on sexual relations with married couples. - Gender Champions want to continue to lead Community Dialogues in their congregations. - Some Gender Champions earned the nickname 'Positive masculinity' in their congregations – showing how they are known as role models for this. **Facilitation** - Facilitation improved throughout implementation, and refresher trainings helped. Session (time and content) management continued to be an issue. - The Gender Champions took on ownership of MFF within their congregations to a greater extent than the religious leaders. They were more often identified with intervention activities and worked closely with the couples to organize the Community Dialogues (planning the calendar, facilitating the dialogues) and in recruitment of couples. - Trusting and collaborative relationships were critical between the couples, the Gender Champions and the religious leaders. Joint trainings with health workers were effective to understand roles, responsibilities, and build relationships.
Recommendations for scale up and future implementation	1. Ensure that if unmarried Gender Champions are selected, they are comfortable and have the skills to facilitate conversations for married couples on couple relationships and FP. 2. Facilitation skills improved over the cycles, supported by project staff site visits and coaching, as well as refresher trainings. Support and refreshers should be maintained in scale up. 3. Include tips for session management and time management in Gender Champion trainings to support effective implementation. 4. Provide stipends for costs incurred by Gender Champions. As relevant or desired, develop and maintain signed agreements with the Gender Champions – but clarify that it is voluntary, not a job (like other roles in the church).

Learning Study 3: Community Dialogue Implementation	
Summary of findings	- The Community Dialogue format and content was very well-received by ECC, with potential to be permanent. - Community Dialogue participants thought the format of the content, being influenced by biblical excerpts, was well-received and allowed for stimulating reflection and discussion from common perspectives. - Early cycles of Community Dialogues demonstrated that the FP content Gender Champions were responsible for was too much, and refresher trainings and adjustments were needed. - Multiple activities in the church could lead to clashes with Community Dialogue times – this was improved through more regular communication between faith leaders and Gender Champions, and forward planning on cycle dates, celebrations, and diffusion events. - The majority of congregations held one catch up session per week of each cycle for couples that could not make the main session, which placed an additional time burden on the Gender Champions, as well as additional transport costs for meeting with the couples. - Ineligible couples (based on set criteria of newly married couples/first-time parents) were unhappy that they were excluded from recruitment. - Participating couples expressed wanting the sessions to cover additional content and be longer lasting (ongoing).
Recommendations for scale up and future implementation	1. If the FP Talk is maintained in a similar format at scale, find more time for the CHW to answer questions and build relationships with couples, and reduce burden on Gender Champions. 2. Cover the transport costs for Community Dialogues, or think further about where is best to hold them for participants. Let each group decide when and where is best to meet (not necessarily Sundays at church). 3. Given varied issues with attendance, find non-burdensome ways to catch up couples. Provide content handouts for reading, alternative times for sessions for many people, etc. 4. Encourage participating couples to be catalysts for change in their communities through linking them together with others who've also completed the dialogues to share experiences, and reflect further on how they can model change. 5. Enlarge the selection criteria of participating couples at scale to remove the newly married couple/first-time parent criteria, which excluded other young couples or youth who could benefit from the intervention. 6. Include other topics to improve couple relationships – for example, managing household finances.

Learning Study 4: Diffusion Activity Implementation	
Summary of findings	- The reach and coverage of the suite of diffusion activities was vast – specifically, the community mobilization events enabled a more open atmosphere in the congregations to speak about IPV and FP with other church members during ongoing advocacy events with good attendance. - Couple testimonies were a useful way to recruit couples to the intervention and raise awareness of MFF, while also providing other couples in the congregations with other models of change in addition to the Gender Champions. - Sermons were well-liked by faith leaders who enjoyed delivering them. Topics could have been analyzed in real-time to ascertain if certain ones were avoided because of discomfort or resistance, and could have further informed refresher trainings. - Community mobilization events required budget and more planning, which could be an additional burden to the Gender Champions to organize. - Various intervention themes were covered throughout activities, however, monitoring only tracked which overarching theme was discussed (FP, IPV, positive masculinities), rather than the specific topic. Nuances of the topics got lost at large-scale events – lending to reflection on what should be covered/when, and how much oversight is needed on content to ensure they align with programmatic messages/messaging. - Throughout all diffusion activities, MFF messaging was prominent from monitoring data. However, to a certain degree, it is hard to know to what extent they sparked further reflection outside of the activities. FGDs with implementers confirmed that participants shared messages and calls-to-action, but this is hard to monitor.
Recommendations for scale up and future implementation	1. Monitoring diffusion was difficult. At scale, implementers should reflect on how to capture how diffusion activities and messages reach further outside of the immediate events and circles. 2. At scale, the organized diffusion activities should be implemented in parity across settings to ensure broad coverage from sermons, story sharing, and events to reach a maximum number of people and achieve a tipping point for change.

	3. Sermons, celebration events, and couple testimonies were all well-received and easy to implement, proving value at scale. Community Mobilization events were popular, but may be harder to scale. 4. Coverage of overarching themes (e.g. FP) was clear from activities, but specific topics and nuance of the messaging was not (e.g. importance of couple communication for making decisions in FP). If interested, in future implementation, teams should ensure monitoring includes the details of messaging shared, by whom, and when.

Learning Study 5: Health Service Linkages	
Summary of findings	- There was initial resistance to FP by faith leaders in trainings and early implementation, given concerns over specific content. Additional support and discussions were needed to update on content and introduce CHWs to faith leaders. - The health talk, designed as an introduction and invitation to further consultation at the clinic, was limited to 20 minutes. However, couples were keen to ask questions and capitalize on the opportunity to learn more about FP. This showed a high level of interest in the topic, but also caused issues of timing. - Monitoring responsibilities between CHWs and Gender Champions needs to be clear in replication. CHWs may track referrals, but should not be responsible for other monitoring. - CHWs had to adjust descriptions of available services, and importantly, associated costs early in implementation. Participants should be informed about any costs they would incur when visiting the clinics. - With the referral cards, CHWs needed to communicate the exact process to follow when arriving at the clinic, as some clinics were large and only certain individuals were trained on protocol. - Short-term discontinuance of the hotline was not communicated with participants who had the contact information and believed it to be operational. Any issues with supportive linkages to services needs to be communicated.
Recommendations for scale up and future implementation	1. Strong relationships should be formed between CHWs and Gender Champions, but also with faith leaders to ensure no disruptions or confusion over content or activities. 2. In this service linkage model, CHWs are responsible for FP content. At scale, the model may adjust, based on shifting realities. Adequate training or support will be needed on FP content. 3. At scale, implementers should think through what needs to be monitored in terms of service linkages and uptake, and train appropriate monitoring users on data needed, process, and intended learnings. 4. Referral card systems for tracking clinic visits, and longer-term FP uptake can be effective, but also difficult to maintain once provided. It's important to communicate clearly to participants what to do with them, and have a very clear protocol at receiving clinics. 5. Any costs associated with services must be communicated with participants. 6. Where hotlines, or other referral services may be available in scale up, better communication will be needed on available services, timeframes, and constraints to participants.

Results of the learning studies were shared internally among team members for discussion and reflection as scale up activities underwent planning, as described in **Section 5**, below. The learning studies and resulting 'findings' also allowed the team to synthesize monitoring data (as shared above throughout this section), as well as adjust the monitoring system for scale up. In addition to informing learnings for scale up among the team, and with new implementers, they provided opportunity for MFF stakeholders to share insights with the program team and opened discussions for their pathway to scale. Additional value could be gained from conducting learning studies at midterm, in order to make adjustments during the implementation phase, or to plan and resource for multiple learning studies during implementation to better understand and strengthen the intervention. Many learnings gleaned from these studies are synthesized in the Passages Project program brief: Adaptive Management: Learning and Action Approaches to Implementing Norms-shifting Interventions.

Section 4
Research Results

Research design rationale and objectives

MFF was designed to shift norms in order to ultimately change behaviors (see **Figure 4**), thus the evaluation research was designed to measure and understand shifts in norms. Specifically, **it sought to provide evidence on the potential of this intervention to shift social norms and increase FP use, decrease IPV, promote positive masculinities (i.e., male engagement in household work and childcare), and increase diffusion of social norms beyond direct intervention participants**.

Research objectives were formulated based on assessing the effectiveness of the MFF intervention based on assumptions outlined in the program ToC (**Figure 4**); outlining the social norms the intervention seeks to shift, the diffusion of ideation, the intermediate outcomes, the behavioral outcomes, and the overall impact the program sought to achieve. Based on emerging social norms theory, the MFF ToC hypothesized that a faith-based approach provides a specific community within which norms shifts can be effective for behavior change. Further, it hypothesized that the ability of organized diffusion to support new gender transformative attitudes and norms due to the social connections, the influence of the scriptures in informing behaviors, and the role of influencers will allow for an enabling an environment for sustained change.

The evaluation research included a series of complementary mixed-methods studies in 17 Protestant congregations selected for the intervention and research. The three main objectives of the evaluation research were to:

- **Objective 1:** Determine the extent to which MFF increased voluntary FP use, reduced IPV, and promoted positive masculinities among newly married couples and first-time parents participating in the intervention.
- **Objective 2:** Explore the relationship between social norms and MFF outcome behaviors, and determine the extent to which MFF shifted norms promoting voluntary FP use, reduced IPV, and positive masculinities amongst newly married couples and first-time parents participating in the intervention.
- **Objective 3:** Understand diffusion of MFF messaging within wider religious congregations.

Identifying study sites

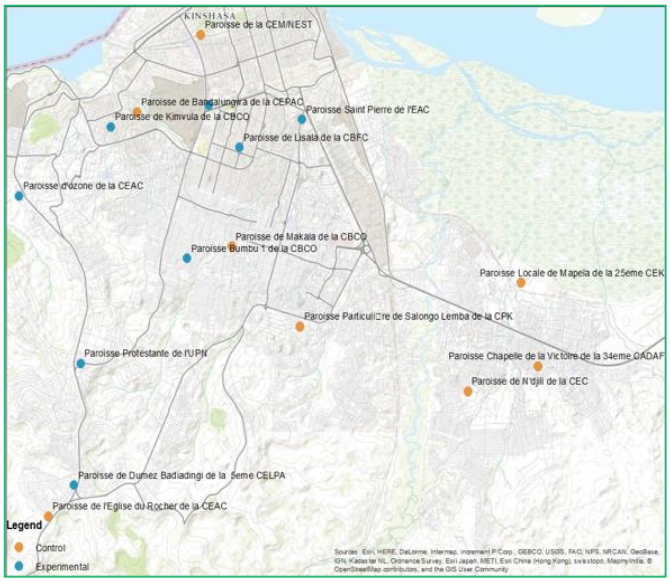
Seventeen of Kinshasa's 24 districts were represented in this study. The 17 congregations are located within the following districts in the Kinshasa area: Gombe, Kinshasa, Lingwala, Kintambo, Ngaliema I, Ngaliema II, Mont Ngafula, Makala, Matete, Bumbu, Kinsenso, Bandalungwa, Kalamu I, Kasavubu, Limete I, Limete II, and Ndjiki I. Sites were selected randomly from ECC congregations based on presence of an ASF/PSI clinic, congregation size (small/large), and urbanization (see **Figure 7**).

Research methodology

The MFF intervention evaluation was designed as a mixed methods, prospective, two-group, pre-/post-test study, with 17 congregations randomly assigned to a comparison (nine congregations) or intervention group (eight congregations), from selected sites above. **Objectives 1 and 2** (above) were assessed through a quantitative survey distributed to couple members in the 17 congregations (**Figure 8**), meeting eligibility criteria for the intervention in both intervention and comparison congregations. These objectives allowed us to explore the effectiveness of the MFF intervention in

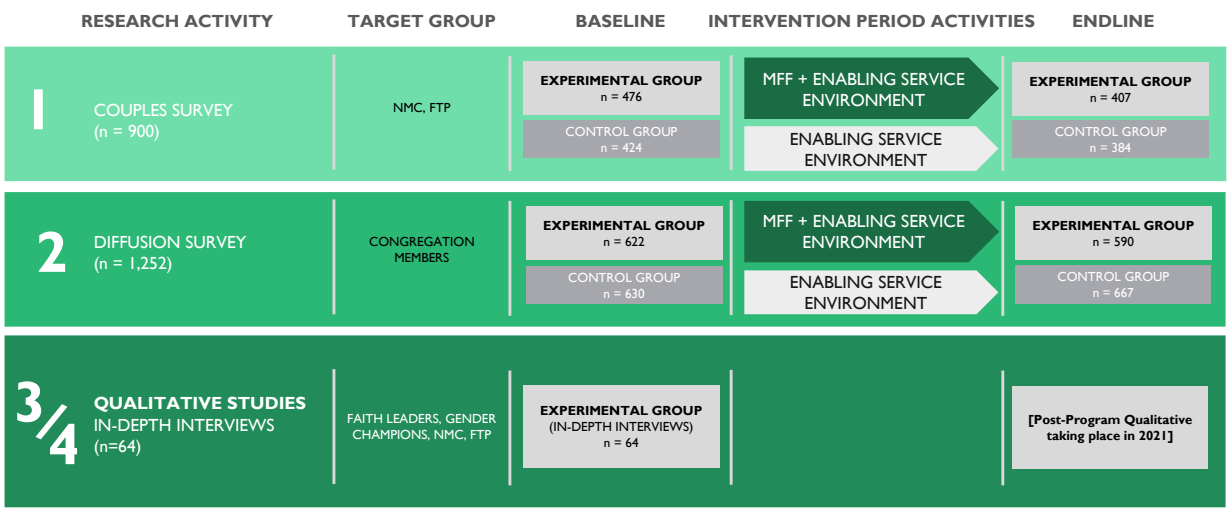
shifting key behaviors for young couples, and to assess the relationship between normative shifts and behavioral change consistent with the MFF ToC. **Objective 3** was assessed through a quantitative survey distributed to adult members of the wider congregation in the 17 congregations. Qualitative methods were conducted at baseline (with an additional round of data collection in 2021) in order to provide additional context across the objectives and, in particular, to better understand pathways of normative shifts and other key components of the MFF ToC.

Figure 8. MFF Study Sites



To reach the set objectives, a two-stage stratified sampling design was used to assign congregations. The intervention group received the MFF intervention (i.e., Community Dialogues), whereas the comparison group only received the enabling service environment activities. **Figure 9** shows the four research activities comprising the MFF evaluation study. For each research activity, the target group, the sample sizes for both intervention and comparison groups, and the timing of the activity are also shown. Each of these research activities are explained in further detail within the discussion that follows.

Figure 9. MFF Research Design



Research populations, sample size, and selection

Newly married couples and first-time parents were recruited for **the couples survey,** based on the female member of the couple being a member of a selected congregation between the ages of 18-35 years. Male partners could be any age as long as they were partnered with a woman 18-35 years. All participants were considered either newly married (married within the last three years or cohabitating within the last three years) or first-time parents (had a first child within the last 3 years), and regular attendees of the selected congregation. **Newly married couples** were defined as heterosexual couples that had been married or in a committed monogamous relationship for three

years or less. These couples did not have children and were not expecting a child. These couples could self-identify as newly married and did not need to be legally married or cohabitating. This definition included couples who were engaged to be married. **First-time parents** were defined as heterosexuals in partnerships who had had their first child together within the last three years. They could be married or unmarried and could have more than one child, as long as their eldest was less than three. This definition included couples expecting a child for the first time. For the couple survey, only one member of each eligible couple was selected for inclusion. At endline, only individuals who had participated in the intervention were considered for the intervention sample.

The couple survey was originally designed to randomly recruit 30 men and 30 women from each of the 17 congregations, for a total of 1,020 couple members at baseline. Although a random sampling methodology for individuals was planned, Congregations Readiness Assessments (*as described above*) completed during program start-up indicated an insufficient number of eligible couples present in the congregations. As a result, the research methodology was adjusted to select one member from each couple that met eligibility criteria for the intervention and research. Congregational leaders assisted in the process of identifying eligible couples and inviting eligible congregants/couples to specific sermons, where the intervention and research was explained to the congregation. Over the course of the intervention, new couples were enrolled in the intervention activities on a rolling basis, but these new inclusions were not surveyed at baseline. In addition, many participants who had completed baseline surveys subsequently dropped out of the intervention. At endline, we made a concerted effort to identify and contact all participants who had undergone the intervention and completed a baseline survey (approximately 60% of our sample), and supplemented the sample with participants in the intervention that did not complete a baseline survey. At baseline, 901 respondents were surveyed, and at endline, 791 respondents were surveyed.

For the **diffusion survey**, those included were individuals, 18-49 years and registered as members of the congregations. The purpose of this survey was to assess diffusion by and through newly married couples and first-time parents in their reference groups and broader faith community. Members who participated in the couple survey along with individuals who were attending the congregation for the first time were excluded from this recruitment process. The diffusion survey was originally designed to randomly recruit 50 men and 50 women from each of the 17 congregations, for a total of 1,700 respondents. Random sampling of participants for the diffusion survey was conducted among a sampling frame of participants meeting the inclusion/exclusion criteria, and volunteering for participation after faith services during the recruitment period. At both baseline and endline, a cross-sectional sample of 1,257 respondents was surveyed.

For the **baseline qualitative study**, 64 in-depth interviews were conducted with 16 faith leaders, 16 Gender Champions, and 32 prospective Community Dialogue participants in the eight intervention congregations. All respondents were selected through purposive sampling, and selection proceeded until a saturation of themes from the in-depth discussions. All respondents were recruited by the research team, with support from ECC and Tearfund, who met the criteria, given their role in the intervention.

The protocol and all research studies were approved by the Institutional Review Board (IRB) of Georgetown University and the Ethical Committee of the School of Public Health, University of Kinshasa, DRC, for the local IRB. The local research partner for both baseline and endline, Health Focus, facilitated and supported the process of local ethical approval of the research study. Data for the couple and diffusion surveys and qualitative interviews at baseline were collected concurrently, from September 2016 to January 2017. Endline data collection took place from December 2018 to February 2019.

Research tools

All quantitative surveys and qualitative interview guides were developed in collaboration between IRH, Tearfund, and other Passages partners, and reflected the MFF Theory of Change (ToC) model (see **Figure 4**). The couple survey included items relating to behaviors and intentions, attitudes, self-efficacy, relationship quality, couple communication and decision-making, and social norms (i.e., descriptive norms, injunctive norms, reference groups, sanctions) relating to voluntary FP use, IPV, and positive masculinities (e.g., gender and male engagement in household chores and childcare). The diffusion survey included a shorter list of items relating to behaviors, attitudes, and social norms, as well as items assessing a respondents' communication with members of their congregation relating to target behaviors. The baseline qualitative guides included lines of inquiry related to attitudes, social norms, and communication patterns around target behaviors, as well as understandings of biblical Scriptures relating to these topics.

Data analysis

This study was originally designed to be longitudinal to provide difference-in-difference estimates, comparing intervention and comparison populations at baseline and endline. However, the longitudinal design could not be maintained and, therefore, difference-in-difference estimation was not an appropriate statistical analysis. Instead, descriptive analyses of the survey data were performed to understand the distributions of key variables by study arm. Key variables of interest and social norms scales were compared by study arm, as were key populations (men vs. women and newly married vs. first-time parent), using chi-square tests of independence for categorical variables and t-tests for continuous (or quasi-continuous) outcomes at baseline and endline. All quantitative analyses were completed in Stata 16.

Qualitative analysis for the baseline in-depth interviews was conducted using thematic content analysis based on qualitative codebooks developed by IRH and reflecting objectives, the MFF ToC, and emerging topics generated by the data. Data triangulation was used to identify concepts that could be validated by a combination of data sources. All qualitative analyses were completed using ATLAS.ti 10 software.

Development and assessment of quantitative social norms measures

The couple survey included questions to elicit perceptions of social norms related to target behaviors. We asked questions about descriptive and injunctive norms relating to voluntary FP use, IPV, and male engagement in household chores and caregiving. For each question, we inquired about the influence of reference groups, including faith leaders, partners, and others in the congregation. All social norms items used a four-point ordinal response scale.

We developed a statistical analysis plan to identify the latent social norm constructs by assessing which social norm survey questions captured similar aspects, allowing us to determine their associations with target behaviors. To assist with data reduction and to assess the latent structure underlying the social norm items, we first conducted exploratory factor analyses (EFA) on the baseline couple survey sample using SPSS 21. Then, we conducted the EFA with the entire sample to determine the latent constructs and retained items with factor loadings of 0.4 or higher. We also conducted three separate EFA for FP, IPV, and gender equality, respectively. We included all survey items that were intended to analyze social norms, and used Cronbach's Alpha statistics to examine the internal consistency of each derived factor. We named each factor to align intuitively with the factor's score; that is, a higher score indicates greater agreement. For each of the social norm constructs, all the underlying manifest variables had high factor loadings (i.e., all over 0.50), and all communalities were at or above 0.30. The Cronbach's alphas for all factors were over 0.75, indicating the factors were internally consistent.

Table 5 shows results of the factor analysis, revealing two distinct social norms constructs related directly to FP use, combing responses from women and men. Seven social norms items that asked about injunctive FP norms loaded onto the first construct, and two items designed to discern descriptive norms of FP use loaded onto the second FP social norm construct. Similarly, the social norms related to positive masculinities loaded onto two constructs and results were similar for males and females (**Table 5**), with the resulting factors relating to a husband's role in household work and a husband's role in childcare, rather than type of norm (i.e., descriptive vs. injunctive). Notably, in this case, both constructs were comprised of items asking about injunctive norms, and the reference groups referred to in these two sets were the same: faith leaders, partners, newly married couples and first-time parents in the congregation, and influential people.

Finally, the social norms related to IPV were found to be sex-specific (**Table 5**), loading onto three constructs related to experiencing IPV among women and two for perpetrating IPV among men. For women, four social norms items that asked about injunctive IPV norms with faith leaders and members of their congregations loaded onto the first construct; three items that asked about injunctive IPV norms with husbands and influential others loaded onto the second construct; and two items designed to discern descriptive norms relating to IPV loaded onto the third construct. Among men, seven items that asked about injunctive IPV norms loaded onto the first construct and two items designed to discern descriptive norms relating to IPV loaded onto the second construct. The IPV injunctive norm construct included items about the respondents' perceived approval of IPV from the congregation, faith leaders, and other important influencers.

Table 5. Results of Factor Analysis—Social Norms Scales

Injunctive FP Norms: $\alpha = 0.837$
Members of this congregation think it is appropriate for newly married couples to use modern methods of FP.
Members of this congregation think it is appropriate for first-time parents to use modern methods of FP.
Faith leaders in this congregation think it is appropriate for first-time parents to use a modern method of FP.
Faith leaders think it is appropriate for newly married couples to use a modern method of FP.
In matters related to FP, people whose opinions are important to me think I should use a modern method of FP.
My partner thinks we, as a couple, should use a modern method of FP.
Faith leaders in this congregation think my partner and I should use a modern method of FP.
Descriptive FP Norms: $\alpha = 0.830$
Perceived proportion of congregation in which newly married couples use modern FP.
Perceived proportion of congregation in which first time parents use modern FP.
Household Gender Role Norms: $\alpha = 0.860$
Most newly married couples and first-time parents that I know in this congregation approve husbands sharing household work.
People whose opinions are important to me approve of the husband sharing in the household work.
Faith leaders in this congregation think my partner and I should both share in the housework.
My partner thinks we should both share in the housework.
Childcare Gender Role Norms: $\alpha = 0.789$
My partner thinks we should both share in the responsibility of childcare.
Faith leaders in this congregation think my partner and I should both share in the responsibility of childcare.
Most newly married couples and first-time parents that I know in this congregation approve of the husband sharing in the responsibilities of childcare.
People whose opinions are important to me, approve of the husband sharing in the responsibilities of childcare.
Faith Community Injunctive IPV Norms—Females: $\alpha = 0.851$
Members of this congregation expect a husband to force his wife to have sex even when she does not want to.
Members of this congregation think it is ok for a husband to beat his wife at times.
Faith leaders think it is ok for a husband to beat his wife at times.
Faith leaders think it is ok for a husband to force his wife to have sex even when she does not want to.
Partner and Influential Others Injunctive IPV Norms—*Females*: $\alpha = 0.800$
Husband thinks it is ok to beat me at times.
Husband thinks it is ok to force sex upon me even when I don't want to.

People whose opinion is important to me think it is ok for my husband to beat me at times.
Descriptive IPV Norms—*Females*: α = 0.803
Perceived proportion of congregation where husband beats his wife at times.
Perceived proportion of congregation where husband forces sex on his wife even when she doesn't want to.
Injunctive IPV Norms—*Males*: α = 0.849
Members of this congregation expect a husband to force his wife to have sex even when she does not want to.
Members of this congregation think it is ok for a husband to beat his wife at times.
Faith leaders think it is ok for a husband to beat his wife at times.
Wife thinks it is ok for me to force sex upon her even when she doesn't want to.
Faith leaders in this congregation think it is ok for me to beat my wife at times.
People whose opinion is important to me think it is ok for me to beat my wife at times.
Descriptive IPV Norms—Males: α = 0.769
Perceived proportion of congregation where husband beats his wife at times.
Perceived proportion of congregation where husband forces sex on his wife even when she doesn't want to.

These measures proved to be valid and reliable for this context and are used to evaluate whether and to what extent the MFF intervention has shifted norms relating to FP, IPV, and gender. To date, there are numerous normative change programs such as MFF in the field and going to scale. Many of these are doing so, however, with scant evidence for the desired normative change outcomes, due in part to challenges measuring social norms due to their multifaceted and contextual nature. In this case, we were able to develop rigorous Scales through statistical factor analysis for evaluation of the MFF intervention's impact on desired normative change outcomes related to gender equity and roles, FP, and IPV. In addition, these normative scales enabled interrogation of the different components of the MFF program theory of change for their relative effects on the MFF behaviors of interest, as discussed below.

Research findings

Baseline Qualitative Study findings

At baseline, we conducted in-depth interviews in eight experimental Protestant congregations with selected faith leaders, Gender Champions, and Community Dialogue participants to explore attitudes, behaviors, and social norms regarding IPV, FP, and positive masculinities, their interpretation of biblical Scripture related to these issues, and how they communicate and take action on these topics within their faith communities. Findings provided valuable context across the three research objectives. In particular, they provided additional insights into the relationships between social norms and MFF outcome behaviors prior to intervention-related to conceptions of masculinity, IPV, and FP.

First, regarding **conceptions of masculinity**, when asked what it means to be a man in their community, most respondents stated that the man is the head of the household, and a role model for his community. Respondents highlighted three main responsibilities: (1 marriage; (2 the capacity to provide for the household; and (3 being able to respond to the community's needs. A faith leader explained: "*In our community, a man has to be married to be called a man, because then the community knows that he is responsible for the household. Here we say that a man is someone who has a field and a fireplace. The fireplace is the women, and the field is his work.*"

Two thirds of respondents felt it was important that men accepted the responsibilities given by God for positively developing and leading a household, providing for their children's education, and meeting the needs of all of those who rely on them without becoming selfish and limiting women's authority within the household and community. However, about one-third of all respondents agreed that men were superior to women because '*man was created in the image of God before the woman.*' Women's views of masculine identity, as well as their own roles, did not differ greatly from those

described by men, although some female respondents felt that there were women who were more responsible than men, and who fulfilled their duties better. Specifically, they thought that some men exaggerated their role, which could create tension within couples. Most participants of both sexes said that they derived their conduct and way of life from biblical Scriptures, which advised men to love their wives and provide care, security, and protection, but also advised women to submit to their husbands. According to faith leaders, men were the masters of the household and were supposed to guide their households, including taking care of and educating children, cooking, and carrying out other household chores. While some men and Gender Champions viewed men helping women with household chores as non-masculine and weak, most male respondents thought that the husband should assist his wife in the home. Women agreed that when there is harmony in the home and men helped their wives with household chores, it demonstrated his power and love within the couple. Participants also highlighted that communication was an important foundation of harmony.

Regarding **IPV**, a male Community Dialogue participant shared, "*First, violence is not a good thing; it provides no solution. It is necessary to develop dialogue within the couple to solve all problems. Whatever the circumstances, violence is not acceptable in any form."* Regarding male violence against women, most respondents said there were no circumstances where violence would be accepted as a way to solve problems in a partnership, and cited laws stating that violence is a punishable offense. The best solution, no matter how serious the situation, was thought to be dialogue and correcting the partner with gentleness and patience, as taught by God.

Several types of violence were reported in interviews as common, including rape, early or forced marriage, sexual harassment, economic violence, physical violence, and verbal violence. The respondents acknowledged that a minority of men used violence to have sex with their wives or to settle a dispute in their homes. Some women normalized violence in a relationship, because they relied on a saying: *'kobunda to pe kosuana ezali pilipili pe mungua ya libala,'* which means that fights and quarrels work to strengthen a couple and their relationship. According to most respondents, the use of violence by men against their wives or partners was unacceptable, since marriage was a work of God that brought forth self-fulfillment and allowed procreation to fulfill the word of God: "*Go, multiply, and fill the earth and have a happy life. Those who loved their bodies should not seek to harm themselves, and a wife was a part of her husband's body" (Gender Champion).*

Participants reported mixed views of **FP**. According to some, the use of contraception was a seen as positive, because current social and economic situations had deteriorated, and people needed to plan births when there were fewer jobs and a struggle to make a living. According to these participants, God would approve of child spacing because "*He had created the whole mankind and had also given the opportunity and intelligence to manage what he had created*" (*Faith Leader*). Passages from the Bible were referenced as analogous to "*thinking through the resources required to finish building a house before starting*" (*Gender Champion*). In other words, people could have as many children as they wanted, but they had to ask whether, given the current situation, they would be able to provide full care for the children, educate them, and enable them to secure their future. Many other respondents, however, contended that the Holy Scriptures directed humans to multiply and fill the earth. Using FP, therefore, meant limiting God's abilities. While many agreed that FP was a very important option for young couples finding their way in a difficult socioeconomic climate, many noted that the community still largely disapproves of contraception use, especially among youth.

Further, many respondents stated that they believed most Christians would refuse to use condoms or withdrawal, believing them to be contrary to the Holy Scriptures. Respondents perceived that many Christian couples were using the rhythm method, which is based on a woman's menstrual cycle, as they believe that is the only method that conforms to Scriptures. *"Family planning is the best solution that allows us to properly assume our responsibility as parents. However, the best method remains the timing, as I have a normal menstrual cycle, and not the other methods that bring us complications and infections (Female Community Dialogue Participant).* Respondents from all

groups believed that both partners should be involved in FP decision-making, because this matter concerned both, for the welfare of their home. Furthermore, many respondents stated that a wife should not keep contraception use a secret because it may breed distrust and show a lack of confidence in her husband. A responsible husband was thought to be one who helped his wife space births and supported her in the use of modern contraception. Participants acknowledged that some men, however, did not assume their responsibilities and needed additional information about FP.

According to faith leaders, people should be able to assume their own responsibilities because the Bible did not make any explicit reference to child spacing, and did not clearly determine the number of children a couple *should* have. *"The Bible says, 'Multiply, be fruitful, and fill the earth.' However, the Bible is not against family planning, because people must be well-educated, otherwise they may create problems. Every couple must first assess their means to determine the number of children they must have to assume their responsibilities. Therefore, the Bible also teaches family planning" (Religious Leader).*

The results of this baseline qualitative study indicated that at baseline, most respondents did not question male domination in the cultural context, but stated that such privilege also comes with a responsibility. A 'real man' gains his authoritative position through his skills as a non-violent leader and ability to produce, provide for, and protect the family. These perceptions were heavily influenced by respondents' perceptions of biblical Scripture, confirming relevance and opportunity of the MFF intervention. Whether related to violence or reproductive health, most women also reinforce those norms through their gendered expectations of men. At the same time, many respondents valued 'harmony in the household' through communication, shared household work and decision-making, and the ability to provide for the family's needs and desires. The findings also demonstrated specific opportunities for MFF messaging relating to couple communication, gender-equitable household roles, FP use, and conflict in relationships for intervention components.

Quantitative Couple Survey findings

We conducted surveys in eight experimental and nine comparison Protestant congregations with eligible young couples at baseline and again, after 18 months of the MFF intervention. In the survey, we explored attitudes, behaviors, and social norms, as well as personal self-efficacy, relationship quality, and couple communication regarding IPV, FP, and positive masculinities. Findings were relevant for research **Objectives 1 and 2**; to determine change in MFF outcome behaviors and social norms, as well as the relationships between social norms, outcome behaviors, and other key concepts in the program ToC. Results for the quantitative couple survey are organized below into outcome behaviors (FP use, IPV, and positive masculinities) as well as social norms findings.

The sample at baseline included 425 individuals in the comparison population and 476 individuals in the intervention population as seen in **Table 6**. At endline, there were 384 individuals in the comparison population and 407 individuals in the intervention population. Samples for both intervention and comparison congregations were fairly evenly split among men and women. Although there was a higher proportion (59.7%) of individuals in a newly married couple at baseline, by endline, the majority (57.0%) of individuals were classified as first-time parents. Intervention and comparison samples were relatively similar demographically, with similar age, education, and religiosity breakdowns. There were small but significant differences comparing samples by urban/peri-urban status.

Table 6: Intervention Target Groups

	Baseline, Comparison	Baseline, Intervention	p-value*	Endline, Comparison	Endline, Intervention	p-value †
Total (n)	**425**	**476**		**384**	**407**	
Sex			0.105			0.735
Men	180 (42.4%)	228 (47.9%)		189 (49.1%)	206 (50.6%)	
Women	245 (57.6%)	248 (52.1%)		195 (50.9%)	201 (49.4%)	
Target group			0.477			0.560
Newly married couples	259 (60.9%)	279 (58.6%)		161 (41.9%)	179 (44.0%)	
First-time parents	166 (39.1%)	197 (41.4%)		223 (58.1%)	228 (66.0%)	

* Comparing intervention and comparison samples at baseline
† Comparing intervention and comparison samples at endline

FP use: Respondents were asked whether they were currently doing anything to prevent pregnancy, and, if so, what. Based on their responses, they were categorized as using any contraception, modern contraception, short-acting method of modern contraception, long-acting reversible contraception (LARC) or permanent method, fertility awareness method (FAM), and traditional or other method (see **Table 7**). Details on the methods included in each of these categories is provided in the detailed endline report, which shows self-reported voluntary use of contraception. Data from pregnant couples were excluded. At endline, 53.4% of all non-pregnant respondents from intervention congregations reported that they were currently using a modern method of contraception voluntarily within their relationship, compared to 40.1% at baseline, suggesting that more couples wanting to use modern contraception were using it at endline. This was a large improvement from 40.1% of respondents in intervention congregations reporting using modern contraception at baseline. It was also a statistically significant ($p<0.05$) difference compared to 45.3% of respondents in comparison congregations reporting voluntary use of modern contraception at endline. Short acting methods were the most common method used among intervention populations at endline (41.9%).

Table 7: Contraception Use

	Baseline, Comparison	Baseline, Intervention	p-value*	Endline, Comparison	Endline, Intervention	p-value†
Total (n), non-pregnant couples	**372**	**412**		**318**	**339**	
Currently use any MC method‡	144 (38.7%)	165 (40.1%)	0.702	144 (45.3%)	181 (53.4%)	**0.038**
Currently using short-acting method§	128 (34.4%)	148 (35.9%)	0.658	120 (37.7%)	142 (41.9%)	0.277
Currently using LARC/permanent method‖	6 (1.6%)	12 (2.9%)	0.225	13 (4.1%)	19 (5.6%)	0.367
Currently using FAM method¶	14 (3.8%)	14 (3.4%)	0.783	20 (6.3%)	34 (10.0%)	**0.081**

* Comparing intervention and comparison samples at baseline
† Comparing intervention and comparison samples at endline
‡ MC (modern contraception) methods includes: condoms, oral contraceptive pills, injectables, implants, intrauterine devices (IUD), sterilization, Standard Days Method (SDM), lactational amenorrhea method (LAM)
§ Short-acting methods includes: condoms, oral contraceptive pills, injectables
‖ LARC (long-acting reversible contraception)/permanent methods includes: implants, IUD, sterilization
¶ FAM (fertility awareness methods) includes: SDM, LAM

Experience of or perpetration of IPV: Male respondents were asked if they had perpetrated acts of emotional, physical, and sexual violence against their wives in the previous 12 months, and specifically, violence to discourage FP use (**Table 8**). Women were also asked whether they had experienced these forms of violence in the previous 12 months (reported separately in **Table 9**). At endline in intervention congregations, 61.7% of men reported perpetrating and 62.2% of women reported experiencing any form of IPV. For men, this was a statistically significantly ($p<0.05$) lower proportion of men reporting perpetrating any IPV in intervention congregations compared to men in comparison congregations (71.9%). However, there were no statistically significant differences comparing women experiencing any IPV in intervention and comparison congregations (66.4%) at endline.

Looking at changes in IPV by type, men in intervention congregations were statistically significantly ($p<0.05$) less likely to report perpetrating emotional violence (54.8%) compared to men in comparison congregations (64.8%). Men in intervention congregations tended to report less perpetration of all forms of IPV, but significant ($p<0.05$) differences among intervention and comparison men were only observed for using violence to discourage FP use (6.5%) in intervention congregations compared to men in comparison congregations (11.0%). Similar to men, women in intervention congregations were statistically significantly ($p<0.05$) less likely to report experiencing emotional violence (54.1%) compared to women in comparison congregations (61.1%). However, no significant differences were observed for other types of IPV reported by women.

Table 8: Perpetration of Intimate Partner Violence—Men

In the previous 1 yr., has perpetrated some form of…	Baseline, Comparison	Baseline, Intervention	p-value*	Endline, Comparison	Endline, Intervention	p-value †
Total (n)	**180**	**228**		**150**	**206**	
Emotional violence			0.217			**0.018**
Often/sometimes	103 (58.5%)	144 (64.6%)		94 (64.8%)	109 (54.8%)	
Never	73 (41.5%)	79 (35.4%)		51 (35.2%)	90 (45.2%)	
Physical violence			0.503			0.321
Often/sometimes	53 (30.3%)	61 (27.2%)		41 (28.1%)	47 (23.4%)	
Never	122 (69.7%)	163 (72.8%)		105 (71.9%)	154 (76.6%)	
Sexual violence			0.553			0.441
Often/sometimes	20 (11.3%)	29 (12.9%)		22 (15.2%)	21 (10.6%)	
Never	156 (88.6%)	196 (87.1%)		123 (84.8%)	178 (89.4%)	
Violence to discourage FP use			*0.090*			**0.041**
Often/sometimes	18 (10.2%)	27 (12.1%)		16 (11.0%)	13 (6.5%)	
Never	158 (89.8%)	197 (87.9%)		130 (89.0%)	188 (93.5%)	
Any violence	118 (67.1%)	158 (70.5%)	0.454	105 (71.9%)	124 (61.7%)	**0.047**

* Comparing intervention and comparison samples at baseline
† Comparing intervention and comparison samples at endline

Table 9: Experience of Intimate Partner Violence—Women

In the previous 1 yr., has experienced some form of…	Baseline, Comparison	Baseline, Intervention	p-value*	Endline, Comparison	Endline, Intervention	p-value †
Total (n)	**245**	**248**		**234**	**201**	
Emotional violence			0.483			**0.049**
Often/sometimes	141 (58.0%)	135 (54.9%)		140 (61.1%)	106 (54.1%)	
Never	102 (42.0%)	111 (45.1%)		89 (38.9%)	90 (45.9%)	
Physical violence			0.943			0.549
Often/sometimes	46 (19.0%)	47 (19.3%)		46 (20.4%)	35 (18.0%)	
Never	196 (81.0%)	197 (80.7%)		180 (79.7%)	159 (82.0%)	
Sexual violence			1.000			0.548
Often/sometimes	35 (14.4%)	35 (14.4%)		26 (11.9%)	27 (13.9%)	
Never	208 (85.6%)	208 (85.6%)		193 (88.1%)	168 (86.2%)	
Violence to discourage FP use			0.650			0.631
Often/sometimes	25 (10.3%)	25 (10.2%)		15 (6.6%)	11 (5.7%)	
Never	217 (89.7%)	221 (89.8%)		214 (93.4%)	183 (94.3%)	
Any violence	160 (66.7%)	155 (63.8%)	0.506	148 (66.4%)	120 (62.2%)	0.373
* Comparing intervention and comparison samples at baseline						
† Comparing intervention and comparison samples at endline						

Social norms measures across outcomes: Table 10 presents the results from tabulating scale and index scores from the social norms measures (*described above*). Scores range from 0 to 4, with higher numbers signifying our hypothesized change of norms (FP use perceived as *more* typical and accepted behavior, IPV perceived as *less* typical and accepted behavior, and male engagement in household work and childcare as *more* typical and accepted behavior). For social norms relating to perceptions of FP use as typical (descriptive norms) and accepted (injunctive norms) behavior among reference groups, we saw increases in perceptions of FP use as typical and accepted behavior in intervention congregations from baseline to endline. However, increases occurred in comparison populations as well, and at endline, there was no statistically significant difference comparing intervention and comparison populations for social norms measures relating to FP.

For social norms measures relating to IPV, we unexpectedly saw an increase in perceptions that IPV was a typical behavior in congregations (IPV descriptive norms) from baseline to endline in both intervention and comparison congregations. At the same time, we saw slight decreases in perceptions that IPV was accepted behavior among their reference groups from baseline to endline in intervention and comparison populations. At endline, we observed that respondents in intervention congregations were statistically significantly ($p<0.05$) more likely to report that IPV was more acceptable in their congregations compared to respondents in comparison congregations. We are uncertain of the nature of this unintended consequence, and will be exploring this finding with additional qualitative research.

Finally, there were slight increases from baseline to endline in perceptions that male engagement in household work and childcare were typical and accepted behavior in their reference groups. However, these perceptions improved in comparison congregations as well, and at endline, and there were no statistically significant differences between intervention and comparison samples.

Between baseline and endline, men and women reported a shift in those individuals whose opinions matter to them (i.e. their reference groups) for voluntary use of modern contraception. In both intervention and comparison congregations, more participants at endline considered their partner and/or a health worker as important reference groups, and fewer listed their faith leaders,

mothers/in-law, or fathers/in-law as key reference groups, and there were no significant differences in these changes, comparing intervention and comparison groups. Notably, this finding was not anticipated, as it was not a change that was targeted in the intervention, nor was it a hypothesized outcome in the ToC.

Table 10: Social Norms Measures

As perceived by respondent…	Baseline, Comparison	Baseline, Intervention	p-value	Endline, Comparison	Endline, Intervention	p-value
Total (n)	**425**	**476**		**384**	**407**	
FP descriptive norms: mean (SD)	1.98 (0.68)	2.08 (0.73)	**0.039**	2.17 (0.59)	2.24 (0.67)	0.132
FP injunctive norms; mean (SD)	2.84 (0.47)	2.91 (0.54)	**0.040**	2.95 (0.53)	2.97 (0.46)	0.581
IPV descriptive norms: mean (SD)	3.33 (0.79)	3.30 (0.78)	0.548	3.13 (0.69)	3.08 (0.76)	0.357
IPV injunctive (faith community) norms (women only): mean (SD)	3.12 (0.40)	3.12 (0.41)	0.938	3.26 (0.52)	3.17 (0.41)	**0.011**
IPV injunctive (husband/important others) norms (women only): mean (SD)	3.17 (0.41)	3.14 (0.38)	0.376	3.32 (0.47)	3.25 (0.41)	**0.014**
IPV injunctive norms (men only): mean (SD)	3.17 (0.38)	3.15 (0.38)	0.495	3.30 (0.43)	3.22 (0.37)	**0.003**
HH work norms: mean (SD)	2.65 (0.62)	2.64 (0.65)	0.964	2.80 (0.66)	2.84 (0.55)	0.296
Childcare norms; mean (SD)	3.08 (0.47)	3.06 (0.51)	0.675	3.14 (0.57)	3.15 (0.47)	0.868

Scores range from 0 to 4, with higher numbers signifying our hypothesized change of norms (FP use perceived as more typical and accepted behavior, IPV perceived as less typical and accepted behavior, and male engagement in household work and childcare as more typical and accepted behavior).
* Comparing intervention and comparison samples at baseline
† Comparing intervention and comparison samples at endline

Looking at other aspects of the MFF ToC (**Figure 4**) there were large, significant differences in individual attitudes at endline, with respondents in intervention congregations significantly ($p<0.01$) more likely than comparison congregations to agree that both newly married couples and first-time parents can voluntarily use modern contraception. There were also significant differences in self-efficacy, with respondents in intervention congregations significantly ($p<0.01$) more likely to report that they could suggest using modern contraception to their partner, and that they could use modern contraception if they desired. There were also improvements in FP communication between partners, with respondents in intervention congregations significantly ($p<0.01$) more likely to report speaking with their partner about RH topics in the previous one year, compared to endline results from respondents in comparison congregations. However, there was no difference in the involvement of women in FP decision-making, comparing respondents in intervention and comparison congregations at endline.

What about outcomes by newly married couples and first-time parents?
Outcomes were looked at separately for newly married couples (**Table 11**) and first-time parents (**Table 12**) to assess the effect of the MFF intervention on both sub-populations.

For FP, at endline, 44.2% of **newly married couple** members reported using a method of modern contraception voluntarily within their relationship. This was a large improvement from 34.3% at baseline, suggesting that more newly married couples wanting to use modern contraception were using it at endline. However, this was not statistically significant, compared to 41.5% of newly married couples using modern contraception at endline in the comparison congregations. **For first-time parents**, however, 44.6% of those in intervention congregations reported using a method of modern contraception voluntarily within their relationship at endline, which was significantly higher than 35.1% of first-time parents reporting using modern contraception in intervention congregations at baseline, and statistically significantly ($p<0.05$) higher than 34.9% of first-time parents in comparison congregations at endline.

For IPV, at endline, 62.0% of **newly married couple** members reportedly experienced or perpetrated any form of IPV in the previous 12 months. This was slightly lower than 67.2% of newly married couple members reporting this at baseline, but was not statistically significantly different compared to newly married couple members in comparison congregations at endline (66.9%). There were few differences comparing newly married couple members in intervention and comparison congregations at endline, comparing types of IPV experienced or perpetrated, except that newly married couple members in intervention congregations were marginally statistically significantly ($p<0.10$) less likely to report experiencing or perpetrating emotional violence in their relationship.

For **first-time parents** at endline, 61.9% of those in intervention congregations reportedly experienced or perpetrated any form of IPV in the previous 12 months. This was lower than 66.8% of first-time parents reporting this at baseline, and was marginally statistically significantly ($p<0.10$) lower compared to 69.6% of first-time parents in comparison congregations at endline. Lower proportions of first-time parents in intervention congregations reported experiencing or perpetrating emotional (54.0% vs. 61.1%) and physical violence (18.7% vs. 24.7%), but this was not a statistically significant difference. However, first-time parents in intervention congregations were statistically significantly ($p<0.05$) less likely to report experiencing or perpetrating violence to discourage FP use (5.1%) compared to 11.0% reporting this in comparison congregations.

Table 11: Outcomes for Newly Married Couples

	Baseline, Comparison	Baseline, Intervention	p-value	Endline, Comparison	Endline, Intervention	p-value
Total (n)	**250**	**265**		**152**	**165**	
Currently use MC	88 (35.2%)	91 (34.3%)	0.838	63 (41.5%)	73 (44.2%)	0.615
Experienced/ perpetrated emotional IPV	143 (57.9%)	157 (60.4%)	0.569	96 (64.9%)	87 (55.1%)	**0.081**
Experienced/ perpetrated physical IPV	55 (22.2%)	53 (20.4%)	0.622	31 (21.4%)	38 (23.8%)	0.621
Experienced/ perpetrated sexual IPV	25 (10.1%)	24 (9.2%)	0.734	12 (8.4%)	16 (10.0%)	0.629
Experienced/ perpetrated any violence to discourage FP use	23 (9.4%)	26 (10.0%)	0.827	6 (4.1%)	12 (7.5%)	0.203
Experienced/ perpetrated any violence	160 (65.8%)	174 (67.2%)	0.751	97 (66.9%)	98 (62.0%)	0.376

Table 12: Outcomes for First-Time Parents

	Baseline, Comparison	Baseline, Intervention	p-value	Endline, Comparison	Endline, Intervention	p-value
Total (n)	**175**	**211**		**232**	**242**	
Currently use MC	56 (32.0%)	74 (35.1%)	0.525	81 (34.9%)	108 (44.6%)	**0.031**
Experienced/ perpetrated emotional IPV	101 (58.7%)	122 (58.4%)	0.945	138 (61.1%)	128 (54.0%)	0.125
Experienced/ perpetrated physical IPV	44 (26.1%)	55 (26.4%)	0.929	56 (24.7%)	44 (18.7%)	0.121
Experienced/ perpetrated sexual IPV	30 (17.4%)	40 (19.2%)	0.654	36 (16.3%)	32 (13.7%)	0.434
Experienced/ perpetrated any violence to discourage FP use	20 (11.6%)	26 (12.4%)	0.793	25 (11.0%)	12 (5.1%)	**0.020**
Experienced/ perpetrated any violence	118 (68.2%)	139 (66.8%)	0.775	156 (69.6%)	146 (61.9%)	*0.079*

Quantitative Diffusion Survey findings

We conducted surveys in eight experimental and nine comparison Protestant congregations with wider congregation members at baseline and again, after 18 months of MFF intervention. In the survey, we explored congregational perceptions of social norms relevant for MFF outcome behaviors and communication between congregational members regarding these topics. Findings were relevant for the third research objective; to understand diffusion of MFF messaging within wider religious congregations, as posited by the program ToC.

Finally, **Table 13** reports on key variables from the quantitative diffusion survey administered to individual members of the congregations. We saw increases in diffusion of intervention messages and new information around FP, IPV, and gender roles from baseline to endline in intervention congregations. However, diffusion of similar messaging was also occurring in comparison congregations, and there was little difference in diffusion outcomes at endline, when comparing intervention and comparison congregations. Despite not finding significant differences comparing intervention and comparison congregations, we did see some indication that diffusion was increasing from baseline to endline, and particularly for communication around gender roles. Results from both the couple and diffusion surveys suggest that the influence of faith leaders weakened from baseline to endline. We are uncertain if this is an artifact of larger sociocultural trends, but the assumption that faith communities and leaders act as important reference groups needs to be critically examined in light of this finding.

Table 13: Communication and Diffusion into the Broader Congregations

In the last 3 months…	Baseline, Comparison	Baseline, Intervention	p-value	Endline, Comparison	Endline, Intervention	p-value
Total (n)	**634**	**623**		**590**	**667**	
Spoke to someone about FP			0.250			0.225
Never	497 (78.4%)	516 (82.8%)		417 (70.7%)	466 (69.9%)	
Once	68 (10.7%)	51 (8.2%)		96 (16.3%)	101 (15.1%)	
> once	69 (10.9%)	56 (9.0%)		77 (13.1%)	100 (15.0%)	

Spoke to someone about IPV			0.581			0.142
Never	460 (72.6%)	458 (73.5%)		399 (67.6%)	413 (61.9%)	
Once	88 (13.9%)	92 (14.8%)		88 (14.9%)	107 (16.0%)	
> once	86 (13.6%)	73 (11.7%)		103 (17.5%)	147 (22.0%)	
Spoke to someone about gender roles			0.436			**0.002**
Never	449 (70.8%)	461 (74.0%)		394 (66.8%)	390 (58.5%)	
Once	94 (14.8%)	73 (11.7%)		86 (14.6%)	128 (19.2%)	
> once	91 (14.4%)	89 (14.3%)		110 (18.6%)	149 (22.3%)	

These results suggest a number of trends. At endline, we observed a statistically significantly higher proportion of newly married couples and first-time parents reporting use of a modern method of FP in intervention congregations, compared to comparison congregations. In addition, we saw significant reductions in the proportion of men reporting perpetrating emotional IPV in intervention congregations, compared to comparison congregations. While perceptions of typical and accepted behaviors for FP, IPV, and gender roles did improve from baseline to endline, we did not see significant differences in our norms measures at endline comparing intervention and comparison congregations. Although we saw behavioral shifts relative to comparison groups, these did not fully correspond to observed normative shifts as expected from our TOC (Figure 4). Additional reflections are shared below in research limitations and in **Section 6**.

Research limitations

It is important to interpret these results with caution, given the challenges of carrying out the study as designed, and biases inherent in collecting self-reported information on sensitive topics. The pilot study led the MFF team to derive several recommendations for researchers, implementers, and policy-makers alike, summarized in **Table 14** and further below.

Although the intervention and study were designed at baseline as a cluster randomized control trial, several recruitment and sampling challenges altered this design, including insufficient numbers of eligible couples across congregations, more mobility than anticipated between congregations over the course of the intervention, the endline enrollment period coinciding with the run up of the 2018/2019 national elections in the DRC, and a prolonged period of economic instability. This affected the frequency of congregation attendance and the mobility of congregants, resulting in challenges in retaining and following up with the baseline respondents at endline. For these reasons, the study reverted to an intention-to-treat analysis and treated the surveys as two cross-sectional surveys at baseline and at endline. The change in study design limits the ability to establish causation, specifically that the intervention directly caused the changes in target outcomes. This study was two points in time with differing populations, and, therefore, does not provide robust estimates of change solely because of the intervention.

Survey responses at endline could have been affected by MFF messaging, as it may have potentially sensitized respondents in ways that could affect results (e.g., a respondent might be more likely to report high prevalence of IPV in their community than before, because they are now more aware of what constitutes IPV). Additionally, the intervention aims to promote wide diffusion of messaging, which makes it challenging to assess exposure to the intervention in a meaningful manner. Despite changes in the design, the study still includes two representative samples with sufficient statistical power to compare intervention and comparison congregation samples at baseline and at endline, and provides some evidence for change during this limited timeframe. In addition, the diffusion survey and couple survey conducted among separate samples and with different measures, appear to

broadly align in trends, particularly when comparing social norms measures between the samples. Full endline results can be found in the 2020 published endline report.

Additional investigation is underway in 2020, with future qualitative work consisting of three objectives to provide context and better understand findings from research discussed in this report. This research will seek to describe: 1) from whom and with whom young men and women receive and share information, respectively, on FP use, reproductive health, and IPV in intervention and comparison sites; 2) how young men and women in intervention and comparison sites processed, internalized and made decisions regarding FP, reproductive health, and IPV; and 3) how young men and women engaged in MFF and/or other FP or IPV programming in intervention and comparison sites.

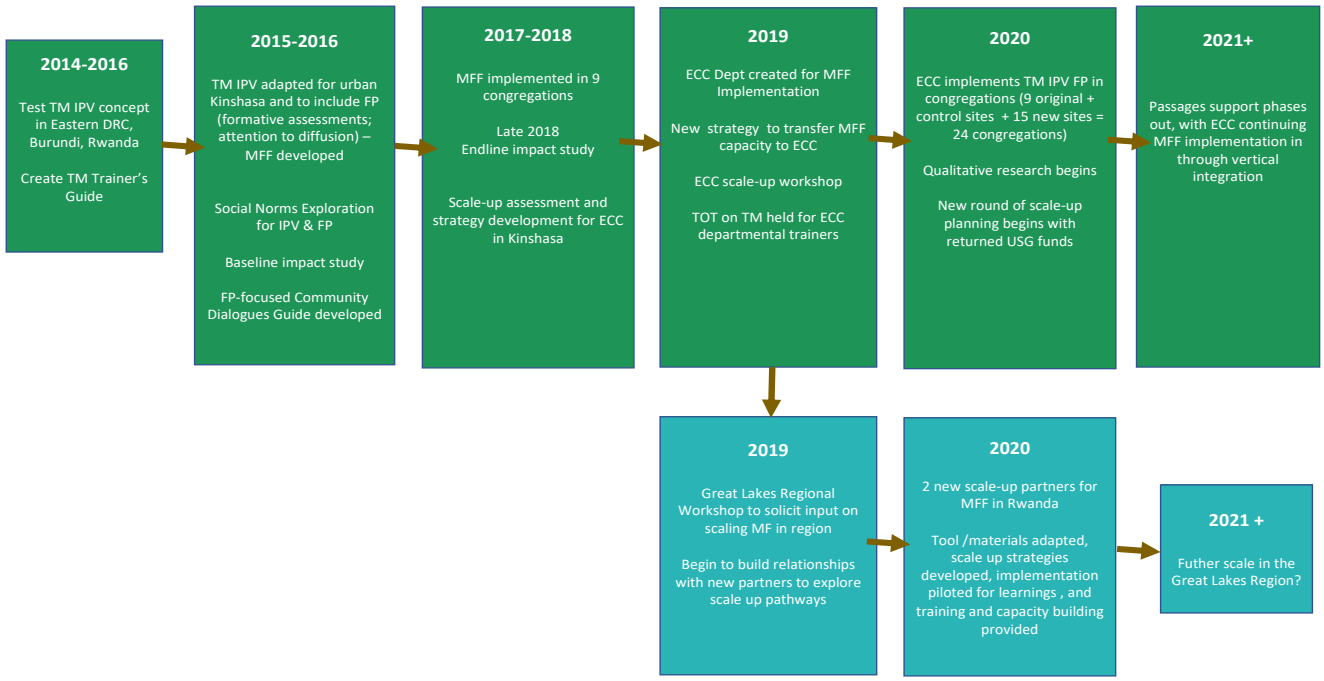
Table 14. Broad recommendations gleaned from our evaluation for future investigation

Theoretical (guiding formative research)	**Methodological** (guiding research design and implementation)
• **Understand differences in intervention** between **social networks in urban vs. rural congregations** • **Understand additional reference groups, outside faith communities** • **Better understand the shifting influence of faith leaders as reference groups for outcome behaviors (shift to spouse), and what shifting reference groups means for programs** • **Explore the role and influence of cross-cutting (meta) norms for MFF target behaviors**	• Ensure linguistic and cultural interpretations of items are clear and accepted, particularly as they relate to local understanding of norms • Develop, test, and administer valid and reliable social norms scales • Conduct sensitivity analysis to strengthen social norms scales • Assess other behavioral influences on behavioral outcomes • As feasible, test alternative normative items to improve discernment of differences between populations with very high approval across sub-populations (e.g., injunctive IPV norms)

Section 5
Poising and Planning for Scale up and Replication of Masculinite Famille, et Foi

Designing and planning for scalability

Figure 10. MFF Scale Up Pathway



In preparation and anticipation of a successful pilot, the MFF intervention was designed for scale (guided by the ExpandNet framework) from conception, in order to maximize its impact and reach. MFF includes specific characteristics to create a smooth transition from pilot to scale up and replication. First, there is a simplicity in the innovation, which uses easy language to explain concepts, practical activities, and engaging discussion. Also, MFF is designed to be embedded within existing communities and structures, specifically within existing congregation activities. This choice was made to foster institutional leadership and ownership for the MFF activities within individual congregations and throughout the ECC leadership hierarchy. Finally, the intervention is designed to scale up youth-friendly health services through the existing health clinics network near the ECC congregations, to establish the appropriate linkages for MFF participants.

The national leadership of ECC was engaged from the start of planning, and participated in the initial faith leader workshops in October 2016, as well as the first stakeholder meeting in May 2017. They also participated in a subsequent stakeholder meeting in October to continue sharing implementation progress and invite feedback. Given ECC's central role scaling up and institutionalizing MFF, we continued to hold bi-annual stakeholder engagement days with their national leadership. These meetings provided an opportunity to share updates on participation in the Community Dialogues, health clinic utilization based on ASF data, and testimonies from couples, Gender Champions, and faith leaders involved in the project. It was also an important space to

address challenges and concerns raised by the ECC leadership, and to emphasize the purpose of the pilot as a precursor to scale up, as well as obtaining input on ownership of the project and the scale up strategy. A scale up meeting with key stakeholders, including ECC leadership, took place in October 2018 to ensure agreement on the proposed scale-up strategy. In addition, the TAG, described above, acted as a guiding body for intervention activities and the feasibility of future scale up.

Costing to inform implementation & scale up

As discussed in **Section 3**, an activity-based costing study was carried out by the project team throughout years 1-3 of the project to better understand costs, both monetary and in-kind, that were incurred at each phase of the project's implementation, in order to inform scale up planning and ongoing sustainability/ownership. In summary, the overall cost of resources used to implement the intervention over a three-year period was approximately $610,000. Just under one-third of the resources was used to prepare for intervention implementation and stakeholder engagement. Over one-third of resources was used to support the core intervention components, dominated by the ongoing Community Dialogues with young couples, men, and women. The remaining one-third of resources was used to prepare for the planned scale up piloting and ownership transition of the intervention by building the capacity of local staff, and for indirect support (including program monitoring, as well as overhead costs, such as office rent and expenses, bank fees, and audit costs). Costing insights were a valuable resource in informing future plans to integrate the MFF approach within ECC structures, and, in a more generalized application, informing scale up and replication in new geographies as well.

Building ownership with partners

ECC is best positioned to be the primary user organization for scale up, as it is the largest Protestant church organization in the DRC. The wide network of ECC congregations in Kinshasa and throughout DRC offers the opportunity to enable horizontal scale-up in 300,000+ parishes countrywide, with the potential to diffuse up to 25 million members. In addition, the ECC leadership's buy-in of the pilot intervention in the initial 8 intervention congregations has created an appetite for implementation in the 9 control congregations, and then wider interest for the 15 additional congregations, to total 24 congregations in Kinshasa. Significantly, MFF can be institutionalized into ECC's existing departments and theological teaching across thousands of churches across the DRC. To support the scale-up strategy, and as an expression of their commitment to MFF, ECC voted to establish a specific "MFF Department" to oversee the scale up throughout the organization.

Handover and transitions:

Kinshasa adaptation and integration

As part of handing over MFF to ECC for scale up, several workshops were conducted in September and October 2019 with ECC leadership and heads of departments interested in adapting the MFF model, then institutionalizing and expanding the approach within their existing activities. The MFF pilot was run through the Deaconry department within ECC, but other departments were also interested. The MFF ECC team carried out a mapping of 8 ECC structures to document how they engage with parish-level activities, their knowledge and understanding of the MFF project, and how they thought MFF could be integrated into their work. These departments were: The National Federation of Protestant Women, The Federation of Protestant Youth, The National Federation of Protestant Men, The Kinshasa Pastors' Council, the Theology Commission, the Department of Evangelism, the Department of Christian Education, and the Department of Lay Ministers. The mapping highlighted that some departments were better suited to the integration due to their support and links with parish-level activities, for example, the Youth and Women's departments, which were responsible for youth and women's groups at the parish-level through DRC, while the

Theology Commission had less oversight and communication with parish level leaders. On the basis of this mapping, six of the ECC departments were invited to attend the integration workshops. These workshops were key in developing buy-in among ECC department heads for MFF integration, and their attendance indicated high levels of perceived need, acceptability, and commitment for MFF. The September 2019 workshop was also the first time that faith leaders were trained with their spouses – at ECC's request – to ensure couples at the leadership level were on a shared journey of gender transformation. The workshop provided space for department heads to reflect on IPV and FP in their communities, understand the MFF model in detail, and better understand its impact in the pilot phase, through monitoring data and qualitative feedback. Following a SWOT analysis, the ECC project team refined the selection to 4 departments selected for their interest and engagement, their national networks, and the alignment of MFF with their existing focus and activities.

Table 15. ECC Departments leading MFF integration into activities

ECC DEPARTMENT	*PROGRAMS AND PATHWAYS TO SCALE*
National Federation of Protestant Women	• Oversees women's activities in all parishes • Ability to mobilize large number of female volunteers • Access to number of training and retreat centers • Ability to mobilize funding • Membership drawn from across DRC – diversity of Congolese cultures and provinces
The Federation of Protestant Youth	• Strong links with youth groups in all ECC parishes • Engaged and active group of youth volunteers • Openness to new ideas and approaches
The National Federation of Protestant Men	• Oversees activities of men's groups across ECC parishes • Work in effective collaboration with Youth and Women's federations
The Kinshasa Pastors Council	• Regular contact and communication with all pastors in Kinshasa • Ability to integrate MFF into theology teaching • Influence in biblical studies and theological training

In October 2019, a four-day training of trainers workshop on TM to support MFF scale-up was organized in Kinshasa. The purpose of this workshop was to increase the internal training capacity on the approach within ECC ahead of scaling up.

The ECC scale up strategy focuses on institutionalization (vertical expansion) within leadership and ECC departments and piloting activities (horizontal expansion) in 24 new congregations to build a large network of TM or MFF supporters. Core scale up activities include:

1. **Integrate MFF activities into 4 key ECC departments: The National Federation of Protestant Women, The Federation of Protestant Youth, The National Federation of Protestant Men, and The Kinshasa Pastors' Council.** These four departments champion MFF at the ECC executive level and plan activities in their spheres of interest, for example, sessions on MFF in national conferences for youth, and for women in church and political leadership. The departments will also hold trainings for their members at the national, provincial, and parish level. For example, training 60 female pastors in Kinshasa in MFF, and training 80 youth leaders overseeing pre-marriage counselling. In addition to their own activities, each department supports and encourages the parish level leaders linked to their ministries (women, youth, etc.) in their implementation of MFF.

2. **From pilot adjustments, implement MFF in 24 congregations in Kinshasa, using the original 9 control sites and an additional 15 congregations selected by ECC.** Selection criteria included that the congregation had more than 300 members, that there was a known health clinic nearby for FP referrals, and the congregation was aligned with ECC policies and statutes. More congregations are interested in the project, however, 24 was

agreed upon as a feasible number to support in this phase of scale up. In scale up, it was decided to remove the age criteria so that all interested couples could participate. In order to reduce costs to increase sustainability, the service linkages have been adapted with Gender Champions directing participants to the nearest *Confiance* clinic for further FP information at the end of the Community Dialogues, rather than inviting a health worker to attend.

3. **Radio broadcasts are planned with 3 national radio stations (Radio ECC, Radio Sango Malamu and Top Congo FM) to diffuse MFF messaging across DRC.** Radio ECC (3 million listeners) and Radio Sango Malamu (5 million listeners) will each broadcast 17 MFF-focused radio programmes twice a week over 5 months. These are a series of 15-minute-long pre-recorded segments unpacking the importance of FP, issues of SGBV, and positive masculinity, based on the MFF curriculum which air during the MFF intervention period. These stations are popular stations in Kinshasa and Gender Champions and faith leaders will also encourage congregations to listen to these shows.

   A series of five 90-minute radio shows will also be broadcast on Top Congo FM (over 12 million listeners) on MFF topics each month during the same intervention period. Members of the ECC MFF project team and senior ECC leaders trained in MFF will each discuss set topics, and will include a call-in section for listeners' questions and discussions with the ECC MFF presenters.

4. **Support and cultivate cultural activities**. Suggested and led primarily by the supporting structure, the Federation of Protestant Youth will use drama, song, poetry, and spoken word to further disseminate intervention messages on FP, violence, and gender equality during Sunday services at 14 congregations, staggered over the 10 month intervention period. Following the artistic presentation, Gender Champions facilitate a conversation with attendees on the theme of the event. In each congregation, the youth work with the ECC Dram'Arts group to develop and deliver the sketches and presentations to build the skills of the youth to continue developing similar presentations.

A learning agenda will be conducted at the end of this scale up phase, involving review of monitoring data and FGDs with faith leaders, Gender Champions, and couples from both former control sites and new, additional congregations, as well as with ECC department heads. Learnings from this phase will enable ECC to make additional adjustments ahead of their continued scale up, and provide important insights for scaling of social norm interventions.

Positioning the Masculinite Famille, et Foi adaptation in the Transforming Masculinities journey to scale

In October 2019, Tearfund and IRH held an MFF workshop in Kigali, Rwanda, to explore scaling MFF within the Great Lakes region. Initially, this workshop was developed in response to the USAID funding restrictions on continuing scale up in Kinshasa, which then presented an opportunity to explore potential partnerships in the region with health-focused partners, both faith-based and secular. Passages and Tearfund offered the MFF model as a potential tool to both strengthen the work of NGOs already addressing GBV and/or FP/RH, as well as for those looking for a model to begin responding to these needs.

The Great Lakes regional workshop brought together 42 participants from over 16 organizations working in the region to: 1) learn about gender transformative work and evidence from the first adaptation of TM as MFF under Passages; 2) reflect on Tearfund's experience implementing and evaluating the TM pilot in eastern DRC; and 3) discuss possibilities for MFF adaptation and scale up. The workshop created space to share other regional NGOs' approaches, as well as present previously

developed TM scale up pathways and explore the interest of workshop participants in and potential partnerships for scaling and adapting the MFF approach.

Following the workshop, participants were invited to apply for a small amount of funding to enable adaptation of MFF to their contexts and scaling the innovation through their existing organizational activities. Six organizations applied and went through a review process assessing organizational capacity, existing portfolio, plans for sustainability, and alignment with Passages goals. The Association Mwana Ukundwa and Health Development Initiative were selected as scale-up partners to work with Passages for a period of 12 months, in order to position them for MFF scale up through 2021.

The workshop was also an opportunity for Tearfund to raise broader awareness of the intervention approach and to explore grounding for its uptake in implementation in other countries, as well as the DRC and Rwanda, outside of Passages funding. MFF has already been adapted in Plateau State Nigeria to include a component on peace-building and addressing social norms on gender, FP, and inter-religious relationships through funding from the John Templeton Foundation (July 2018-June 2021).

Box 9.
Developing the Implementation Guide to Transforming Masculinities

From 2019-2020, with Passages support, Tearfund led the development of detailed Implementation guidelines for implementing TM intervention. This is a hands-on guide to support implementers from deciding to take the intervention on, through the planning, adapting, implementing, and monitoring phases. Guidance and tools are also provided to facilitate use and uptake.

The implementation guide (**Box 9**), designed and written for replication of MFF by external organizations and other Tearfund country teams, has strengthened the core design of TM, and will enable existing partners to integrate FP into their work addressing IPV. The guide and learning process has also clarified the existing TM adaptations, which include FP, inter-religious relationships, female genital mutilation/cutting, and women's economic empowerment, while remaining focused on SGBV and addressing gender inequality.

Scale up will be implemented through 2021, and learnings documented by IRH together with Tearfund and new scale up partners in the DRC and Rwanda.

Section 6
Learnings and Future Directions

The MFF adaptation of TM, a gender-synchronized and transformative approach, sought to assess whether working with **faith-based organizations can be effective for shifting norms and sustaining behavior change** related to FP and IPV. Given the critical role men play in FP decisions, gender norms that influence and shape masculine norms, and the influence of religious texts on gender norms and FP, the adaptation focused on addressing the intersections of these, focusing on **newly married couples and first-time parents** for the core intervention activities. Designed for scale up, MFF operated at the community level, engaging faith leaders, Gender Champions, and young couples through transformative trainings, Community Dialogues, and organized diffusion to shift norms, complemented by linkages to strengthened youth-friendly health services. A research-to-action approach was used throughout implementation to assess progress, effectiveness, reach, and scalability, and to make adjustments throughout the project span, including formative research, pre/post evaluation, and program learning studies.

Throughout this final report, we've shared MFF's pathway from design, through implementation, evaluation, and scale up. Below, we share our broader synthesized learnings testing the hypothesis that working with faith communities can be effective for norms-shifting interventions. First, we narrow into MFF's contribution to answering this question, and second, we share broader learnings for the field. Finally, we share insights for scaling up norms-shifting interventions and final reflections on MFF's future directions.

Our learnings on working with faith communities to shift norms.

First, we synthesize learnings specific to working with faith leaders and communities to shift norms:

1. **Faith leaders act as powerholders and have great influence on forming or shifting norms influencing FP behaviors.** The MFF intervention was designed on the basis of previous work which emphasized the importance of faith leaders as key influencers and power holders within their communities, who have the potential to become advocates to shift social norms when positively engaged. The Social Norms Exploration Tool findings confirmed the importance of faith leaders as key social references for young couples, especially male couple members. The transformative trainings supported faith leaders to reflect on how power is held unequally in communities, specifically between men and women, but also within leadership hierarchies. Scriptural references and discussions on leadership as service and the equal value of all people fostered acceptance and commitment to the MFF intervention, addressing gender inequality and FP needs. The ethnographic studies also showed the importance of faith leaders' influence to reinforce harmful social norms, and the necessity of ongoing conversation with faith leaders to strengthen understanding to bring about positive change.

2. **In engaging faith leaders in implementation, strong partnerships are needed and, indeed, a critical success factor.** Faith communities, in addition to faith leaders as individuals, were highlighted as important reference groups for young couples in the formative research and baseline. These were individuals who hold other leadership positions, who join with members in faith activities, and broader religious communities. As such, it is important that the intervention worked with trained youth leaders (Gender Champions) within the model, engaged alongside the religious leaders, to have multiple spokespeople and role models to communicate messages to the congregation in their words and actions.

Regular communication and collaboration between religious leaders, Gender Champions, couples, and project staff were important for harmonizing project messaging and enabling smooth running of the project. Learning studies and reflection meetings also highlighted the importance of establishing strong relationships between the health providers, the faith leaders and Gender Champions through joint trainings and meetings to share knowledge and perspectives.

3. **Faith communities have great potential for diffusion of new ideas and behaviors, yet, there's much to learn about these social networks in urban settings.** The faith communities MFF worked with were bounded by shared values and belief systems. Through the monitoring data we saw that faith leaders spread MFF messaging to their broader congregations throughout the intervention timeframe, and couples' stories of change also interested the wider congregation – shown by the interest in participation from members beyond the target young couples – and the learning studies highlighted interest in diffusion activities, engagement of faith leaders, and the reach of the community mobilization events. The midline ethnography and evaluation confirmed that diffusion was occurring within the congregations, and also potentially between congregations, as seen in the cited exposure in control congregations. This raises the issue of faith congregations being an ideological community, but not always a closely geographically bounded one. Congregation members in Kinshasa travelled from their neighborhood in one part of the city to a church in another. This is positive for widespread diffusion of ideas, but raises challenges on how to reach a tipping point for normative change when individuals belong to multiple social networks. It also requires intervention monitoring tools to capture how diffusion is being spread within congregations, and to wider social circles outside the intervention sites themselves.

Our broader learnings for norms-shifting interventions.

Here, we provide our broader takeaways for norms-shifting interventions:

1. **A well-defined hypothesized pathway for norms change is helpful to guide implementation and evaluation, but the pathway of change may be complex.** The MFF theory of change hypothesized that shifting the normative environment would enable behavior change in the target outcomes and would precede these behavior changes. However, the relationship between behavior, attitudes, and norms proved to be complex and intertwined, as seen in the evaluation results which show more change in behaviors and attitudes, as well as self-efficacy, than norms. There is still more to be learned about the interplay of norms and behaviors and the timeframe in which such shifts may emerge. It is, therefore, helpful to define a pathway to change at the outset, but also important to revisit the theory of change during implementation as further insights are gained.

2. **In order to shift gender norms, programs should center power dynamics in a process of gender transformation to see sustained change.** The TM model centers discussion of unequal power distribution in society, especially between men and women, and uses scriptural reflection to challenge this inequality. Directly discussing unequal power, opportunities and resources held by men in the trainings and Community Dialogues is especially necessary when engaging with patriarchal institutions. Gender-balanced trainings and mixed facilitators forced male religious leaders to intentionally involve female religious leaders and listen to their experiences. The focus on Jesus Christ as a role model provided participants with an alternative narrative of servant leadership and positive, inclusive masculinity. The journey of change, however, is not linear, and the ethnographic research emphasized the importance of ongoing coaching and conversation with leaders to ensure

gender transformative messaging was maintained in diffusion activities.

3. **Segmenting individuals in life course transitions and applying a life course lens increased understanding of the specific norms relevant to FP and IPV for specific groups, and how to program to shift them.** Formative research through the Social Norms Exploration Tool demonstrated that both the reference groups (who influenced norms and subsequent behaviors) and the norms themselves varied between **newly married couples** and **first-time parents.** This provided both a challenge in program implementation to determine how best to engage the specific groups, and to know where to intervene for the biggest impact. Intervention messaging was adjusted to reflect the lived realities of newly married couples and first-time parents, and where different opportunities existed, for example, for supporting FP information and access. Results at endline demonstrated results that supported many shifts in supporting a more supportive normative environment for newly married couples in intervention sites, such as greater intention to use FP, increased communication with partners on FP and RH, and greater social support for newly married couples using FP (descriptive norms). However, a challenge for programs seeking to work with both groups concurrently is recognizing and tracking that those life course transitions may fall in short time frames, as those newly married may soon become first-time parents and programs may need to track those transitions.

4. **Programs seeking to shift norms should consider that reference groups may shift as a result of program activities.** Due to the complex nature of norms and shifting social structures, in addition to the program activities, social reference groups initially identified in formative research can change during the intervention period. Conducting the Social Norms Exploration Tool at the outset of MFF highlighted the importance of religious leaders, confirming a central piece of the intervention design. However, by the evaluation, religious leaders were less important overall, and priority was given to respondents' partners. It could, therefore, be useful to look at social reference groups at midterm to track any shifts and changes needed to reach the relevant groups.

5. **Monitoring shifts in norms during program implementation is challenging, but possible. Qualitative methods yield actionable findings.** Monitoring norms requires regular reflection on multiple forms of data and discussion of shared perspectives from project actors. Using adaptive management techniques for program implementation, integrating regular feedback meetings with participants, and monitoring visits by project staff that feed into reflection meetings with implementers and key stakeholders are all helpful in providing insight into possible shifts during the intervention timeframe. Learning studies gathering qualitative data alongside quantitative data can further guide implementers' understanding of any shifts that may be occurring. These studies need to be conducted and analyzed in a short period of time to allow interventions to respond to any implementation learnings.

Our learnings on evaluating norms-shifting interventions.

Here we share our learnings on the appropriateness of the research design and its ability to respond to research and programmatic objectives:

1. **Context must be carefully considered in designing research to effectively evaluate norms-shifting interventions, and randomized controlled trial (RCT) designs may not be the most appropriate for a given context.** The evaluation of MFF was originally conceived as a cluster-RCT design, which could not be maintained from baseline to endline. This was due to a number of factors, most directly to significant loss to follow-up from baseline to endline and contamination between intervention and comparison

sites. We continue to try to understand the factors that led to such a high degree of loss to follow-up and contamination, including the nature of the intervention (e.g., mobile and urban population), the nature of the research design (e.g., proximity of intervention and comparison congregations), and sociopolitical context (e.g., conducting the endline during an economic downturn and lead up to an election). While our ability to firmly establish causation was limited, the design was flexible enough to allow for investigation of differences between intervention and comparison congregations at endline among key social norms and behavioral indicators, as seen in the endline quantitative report.

2. **Social norms can be measured with a high degree of validity and reliability; to which MFF measures contributed.** We developed scales for social norms for each of the three key MFF outcomes through factor analysis. Factors broadly corresponded to theory and distinctions between descriptive and injunctive norms for FP and IPV, with sex differences for IPV scales. Scale scores for social norms were fitted into structural equation models, demonstrating associations between social norms and other factors of the MFF ToC, and giving further support for the hypotheses in the ToC. These efforts at developing and testing multiple models required a significant resource and time investment, which may not always be feasible. However, our measures are a resource that can be adapted to other norms-shifting interventions working in comparable contexts and contribute to a growing body of normative scales. Social norms scales are further described in the in the endline quantitative report.
3. **Qualitative methods provided key contextual information to better understand social norms in this context and unexpected findings in the quantitative data.** First, findings from the application of the Social Norms Exploration Tool during formative research helped to refine survey items, and in particular, contributed to the development of social norms items and scale development. Baseline qualitative research findings provided additional insights into the relationships between social norms and outcome behaviors prior to implementation informing program adjustments. The inclusion of ethnographic research conducted at midline offered unique insights into understanding quality and fidelity of MFF implementation, acceptability of and satisfaction with the intervention activities, and diffusion of messaging. While some shifts were seen among couples, the ethnography report highlighted that transforming these deeply rooted attitudes and beliefs is a difficult, long-term endeavor informing additional program learning studies to prepare for scale up.
4. **Measuring and understanding the dynamics of organized diffusion of MFF messaging is challenging in a highly mobile, urban context.** We assessed communication about and diffusion of MFF messaging to the wider congregations through qualitative and quantitative methods. Findings suggest that diffusion occurred and continued occurring in both intervention and comparison congregations, the latter potentially due to the mobility of respondents between these congregations in an urban environment. Other non-MFF messaging efforts might also be potentially complicating our understandings of MFF diffusion. Future qualitative work is being conducted to better understand the mechanisms of diffusion. Where possible, programs seeking to understand diffusion should consider social network analyses.

Our learnings on preparing for scaling up norms-shifting interventions.

Here we share our learnings on poising, or preparing, for scaling up MFF:

1. **Norms-shifting interventions tested in one setting must be carefully adapted to another, considering context and appropriateness**. In MFF's experience, moving the tested intervention from rural eastern DRC to urban Kinshasa DRC, a very different context, impacted implementation significantly. MFF was designed to be scalable, however, because social norms are context-specific, social norms-formative research is needed to inform any

needed adaptations when scaling to a new context/site. MFF was the first project to use the rapid and participatory Social Norms Exploration Tool, and has contributed to broader learnings about its application, and has since been used for ~15 projects.

2. **Adapting to include RH activities to a program focused on IPV and gender transformation requires strong health care linkages.** A norms-shifting intervention at the community-level, MFF linked participants to health care. In its ToC, MFF sought to create a normative environment in which young couples would face reduced barriers to seeking care; strengthening the health care environment for youth-friendly service provision, and providing clear health care linkages helped nurture this environment. In scaling to new contexts, **consider services that may need linkages to the community** (such as to health, or GBV response). A Passages Project brief provides guidance to programs on linking community-based norms-shifting interventions to health care as one resource.
3. **In new settings, or with new partners, monitoring systems should focus on feasibility and acceptability, but also consider capturing norms shifts**. Signs of norms shifts can be increased or decreased community acceptance of behaviors, backlash or resistance from power holders or other individuals within the community, whether community consensus of the norm itself shifts, or any positive deviants. However, ensure that the monitoring system is lean and captures data that will be used in practice, find opportunities for reflections (such as regular learning meetings), and opportunities to adjust activities as it may be needed.
4. **Review existing documentation on evidence and programmatic learnings**. Before scaling up MFF, we recommend reviewing all evidence from the TM pilot (*e.g. see list of resources below*), as well as MFF's evaluation, to understand how it was designed and implemented, and how it achieved normative and other outcomes. In addition, understanding the program's underlying values will ensure that, despite adaptations made, you maintain the underlying pathways for shifting norms.
5. **Using existing resources on scale up practice helped guide planning scale up of MFF, in particular in thinking about learning and documenting implementation such as the Implementation Mapping Tool**. The Expand Net global network, and specifically norms-focused guidance from the Social Norms Learning Collaborative, such as the working paper: Considerations for Scaling up Norms-shifting Interventions for Adolescent and Youth Sexual and Reproductive Health or from the Community for Understanding Scale Up (CUSP) all guided MFF scale up.

Where does Masculinite Famille, et Foi go now?

After five years, equipped with evaluation and programmatic learnings, MFF partners have determined that MFF is effective and scalable, and there is broad interest in scaling the program at the community level through new partnerships and collaborations, working with ***both*** faith-based and non-faith-based partners.

Results support that MFF was effective at increasing modern FP use, and improving attitudes and self-efficacy surrounding FP. In particular, first-time parents were more likely to hold supportive attitudes, to discuss FP with their partner, to be confident that they could obtain and use FP, to perceive that their reference group members approve of FP use among first-time parents, and, ultimately, first-time parents were more likely to currently use and to intend to use modern contraception in the future, compared to first-time parents in comparison congregations. However, quantitative endline presents a mixed picture when it comes to norms, attitudes, and behaviors surrounding gender equality and IPV, which are being explored in further research.

As shared in Section 5, through the Passages Project, and continued USAID support, MFF is being scaled up in the DRC. In addition, with USAID support during a consultative workshop in 2019, MFF gained interest and was deemed a promising approach for shifting norms in other countries in the Great Lakes region in Central Africa. Work with new partners in Rwanda continues to scale up MFF.

Finally, interest has also grown among global audiences. MFF partners have leveraged USAID and other donor support to develop implementation guidelines for the broader TM approach, including detailed implementation guidelines in English and French on the MFF adaptation, specifically. Together, with the resources listed below, interested organizations and new partners will have tools at their disposal to consider scaling up this approach.

RESOURCES FOR FURTHER READING

Program Brief: Transforming Maculinities/Masculinite Famille et Foi (English and French)
Program Brief: Intentional Youth Engagement in the Passages Project (highlighting Masculinite, Famille et Foi)
Program Brief: Adaptive Management: Learning and Action Approaches to Implementing Norms-shifting Interventions (highlighting Masculinite, Famille et Foi)
Research Report: Baseline Qualitative Study (email info@passagesproject.org)
Research Report: Baseline Quantitative Couples Survey Study (email info@passagesproject.org)
Research Report: Baseline Quantitative Diffusion Survey (email info@passagesproject.org)
Research Brief: Baseline Results
Research Report: Midline Ethnography Study
Research Report: Endline Quantitative Couples and Diffusion Survey Study
Presentation: Working with first-time parents, findings from Masculinite, Famille et Foi Baseline
Program Tool: Costing of Norms-shifting Interventions: A Passages Project Primer (highlighting Masculinite, Famille et Foi)
Program Tool: Transforming Masculinities Training Guide
Program Tool: Community Dialogues Facilitators Guide with Family Planning
Program Materials: Implementation Guide for Transforming Masculinities
Blog: From My Transformation to Yours
Blog: Improving Voluntary Use of Modern Family Planning Through Shifting Norms with Young Couples

REFERENCE LIST

Adams, M. K. Salazar, E. and Lundgren, R. (2013) 'Tell them you are planning for the future: Gender norms and family planning among adolescents in northern Uganda,' *International Journal of Gynecology and Obstetrics, 123*(1): e7-e10

Barker, G., Ricardo, C., Nascimento, M., Olukoya, A., & Santos, C. (2010). Questioning gender norms with men to improve health outcomes: Evidence of impact. *Global Public Health*, *5*(5), 539–553. https://doi.org/10.1080/17441690902942464

Duff, J. F., & Buckingham, W. W., 3rd (2015). Strengthening of partnerships between the public sector and faith-based groups. *Lancet (London, England)*, *386*(10005), 1786–1794. https://doi.org/10.1016/S0140-6736(15)60250-1

Église du Christ au Congo. (2021, February 11). *Église du Christ au Congo: Une, Sainte, Universelle et Apostolique*. http://ecc.faithweb.com/

Gupta, G. R., Oomman, N., Grown, C., Conn, K., Hawkes, S., Shawar, Y. R., Shiffman, J., Buse, K., Mehra, R., Bah, C. A., Heise, L., Greene, M. E., Weber, A. M., Heymann, J., Hay, K., Raj, A., Henry, S., Klugman, J., Darmstadt, G. L., & Gender Equality, Norms, and Health Steering Committee (2019). Gender equality and gender norms: Framing the opportunities for health. *Lancet (London, England)*, *393*(10190), 2550–2562. https://doi.org/10.1016/S0140-6736(19)30651-8

Haakenstad, A., Johnson, E., Graves, C., Olivier, J., Duff, J., & Dieleman, J. L. (2015). Estimating the development assistance for health provided to faith-based organizations, 1990-2013. *PloS one*, *10*(6), e0128389. https://doi.org/10.1371/journal.pone.0128389

Hardee, K., Croce-Galis, M., & Gay, J. (2016). *Men as contraceptive users: Programs, outcomes, and recommendations*. Working Paper. Washington, DC: Population Council, The Evidence Project.

Hasstedt, K. & Rowan, A. (2016). Understanding intimate partner violence as a sexual and reproductive health and rights issue in the United States. *Guttmacher Policy Review*, 19.

Hillenbrand, E., Karim, N., Mohanraj, P. & Wu, D. (2015). *Measuring gender-transformative change: A review of literature and promising practices*. CARE USA. https://www.care.org/wp-content/uploads/2020/05/working_paper_aas_gt_change_measurement_fa_lowres.pdf

Hindin, M., Kishor, S., & Ansara, D. L. (2014). *Intimate partner violence among couples in 10 DHS countries: Predictors and health outcomes*. DHS Analytical Studies. https://dhsprogram.com/pubs/pdf/AS18/AS18.pdf

Institute for Reproductive Health. (2019). *Community-based, norms-shifting interventions: Definition and attributes*. Institute for Reproductive Health, Georgetown University. https://www.alignplatform.org/sites/default/files/2019-11/lc_nsi_attributes_brief_final_08262019_eng.pdf

Institute for Reproductive Health. (2014). *Male engagement in family planning: Reducing unmet need for family planning by addressing gender norms*. Institute for Reproductive Health, Georgetown University. https://irh.org/resource-library/male-engagement-family-planning-reducing-unmet-need-family-planning-addressing-gender-norms/

Kaneda, T. & Greenaum, C. (2019). *2019 Family planning data sheet*. Population Reference Bureau. https://www.prb.org/2019-family-planning-data-sheet-highlights-family-planning-method-use-around-the-world/

Levin, J. (2014). Faith-based initiatives in health promotion: History, challenges, and current partnerships. *American Journal of Health Promotion*, *28*(3), 139-141. https://doi.org/10.4278/ajhp.130403-CIT-149

Lipsky, A.B. (2011). Evaluating the strength of faith: Potential comparative advantages of faith-based organizations providing health services in sub-Saharan Africa. *Public Administration and Development, 31*(1). https://doi.org/10.1002/pad.586

Lusey, H. (2016). *Gender norms, violence and concepts of masculinity: A qualitative research report on faith communities' perceptions and experience in Bangui, Central African Republic*. Tearfund. https://learn.tearfund.org/-/media/learn/resources/reports/gender-norms-violence-and-masculinity.pdf

Maxwell, L., Devries, K., Zionts, D., Alhusen, J. L., & Campbell, J. (2015). Estimating the effect of intimate partner violence on women's use of contraception: a systematic review and meta-analysis. *PloS one*, *10*(2), e0118234. https://doi.org/10.1371/journal.pone.0118234

Ministère du Plan et Suivi de la Mise en oeuvre de la Révolution de la Modernité, Ministère de la Santé Publique, Kinshasa, République Démocratique du Congo, et MEASURE DHS, ICF International. (2014). *Congo Democratic Republic Demographic and Health Survey 2013-2014*. ICF International, Rockville, Maryland, USA.

Population Reference Bureau. (2005). *A summary of the 'So What' Report: Integrating a gender focus*. PRB Interagency Gender Working Group & USAID Bureau for Global Health. https://www.who.int/gender-equity-rights/knowledge/so-what-report.pdf

Schuler, S. R. Rottach, E. & Mukiri, P. (2011). Gender norms and family planning decision-making in Tanzania: A qualitative study. *Journal of Public Health in Africa, 2*(2): 25

Sedgh, G., Ashford, L.S. & Hussain, R. (2016). *Unmet need for contraception in developing countries: Examining women's reasons for not using a method*. Guttmacher Institute. https://www.guttmacher.org/sites/default/files/report_pdf/unmet-need-for-contraception-in-developing-countries-report.pdf

Tearfund UK. (2014). *Transforming Masculinities*. Glasgow.

United Nations Population Fund. (2014). *Investing in sexual and reproductive health in sub-Saharan Africa*. Fact Sheet. https://www.unfpa.org/sites/default/files/resourcepdf/383%20AIU3%20Regional_SSA_ENG%2011.19.14%20FINAL_0.pdf

United Nations Population Fund. (2011). *Making reproductive rights and sexual and reproductive health a reality for all*. UNFPA. https://www.unfpa.org/sites/default/files/pub-pdf/SRH_Framework.pdf

Voices 4 Change. (2014). *Strategy on working with religious and traditional institutions and leaders*. Voices 4 Change. https://www.eldis.org/document/A101392

Williamson, L.M., Parkes, A., Wight, D., Petticrew, M. & Hart, G.J. (2009). Limits to modern contraceptive use among young women in developing countries: A systematic review of qualitative research. *Reprod Health* 6, 3 https://doi.org/10.1186/1742-4755-6-3

World Health Organization. (2007). *Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions*. Geneva. https://www.who.int/gender/documents/Engaging_men_boys.pdf

World Health Organization. (2020, June 22). *Family planning/contraception methods*. https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception

World Health Organization, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, & South African Medical Research Council. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. WHO. https://www.who.int/publications/i/item/9789241564625