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Research article

What is the potential for interventions designed to prevent violence against women to reduce children's exposure to violence? Findings from the SASA! study, Kampala, Uganda☆

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ABSTRACT

Intimate partner violence (IPV) and child maltreatment often co-occur in households and lead to negative outcomes for children. This article explores the extent to which SASA!, an intervention to prevent violence against women, impacted children's exposure to violence. Between 2007 and 2012 a cluster randomized controlled trial was conducted in Kampala, Uganda. An adjusted cluster-level intention to treat analysis, compares secondary outcomes in intervention and control communities at follow-up. Under the qualitative evaluation, 82 in-depth interviews were audio recorded at follow-up, transcribed verbatim, and analyzed using thematic analysis complemented by constant comparative methods. This mixed-methods article draws mainly on the qualitative data. The findings suggest that SASA! impacted on children's experience of violence in three main ways. First, quantitative data suggest that children's exposure to IPV was reduced. We estimate that reductions in IPV combined with reduced witnessing by children when IPV did occur, led to a 64% reduction in prevalence of children witnessing IPV in their home (aRR 0.36, 95% CI 0.06–2.20). Second, among couples who experienced reduced IPV, qualitative data suggests parenting and discipline practices sometimes also changed-improving parent–child relationships and for a few parents, resulting in the complete rejection of corporal punishment as a disciplinary method. Third, some participants reported intervening to prevent violence against children. The findings suggest that interventions to prevent IPV may also impact on children's exposure to violence, and improve parent–child relationships. They also point to potential synergies for violence prevention, an area meriting further exploration.

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Introduction

Intimate partner violence (IPV) against women is a serious public health concern, with multiple impacts on women's physical, mental, and reproductive health (Boeckel, Blasco-Ros, Grassi-Oliveira, & Martínez, 2014; Devries et al., 2010; Devries et al., 2013; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Maman, Campbell, Sweat, & Gielen, 2000; Stöckl et al., 2013). Child exposure to adult violence is becoming an increasing concern for both practitioners and researchers (Edleson et al., 2007; Guedes & Mikton, 2013). IPV may take a variety of forms including physical, sexual, and emotional violence. Children may be exposed to it through witnessing it, overhearing it, or seeing its effects; being an 'innocent bystander' (Fieggen et al., 2004); or being forced to participate in it, for example by being required to report on their mother's movements (Carpenter & Stacks, 2009; Edleson et al., 2007). There is also growing evidence to suggest that IPV and child maltreatment may often co-occur within the same household (Hamby, Finkelhor, Turner, & Ormrod, 2010; Wathen & MacMillan, 2013). This may be particularly so in contexts where dominant social norms and structural factors position men as the head of the household, dictate both women's and children's subservience and dependence on men, and sanction men's (and adults) use of violence to correct transgressions of expected behavior (Jewkes, 2002; Lansford, Deater-Deckard, Bornstein, Putnick, & Bradley, 2014). This has led to increasing recognition of the need to address IPV and child maltreatment within an integrated framework (Guedes & Mikton, 2013).

Much of the evidence on the impact of children's exposure to violence is derived from high-income countries reflecting a relative dearth of evidence from low- and middle-income settings where economic, social, and political factors may differ in important ways. Available evidence has shown however that children who are exposed to IPV are more likely to experience maltreatment themselves. This may take the form of physical abuse from one or both parents; severe corporal punishment; household dysfunction and neglect; and trauma (Boeckel et al., 2014; Chan, 2011; Holmes, 2013). Children in households where IPV occurs have also been shown to have worse outcomes. Experiences in early childhood are increasingly recognized to affect children's later development, (Carpenter & Stacks, 2009) manifested in adverse health (Pavey, Gorman, Kuehn, Stokes, & Hisle-Gorman, 2014; Sabarwal, McCormick, Silverman, & Subramanian, 2012; Yount, DiGirolamo, & Ramakrishnan, 2011), educational, and behavioral (Evans, Davies, & DiLillo, 2008; Huang, Wang, & Warrener, 2010) outcomes, as well as increased risk of mortality (Ackerson & Subramanian, 2009; Garoma, Fantahun, & Worku, 2012). For adolescents and younger adults, exposure to parental IPV has also been shown to be associated with negative mental health outcomes including anxiety, depression, and substance misuse (Schiff et al., 2014). Furthermore, there is evidence to suggest that boys and girls who grow up in a household where IPV is present are at greater risk of experiencing (for women) or perpetrating (for men) partner violence in adulthood (Feldman, 1997; Stith et al., 2000; Wathen & MacMillan, 2013; Widom, Czaja, & Dutton, 2014). Many of the negative effects experienced by children exposed to IPV may be exacerbated by its impact on maternal mental health outcomes and care giving, including parenting practices, women's ability to bond with children, maternal warmth, and children's ability to adjust under the stress of family violence (Carpenter & Stacks, 2009; Graham-Bermann, Gruber, Howell, & Girz, 2009; Holmes, 2013).

The most direct way to prevent children's exposure to IPV is through preventing IPV in the first place. While the volume of evidence on what works to prevent IPV is increasing (Abramsky et al., 2014; Ellsberg et al., 2014; Heise, 2011) the evidence for the potential to reduce children's exposure to IPV by reducing IPV is limited (Wathen & MacMillan, 2013). Much of the evidence is again derived from high-income settings, and focuses on secondary or tertiary prevention (Cohen, Mannarino, & Iyengar, 2011; Jouriles et al., 2009; Lieberman, Van Horn, & Ippen, 2005; Wathen & MacMillan, 2013). There is also evidence from low-, middle-, and high-income settings of the potential for parenting interventions to improve parent–child relationships, child conduct disorders, and reduce harsh parenting (Cooper et al., 2009; Gardner, Burton, & Klimes, 2006; Knerr, Gardner, & Cluver, 2013). Limited, though increasing evidence is also available on the potential for interventions that are designed to prevent child maltreatment to impact outcomes related to IPV (Dubowitz et al., 2011; Duggan et al., 1999; Sim et al., 2014) which may prove particularly valuable as interventions to prevent child maltreatment may be less effective in households where IPV occurs (Guedes & Mikton, 2013). To our knowledge there is currently no evidence from rigorously-evaluated community-level interventions on the impact of IPV prevention interventions on children's well-being and exposure to violence. This includes their exposure to 'proxy' violence which may occur where children experience violence when they are not necessarily the intended target, for example the transference of anger felt for an intimate partner to a child. One example of a community-level intervention however is SASA!, a phased community mobilization intervention that engages communities to prevent violence against women and reduce HIV risk behaviors. Drawing mainly from qualitative findings, the aim of this article is to explore the extent to which the SASA! intervention affected children's experiences of violence.

The SASA! Approach

SASA! was designed by Raising Voices and in Kampala, is implemented by the Centre for Domestic Violence Prevention (CEDOVIP), both of which are Uganda-based NGOs. Together with the Safe Homes and Respect for Everyone (SHARE) project in Rakai, Uganda (Wagman et al., 2014), SASA! is one of only two community mobilization interventions that seek to achieve primary prevention of IPV and HIV in a low- or middle-income country of which we are aware. Indeed, much of the evidence relating to efficacious interventions in low- and middle-income countries has, until recently, been derived primarily from

research assessing impact on direct intervention recipients (Heise, 2011; Jewkes et al., 2008; Pronyk et al., 2006; World Health Organization & London School of Hygiene and Tropical Medicine, 2010).

SASA! is informed by the ecological model (Heise, 2011) and seeks to prevent violence against women and reduce HIV-related risk behaviors by supporting communities to discuss and engage on issues of gender inequality, violence, and HIV (Abramsky et al., 2012; Michau, 2008). SASA! focuses on positive aspirational programming that supports critical reflection on violence against women and the development of communication and relationship skills. It also seeks to encourage activism against violence at the community level. SASA! is implemented by community members, including male and female 'community activists' (ordinary community members that receive on-going support and training to implement SASA!), professionals (e.g. healthcare workers; police), and local cultural and government leaders. Activists work on a voluntary, unpaid basis and conduct a variety of one-on-one and group activities in their local communities.

SASA! programming is designed to take individuals and communities through four intervention phases that are loosely structured on Stages of Change theory (Prochaska & Velicer, 1997). The content of SASA! activities is not designed specifically for men or for women. In practice however, the logistics of conducting activities (for example where men congregate) mean that some activities are conducted mainly with women or mainly with men. The content of the activities however remains the same. In the first phase, **START**, staff from the implementing organization (in this case CEDOVIP) actively learn about the community. This entails mapping formal and informal social, economic and physical resources and understanding how communities are structured and organized. During the START phase, a number of community activists (who are ordinary women and men resident in the community) are selected by the implementing organization and, together with organization staff, are supported to explore the power they hold within themselves to create change. The second phase, **AWARENESS**, focuses on building activists' confidence as they conduct activities within their communities while also encouraging community members to think critically about men's power over women and how it may manifest. This precedes the **SUPPORT** phase during which the skills and connections between community members are strengthened in order to encourage people to support those who are changing or trying to foster change in their community. In the final stage, the **ACTION** phase, individuals are encouraged to try out new behaviors and celebrate change within their community. Throughout the phases, SASA! works to build a critical mass by engaging a broad range of stakeholders. SASA! employs multiple strategies including local activism activities and media and advocacy strategies, and uses contextually relevant communication and training materials. The content of the various strategies evolves with the SASA! phases.

The SASA! Study

Described in detail elsewhere (Abramsky et al., 2012), the SASA! study had four research components: a pair-matched cluster randomized controlled trial with baseline and endline cross-sectional surveys; a nested qualitative study; an economic evaluation; and operational research. The study was conducted between 2007 and 2012 in Kampala, Uganda. The primary trial analysis showed that all outcomes moved in the hypothesized direction. The intervention was associated with significant positive improvements in community attitudes towards the unacceptability of partner violence and women's ability to refuse sex in relationships, and significant reductions in men's reported engagement in extra-marital sexual relationships. Results were also suggestive of a large intervention effect on IPV. Women's past year experience of physical violence was 52% lower in intervention communities compared to control communities (aRR 0.48, 95% CI 0.16–1.39), although high levels of inter-cluster variation in the prevalence of IPV led to wide confidence intervals around this estimate (Abramsky et al., 2014). Levels of sexual violence also decreased, but to a lesser degree. Among couples that experienced reductions in violence, qualitative research suggested that improvements in communication, reductions in tension, and strengthened trust and joint decision-making were important. Changes in broader community norms also supported these relationship changes (Kyegombe, Starmann, et al., 2014). Secondary analysis of the study data also described the intervention's impact on reported HIV-related risk behaviors and relationship dynamics, particularly among men (Kyegombe, Abramsky, et al., 2014). SASA! was not designed to explicitly focus on children, and the trial did not explicitly address or assess the intervention's effect on children's experience of violence. During the qualitative research however, the potential impact of SASA! on children emerged in two important ways. First its impact on children's exposure to violence, and second, its impact on parents' relationship with their children, including their approach to parenting.

Methods

Study Context

This study was conducted in eight high-density, impoverished communities in two administrative divisions. Kampala has a high prevalence of IPV with 52.3% of women aged between 15 and 49 estimated to have experienced physical and/or sexual violence from an intimate partner (Uganda Bureau of Statistics (UBOS) & Macro International Inc., 2007). The majority of residents were self-employed in the informal sector and approximately half did not progress beyond primary education (Abramsky et al., 2012). Data from the baseline survey also indicate that more than three quarters of respondents lived in rented accommodation and most (61%) used a public tap as their main source of drinking water. Fewer than 10% of households had a flush toilet (Abramsky et al., 2012). At follow-up, the mean number of children living in households in SASA! communities was 1.91. 55% of male respondents and 78% of female respondents were living with at least one child

in residence. Patriarchy, the concentration of both individual and institutional power in the hands of men, is a dominant feature of the social-cultural context (Ssetuba, 2005). Traditional norms around male authority reflect this, with behaviors linked to a dominant form of masculinity that include excessive alcohol consumption, and multiple sexual partners, having been shown to be associated with IPV in Uganda. Violence against women is also broadly tolerated by both men and women (Abramsky et al., 2012). Strong norms that discourage people talking with outsiders about 'family matters' or 'interfering' in the family matters of others, further characterize the setting. Children are culturally considered to belong to their fathers and women often depend on men in order to provide for their children.

Survey Sampling

The study was conducted in eight sites (four intervention and four control) and was designed to assess the community-level impact of SASA! on a number of primary and secondary outcomes related to IPV, HIV-related risk behaviors and relationship dynamics. The baseline and endline cross-sectional surveys were conducted four years apart. Households were randomly selected, and within each household only one eligible member (eligibility criteria: aged between 18 and 49, resident in the area for at least one year, able to speak English or Luganda, and able to provide independent consent) was selected for interview. 1,583 respondents were interviewed at baseline and 2,532 at follow-up (due to a larger budget allowing more households to be sampled). Response rates for both surveys were high, with approximately 98% of eligible respondents completing each.

Quantitative Indicators and Analysis

Quantitative outcomes for this article relate to the 12 months preceding the follow-up survey, and were measured among partnered women who had biological or step-children living in the home (as ascertained by the survey). Certain indicators relate only to the subset of these women who had past year experience of IPV outcomes including indicators of children's exposure to IPV in the home (woman experienced physical and/or sexual IPV; a child was present/overheard incidents of IPV), and measures relating to parenting (woman stayed away from home for at least one night due to IPV; male partner regularly helped to take care of children). All were based on women's reports, as men (especially after an intervention such as SASA!) are likely to underreport perpetration of violence due to social desirability bias and thereby the consequences of this violence for their children. Questions on IPV were the same as those used in the WHO Multi-Country study on Women's Health and Domestic Violence (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005) and similar to those used in the Uganda Demographic and Health Survey (Uganda Bureau of Statistics (UBOS) & Macro International Inc., 2007).

The quantitative analysis included only those women who reported having at least one biological or step-child living in the household. Outcomes in intervention and control communities were compared at follow-up using a cluster-level intention to treat analysis (ITT). Adjusted prevalence ratios, controlling for site pair, age, and marital status, were calculated using a two-stage approach. Individual-level logistic regression was used to predict expected prevalence in each site (based on the age and marital status of community members). Observed/expected ratios for each site were then entered into an analysis of variance model including terms for intervention and site pair. Statistical weighting was applied to account for difference in denominators between sites. All analyses were conducted using STATA 12.0 (StataCorp, 2011).

We recognized from the outset that the study would yield effect estimates with wide confidence intervals (including 1 'no effect') if effect sizes were modest or levels of inter-cluster variance high. Although levels of between cluster variance for IPV were low at baseline, at follow-up, coefficients of variation (k) indicated very high levels of between cluster variation (physical IPV $k = 0.45$; sexual IPV $k = 0.33$). Therefore, as with the main trial analysis, when interpreting the results of this analysis, our emphasis was not only on the statistical significance of individual results, but also on assessing the overall coherence of the findings, including the magnitude of intervention effects and whether the outcomes consistently occurred in the hypothesized direction. Findings from the qualitative analysis were also used to examine the plausibility of the quantitative findings.

Qualitative Study and Analysis

In total 82 participants were included in the qualitative evaluation in two phases of data collection. All interviews were audio recorded. In the first phase, 72 sex-matched in-depth interviews were conducted by four researchers (two female, 2 male) at follow-up. They were conducted with community members (20 women, 20 men), community activists (10 women and 10 men) and community leaders (6 women, 6 men) using a semi-structured tool. Community members were sampled through criterion sampling (Patton, 2002). As part of the survey, community members were asked whether they had experienced or used violence in the past 12 months and also in the period preceding the past 12 months. To be eligible to be included in the qualitative evaluation, community members had to report reduced violence in the past 12 months (as compared to the period before); some exposure to SASA!; and agree to be contacted again following the survey interview. Within these criteria, effort was made to maximize the heterogeneity of the sample (Sandelowski, 1995) in order to capture a broad range of participant characteristics. Community activists and community leaders were sampled based on the advice of CEDOVIP and Raising Voices' staff who had worked closely with them throughout the process of implementation. Community activists and local leaders were purposively sampled to reflect individuals with varying

experiences of implementing SASA!, including an assessment of their level of enthusiasm and the personal and contextual challenges that they encountered. Participants were sampled from all intervention communities.

Not all participants who participated in the main qualitative evaluation were living with a child in residence. In order to specifically explore participants' current experiences of parenting and discipline, and the impact of SASA! on parents' relationships with children, in the second phase of data collection, a further 10 interviews were conducted with parents (5 mothers and 5 fathers) in SASA! intervention communities. These interviews were conducted two months after the completion of the first phase of the qualitative evaluation. For this, individuals were purposively sampled upon the advice of community activists, to ensure that participants had children in residence, and had been involved with SASA! Domains that were explored in these interviews included participants' natal relationships; their experience of violence in childhood; their views on violence against children; their views on relationships between parents and children; and the appropriate role and position of children within families, for example with relation to communication and decision making. During these interviews, the impact of SASA! on these views was also explored. These interviews also examined the extent to which SASA! was affecting parents' behavior, for example through creating space for children' voice or including children in decision-making.

The overall approach to the qualitative data analysis was thematic, complemented by constant comparative methods (Glaser & Strauss, 1967). Following each set of four interviews, research team meetings were held during which the data and emerging themes were discussed. Peculiar properties in the data and emerging themes were also identified and explored in subsequent interviews. Interviews were transcribed verbatim using a single stage transcription protocol (McLellan, MacQueen, & Neidig, 2003). Data analysis continued with intense reading and annotation of the transcripts. Using a constant comparative method of analysis, and assisted by NVIVO 10 analysis software (QSR International Pty Ltd., 2012) the data was coded and a provisional coding frame developed. Through on-going analysis and comparison, the coding frame was refined and included both concepts that were developed a priori as well as those that emerged from the data. The two qualitative data sets were coded separately. The concepts that emerged through each were combined at the point of interpretation and used to develop a model to explain the impact of SASA! on children's experience of violence and parenting, as reported by parents.

Study Ethics

The study adhered to the WHO guidelines for safe and ethical data collection on violence against women (World Health Organization, 2001). All participants provided written informed consent and were interviewed in a private location of their choice. No interviews were conducted with children. Ethical approval was obtained from the ethics committees of the London School of Hygiene and Tropical Medicine, Makerere University and the Uganda National Council of Science and Technology. The trial is registered at ClinicalTrials.gov (NCT00790959).

Results

The characteristics of the sample of women and men with children in intervention and control communities are summarized in Table 1 and reflect a high degree of comparability between intervention and control communities both at baseline and follow up. As expected in this context, a higher percentage of men reported not living with children or step-children. At follow-up a slightly higher percentage of men reported living with children in both intervention and control communities, than at baseline.

Table 2 summarizes the estimates of effect of the intervention on the 4 measures of potential impact on children. All of the outcomes explored improved in the hypothesized direction. Below we discuss each in turn, including both the quantitative finding, and the associated qualitative evidence in relation to this outcome. 35% of men and 54% of women reported that their children had attended SASA! activities. Furthermore, 13% of men and 26% of women reported that they had spoken to their children about SASA!. Not all respondents answered these questions however. In the qualitative data, no notable differences were found in adults' reports of the impact of the intervention on children by the sex of the child. The sections that follow discuss the impact of SASA! on four distinct areas of children's experience: children's exposure to or witnessing of IPV; parent–child relationships; children's experience of violence; and activism around prevention of violence against children.

Impact on Exposure to and/or Witnessing of Violence

At follow-up, women in intervention communities were less likely to report past year experience of physical or sexual IPV than their control counterparts (aRR 0.68, 95% CI 0.16–1.39). Furthermore, among those women who did report past year experience of IPV, fewer reported that a child was present or overheard instances of physical or sexual IPV (aRR 0.58, 95% CI 0.19–1.74). We estimate that reductions in IPV combined with reduced witnessing by children when IPV did occur, led to a 64% reduction in prevalence of children witnessing IPV in their home (aRR 0.36, 95% CI 0.06–2.20).

The findings from the qualitative evaluation also support the suggestion that children's reduced exposure to adult IPV arose from reductions in the levels of IPV, particularly as many participants described how before SASA!, violence was the main way in which differences were resolved. The reduction in violence also had important implications on family disruption

Table 1
Characteristics of survey respondents with children/step children living with them.

	Baseline				Follow-up			
	Intervention		Control		Intervention		Control	
	Men	Women	Men	Women	Men	Women	Men	Women
All respondents	N = 419	N = 374	N = 447	N = 343	N = 768	N = 599	N = 634	N = 529
No children[a]	237 (57%)	83 (22%)	223 (50%)	83 (24%)	347 (45%)	130 (22%)	263 (41%)	120 (23%)
Mean number of children[a]	1.4 (sd = 2.5)	2.1 (sd = 1.9)	1.6 (sd = 2.4)	2.0 (sd = 1.7)	1.7 (sd = 2.5)	2.2 (2.0)	1.9 (sd = 2.4)	2.3 (sd = 2.1)

	Baseline				Follow-up			
	Intervention		Control		Intervention		Control	
	Men	Women	Men	Women	Men	Women	Men	Women
Respondents with children/step-children	N = 182	N = 291	N = 224	N = 260	N = 421	N = 469	N = 371	N = 408
Household-level								
Household has electricity	138 (76%)	194 (67%)	179 (80%)	197 (76%)	370 (88%)	388 (83%)	318 (86%)	333 (82%)
Main drinking water source – public tap	123 (68%)	185 (64%)	171 (76%)	171 (66%)	292 (69%)	307 (65%)	270 (73%)	278 (68%)
Toilet facility – traditional pit toilet/latrine	127 (70%)	183 (63%)	144 (64%)	162 (62%)	238 (57%)	312 (67%)	212 (57%)	253 (62%)
House is rented	126 (69%)	180 (62%)	164 (73%)	191 (73%)	349 (83%)	347 (74%)	301 (81%)	300 (74%)
Individual-level								
Age (years)	32.1 (6.1)	29.9 (7.7)	32.2 (6.3)	30.1 (7.5)	32.9 (7.3)	29.8 (7.3)	34.3 (7.1)	30.9 (8.1)
Buganda Tribe	122 (67%)	202 (69%)	145 (65%)	155 (60%)	269 (64%)	302 (64%)	206 (56%)	255 (63%)
Main religions								
Catholic	75 (41%)	88 (30%)	82 (37%)	82 (32%)	154 (37%)	160 (34%)	125 (34%)	123 (30%)
Muslim	42 (23%)	73 (25%)	63 (28%)	77 (30%)	108 (26%)	113 (24%)	103 (28%)	102 (25%)
Protestant	32 (18%)	85 (29%)	54 (24%)	63 (24%)	112 (27%)	114 (24%)	106 (29%)	103 (25%)
Born Again	24 (13%)	36 (12%)	17 (8%)	33 (13%)	36 (9%)	71 (15%)	24 (6%)	73 (18%)
Above primary education	101 (55%)	94 (32%)	147 (66%)	90 (35%)	279 (66%)	290 (62%)	239 (64%)	241 (59%)
Able to read	173 (95%)	264 (91%)	213 (96%)	234 (90%)	400 (95%)	410 (87%)	339 (91%)	365 (89%)
Does not earn money	3 (2%)	127 (44%)	8 (4%)	124 (48%)	15 (4%)	151 (32%)	5 (1%)	124 (30%)
Ever had a regular partner	182 (100%)	291 (100%)	223 (100%)	258 (100%)	414 (98%)	464 (99%)	367 (99%)	404 (99%)
Had a regular partner in the past 12 months	170 (93%)	256 (88%)	213 (95%)	220 (85%)	399 (95%)	401 (86%)	331 (89%)	326 (80%)
Currently married/cohabiting	142 (78%)	210 (72%)	179 (80%)	180 (69%)	359 (85%)	339 (72%)	290 (78%)	257 (63%)

[a] At baseline, respondents were only asked about their biological children. At follow-up they were asked about biological children and step-children living with them.

as more women described how they either made fewer trips to their natal homes in an attempt to escape the violence they were experiencing, or that they were less likely to permanently leave their marital homes:

> "My children are now free, they are now living with their mother because if it was not for SASA! I would have moved on. I would have gone away" (Female community member #23)

Indeed, women in intervention communities were 49% less likely to have stayed away from home for at least one night in the past year due to IPV (aRR 0.51, 95% CI 0.27–0.98) than their counterparts in control communities. For a few women, being able to remain at home was a particularly valued development because they themselves had not grown up with their parents owing to the violence that had characterized their own childhoods.

> "I grew up with my grandparents. My mother gave birth to three children. . .but was unable to live with my father because of the conditions. If it was today, they would be the cases handled by SASA!. Violence was the main reason that led to their separation and my mother left me at my grandparents when I was about two years old" (Female community member #25)

Some participants also described their desire to not expose their children to violence in part to reduce the likelihood that they would consider violence to be normal and acceptable, and thus something that they could use in their future relationships.

> "That is why I do not want to show them that we have misunderstandings, even when we fight, I don't want the children to know. . .because once that child grows up and starts his or her own family, what he learns here is what they are going to do in their family. . .if [they see abuse] they can even say that my mother was always beaten and they also beat their wives and the girls will accept to be beaten since they feel that it is okay to do it" (Female community member #25)

Table 2
Estimates of effect[b] on child well-being outcomes among currently partnered women with children/live-in stepchildren, comparing prevalence of outcome in intervention versus control communities.

	Baseline[a]		Follow-up			
	Intervention	Control	Intervention	Control	Unadjusted RR[b] (95% CI)	Adjusted RR[c] (95% CI)
Respondent reports past year experience of physical and/or sexual IPV (among partnered respondents with children/step-children)	76/252 (30%)	58/219 (26%)	85/411 (21%)	116/345 (34%)	0.66 (0.33–1.35)	0.68 (0.34–1.38)
Respondent reports that child has been present/overheard physical/sexual IPV in past year						
Among partnered respondents with children/step-children and past year experience of physical/sexual IPV	48/76 (63%)	28/57 (49%)	23/85 (27%)	54/116 (47%)	0.61 (0.18–2.07)	0.58 (0.19–1.74)
Calculated as a percentage of all partnered respondents with children/stepchildren	48/252 (19%)	28/218 (13%)	23/411 (6%)	54/345 (16%)	0.44 (0.06–3.36)	0.36 (0.06–2.20)
Woman stayed away from home for at least one night in past year due to IPV						
Among partnered respondents with children/step-children and past year 'difficult experiences' (including physical/sexual IPV, emotional aggression or controlling behaviors)	28/135 (21%)	17/115 (15%)	35/231 (15%)	59/235 (25%)	0.62 (0.37–1.03)	0.61 (0.37–1.01)
Calculated as a percentage of all partnered respondents with children/stepchildren	28/277 (10%)	17/237 (7%)	35/411 (9%)	59/348 (17%)	0.53 (0.27–1.04)	0.51 (0.27–0.98)
Male partner helps to look after children (among partnered respondents with children/step-children)	191/288 (66%)	172/240 (72%)	233/323 (72%)	151/255 (59%)	1.22 (0.89–1.68)	1.15 (0.91–1.45)

[a] Question wording/item construction changed between baseline and follow-up to improve face validity – those baseline measures closest to the follow-up outcomes are presented here to assess underlying intervention/control community comparability, but baseline/follow-up comparisons are not possible.
[b] Risk ratios calculated at the cluster-level, both crude and adjusted ratios adjusting for community-pair, and weighted according to the number of observations per village.
[c] Adjusted risk ratios generated on the basis of expected number of events from a logistic regression model on individual data with independent variables including age and marital status.

While parents' desire to avoid arguing or fighting in front of their children was not always solely as a result of exposure to SASA!, and was often something that their own parents had tried to do, participants did talk about how SASA! had made them reflect upon the impact of violence in their homes.

Impact on Parent–Child Relationships

Spending Time with Children. Participants described how, in the context of poverty, insecure livelihoods and time-intensive household chores, their time was dominated by the day-to-day running of the household, and how it could be challenging to take time out of their busy day in order to spend 'non-productive' time with their children. Men in particular, often described how their need to 'find money in order to provide for their children' took precedence over playing with them. Qualitative findings emphasize changing attitudes among some men towards their role as a father. For these men, closeness with children was often considered the role of a child's mother who was generally seen as 'softer' and more likely to 'know the needs of a child'. Indeed for some men, their pre-SASA! relationship with their children was characterized by distance and at times fear, even when violence was not a defining feature of the relationship.

> "Before I joined SASA! my children were afraid of me; my children would never hold a conversation with me, but from the time I joined SASA!, I converse with them, they are free with me, they even tell me their problems. . . They even correct me when they feel I'm not right. They no longer fear me. They tell me their problems and I also tell them why I'm not able to give them what they need. Before they used to think that I deliberately refused to meet their needs" (Male community member #18)

Negotiating strong gender norms that dictate men's primary role to center upon provision, for a few men, participation in SASA! led them to reflect upon the value of developing a relationship with their children that extended beyond provision – a finding also hinted at in the quantitative analysis, with men in intervention communities being slightly more likely than their control counterparts to spend time caring for their children (aRR 1.15, 95% CI 0.91–1.45).

Communication and Decision Making. Beyond spending time with their children, and not only as a result of exposure to SASA!, many participants viewed good communication and trust between parents and children as a marker of a good parent–child relationship. Its absence was often interpreted as a marker of a bad parent–child relationship, which was also characterized by fear and distance. Through SASA!, many parents described how they felt more able to communicate meaningfully with their children. For older children, this included communication on important issues such as protecting themselves from unwanted pregnancy, HIV and on relationship advice.

Improved communication with children often went hand-in-hand with greater involvement of children in decision making although this was often focused on issues that directly affected children such as which school they should go to.

> "The main thing that I learnt from SASA! is about having a good relationship with our children. . .if at all there is something new that needs us to consult children, we also involve them and tell them about it and ask for their opinions. This was not how it used to be. I learnt this from SASA!. . .The CA greatly emphasized it" (Female community member #21)

Impact on Children's Experience of Violence

Discipline Practices. For many participants, it was during SASA! activities that they reflected upon what violence is and its consequences in their lives. They noted that what they now recognized as mistreatment of children, was not necessarily labeled in this way in the past. They likewise perceived law enforcement agencies and local government officials as progressively less tolerant of violence against children. As such, for some participants, reductions in their use of violence were due to greater awareness about the laws that protect children, and as such, their fear that using violence against a child might result in repercussions for them. Beyond this however, the beating of children was not always considered violence. Overall, both men and women considered disciplining children to be an important aspect of good parenting with some, although not all, considering beating an important method of discipline. Those who were supportive of beating more often felt that the beatings that they themselves had experienced in childhood were important for shaping them as adults and ensuring that they had qualities that they now valued. Some parents in particular described how beating was especially effective for younger children. Many participants, however, described how through SASA!, they had reflected upon how they were disciplined in childhood or how they were disciplining their children. For some this resulted in them beating their child less frequently or not as an immediate response:

> "Before I joined SASA! I used to think that as a man I used to have all the power in the home so whenever a child made a mistake I would, without understanding, punish the child badly. But from when I joined SASA! whenever a child makes a mistake, I have to first understand the cause of the mistake, and I even take time to talk to the child, when he repeats the mistake, that is when I carry out the punishment but the child has to understand I first talked to him before punishing him" (Male community member #18)

In addition to less physical chastisement, a few parents described how they had engaged with the tone they used when speaking to their children with some describing how 'they stopped barking' at their children or were 'less tough'. One mother also described how following her involvement with SASA!, she reflected upon the effect of her words on her child:

> "[SASA!] showed me that if a person does something wrong. . .they need someone to counsel them so that helped my family a lot. My children were able to have peace. Before [SASA!] it would be a slap. . .I would [also] abuse him [her son] calling him stupid not knowing that whenever you abuse a child and call them stupid he goes to class thinking that Mummy also told me that I am stupid so he attends class thinking that he is stupid" (Female community activist #31)

Amongst a few parents, their engagement with SASA!, often in conjunction with their reflection on their own experience of violence, resulted in them rejecting violence as a method for punishing their children:

> "According to what my children have gone through and how their father would beat them before we separated, I cannot punish my children. I treat them carefully so that they can heal from the trauma they have experienced. . .I do not want them to say that I also mistreat them after going through a lot. . .I want to befriend my children. . .before SASA! I would beat them" (Female community member #7)

The complete rejection of violence was most common amongst parents who were community activists as they felt a responsibility to be exemplary in their rejection of violence before asking their fellow community members to do the same:

> "[when I became a Ssenga (traditional marriage counselor trained and supported by SASA!)] I felt good because I knew I was going to help my community and I was also going to use this as an opportunity to improve as a person. I was very tough, especially with my children. I would just beat my children and would not listen to them. . . I never realized that they were also human beings with rights like adults. . . I was so happy because I was able to realize that I was making a mistake and had to stop after being trained. . .there is no way I would talk to people when I was doing the same mistake that I was telling them to stop. . . it had to start with me and then to other people" (Female community activist #22)

An important means through which exposure to SASA! reduced parents' use of physical violence as part of discipline, was providing parents with non-violent disciplinary alternatives which still ensured that children's behavior was changed or regulated. Both mothers and fathers described, for example, how instead of beating, they used other forms of punishment such as requiring the child to do all the household chores on their own or withholding treats and other things that children valued.

Less Proxy Violence. Amongst a few participants, there was a recognition that children's experience of violence was not always as a result of anything to do with the children themselves but instead their parents' own anger:

> "Now most women mistreat children because of one reason or another. . . she can mistreat the child, even though she is the one who is the biological mother, due to the anger that is sparked off by the man. The anger that she would have poured out on the man she pours it out to the child and yet she is the mother" (Female community member #10)

Through its role in improving relationships, SASA! was credited by many for reducing the tension and conflict in homes which was often recognized to reduce the violence that children experienced:

> "SASA! changed our relationship. . . my husband would use any form of violence like if he wanted to psychologically abuse me, he would get the girl, my step daughter, then he would start beating her. He knew that whenever he would beat the child that I would feel bad. . . but through SASA! activities my husband no longer beats that child. . .so as for me, SASA! greatly changed my relationship" (Female community member #19)

This however was not always easily achieved with some children still being indirectly exposed to on-going violence between their parents:

> "When I was pregnant with this baby he wanted to chase me away. . . I realized that each time I got pregnant, he would be worse. . .This time I went to the nabakyala (SASA! trained women's representative on the local council) and he calmed down and he did not chase me. . . There was also a time when he threw this baby down and almost killed him. . . in the morning he had warned me that he should not find me at home but when he came back he found me on the way with the child and grabbed the baby and we fought and he threw the baby down. . . we went to the police. . . and he was arrested and I went back to my parents. . . when he was released he came for me and we started staying together. . . he was good for some time but then he started it again. . . he still reminds me that I will have to pay for taking him to prison. . . he threatens to kill me" (Female community member #8)

Impact of Activism on Violence against Children

At the community level, engagement with SASA! encouraged some individuals to be less tolerant of violence, both against women and against children. This was seen as important, not just for children's well-being, but also for the community more generally. Children who were from violent homes were often believed to be most likely to 'roam around' and become street children, or to be involved in crime, thus affecting the whole community. Amongst some, participation in SASA! inculcated a sense of responsibility to children and encouraged them to act in response to violence that they observed:

> "Those sessions have helped. . .you find that in slum areas like this, many people make mistakes at home and they do them unknowingly. . .So for us who have been to those sessions [SASA! activities] we are like attorneys for such children or we are like watchmen for abused people in the community. On many occasions I have confronted parents and rebuked their actions. This is common with step mothers but you talk to her and tell her the dangers of what she is doing to the child. Some couples in the neighborhood fight each other but as people who have been to the trainings we have been taught not to just look at them. We intervene and ensure that harmony prevails in the community because we know the repercussions which is something we could not do before. We all believed that those were private things, but now we go and talk to them" (Male community member #10)

The work of SASA! to address IPV, however, was not always considered to be sufficient for addressing the needs of some children who were living in violent situations:

> "When they talk about SASA! they say it is came to prevent violence against women but I see in some homes where parents use violence against their homes [children] but I don't see how SASA! has helped. . . we see children who do not go to school, they keep moving around this community but nothing is being done to help them" (Female community member #5)

Similarly, not all participants considered themselves to have a role in addressing violence against children in their community and that instead this responsibility belonged to others including the police or the local government officials.

Discussion

This article summarizes findings from the SASA! study on the impact of the intervention on children. Overall, the findings report three important changes that suggest the potential impact of IPV prevention interventions for children. First, as a result of SASA!, children in intervention communities were probably less exposed to violence due to reduced levels of intimate partner violence in their households (Abramsky et al., 2014). Second the findings suggest reduced family disruption with women in intervention communities less likely to spend time away from their homes due to IPV than their control counterparts. This may also have implications on the likelihood of children being raised in homes other than their natal homes because of IPV-related disruption. Finally, even when violence continued, the findings suggest that children were probably less likely to witness this violence. We use the term 'probably', as many of the quantitative results did not reach statistical significance. However, given the limited statistical power of the trial, the large effect size estimates for several indicators, and the fact that all indicators shifted in the hypothesized direction, we believe that the evidence provides a compelling case for further research on the potential benefit to children of interventions that seek to prevent IPV.

The plausibility of the findings of the quantitative analysis are also supported by those of the qualitative evaluation with several participants describing reasons why violence was reduced or had ceased (Kyegombe, Starmann, et al., 2014). Although not solely as a result of SASA!, parents described how they were keen to ensure that their children did not witness any IPV that did occur. There was also some suggestion that SASA! influenced parenting practices by encouraging parents to make time for their children through play, improved communication, and increased involvement of children in decision-making. SASA! may also have impacted on children's experience of physical violence by challenging discipline practices. For some parents, exposure to SASA! resulted in them no longer using corporal punishment as a first resort. Instead these parents described how they first warned their children and explained why their behavior was unacceptable before using corporal punishment. A small number also rejected all forms of corporal punishment altogether. SASA! supported this by highlighting alternative, non-violent ways to discipline children. A few parents described how reductions in IPV also resulted in children's reduced experience of proxy violence where the child was not the intended target. There were also examples of how SASA! likewise encouraged some participants to act to prevent violence against children in their communities.

The findings are suggestive of a number of important pathways through which SASA! seems to have reduced violence against women and against children. First, SASA! encouraged participants to reflect upon violence and its consequences for their relationships. Similarly, participants were supported to question their use of power and how it could be used to better effect. Encouraging communication and joint decision-making with partners and children also appears to have emerged as a common pathway of impact. This, along with support and advice on non-violent conflict resolution skills, also encouraged more intimate, connected and co-operative relationships. These changes at the relationship level were also complemented by SASA!'s role in fostering a sense of responsibility to act to prevent violence in their community. In turn, this has been supported by more responsive community-based structures available through, for example, community activists.

The findings make an important contribution to the existing literature on preventing violence within the home. Several authors have highlighted how violence against women and violence against children often co-occur within the same households (Guedes & Mikton, 2013; Jewkes, 2002; Lansford et al., 2014), and highlight that households are important settings where patterns of behavior in later life are cultivated. The overlaps between IPV and violence against children are potentially multiple. Men who are violent towards their partner may also be violent towards their children, either intentionally, or when a child tries to intervene to protect their mother. In settings where women do not have equal status as their partners, or where they are perceived to be 'minors', a similar 'correctional' rationale for the use of physical force may also be used to justify men's use of violence towards their wives (Heise, 2015). In some cases, women who are experiencing violence may also be more likely to use violence to discipline their children (Jewkes, 2002; Lansford et al., 2014).

More broadly, there is strong evidence that parental attachment has important implications on children's emotional well-being and sense of security, and thus ability to cope with the effects of IPV (Carpenter & Stacks, 2009). Parenting skills, particularly those of mothers', have also been shown to be important for more favorable adjustment outcomes and resilience amongst children exposed to IPV (Graham-Bermann et al., 2009). Even where children do not directly experience violence, growing up in a household with partner violence has been shown to increase their risk of experiencing (for women) or perpetrating (for men) violence in adulthood, as well as engaging in other risk behaviors, such as heavy alcohol use and involvement in gangs (Feldman, 1997; Schiff et al., 2014; Stith et al., 2000; Wathen & MacMillan, 2013; Widom et al., 2014).

The study has both strengths and limitations. SASA! is the first randomized controlled trial in sub-Saharan Africa to assess the community-level impact of a community mobilization intervention on population-level prevalence of intimate partner violence. To the best of our knowledge, this is also the first study that has sought to assess whether such programs also reduce children's exposure to violence. The randomized study design, random sample of community members, and the use of an intention to treat analysis are important strengths of this study as they have enabled us to assess the impact of the intervention at the community level instead of amongst self-selecting individuals. It was also possible to consider secular changes that occurred during the study period and control for baseline imbalances between intervention and control communities owing to the repeated cross-sectional design. The qualitative evaluation included a range of stakeholders from

all intervention communities and captures a range of experiences of the intervention and its impact on participants and their families.

The study also has a number of limitations. First, we are unable to rule out the potential spillover effects into control communities which, despite geographical buffers, is a possibility, not least because SASA! relies on the social diffusion of ideas. Levels of intervention exposure may also not have been optimal owing to political unrest following national elections during the study period. The small number of clusters also meant that the study had low power to detect statistically significant effects for many outcomes. The findings of the qualitative evaluation also have limitations. They reflect the experience of those who reported reductions in relationship violence in the period preceding the interview. As such we are not able to evaluate the impact of SASA! on children in relationships in which IPV was not reduced or indeed understand the extent to which changes in children's experience of violence may or may not be correlated with women's in the same households. The findings would also have been strengthened had the views of children themselves been included.

Conclusion

Globally, it is estimated that 30% of women experience violence from their partner. Furthermore, comparable data from 62 countries or areas show that on average, about 80% of children between the ages of two and 14 have been subjected to some kind of violent discipline in the home, with parents being important perpetrators of this violence (United Nations Children's Fund, 2014). There is growing evidence that partner violence is preventable – with some interventions more than halving the levels of partner violence that women experience (Ellsberg et al., 2014; Kim et al., 2007; Pronyk et al., 2006). Much of the existing intervention literature on children's experience of violence has focused either on the potential importance of interventions to support the development of parenting skills, or of interventions to support children who have been exposed to violence (Cohen et al., 2011; Jouriles et al., 2009; Lieberman et al., 2005; Wathen & MacMillan, 2013). The findings of this article are unique in their ability to offer insights into how community mobilization interventions may affect children. Although exploratory, the findings illustrate an additional intervention impact that may have multiple benefits to children in households. The first benefit is direct – by reducing intimate partner violence, children's exposure to violence is also reduced. More indirectly, the findings suggest that some of the attitudinal shifts and core skills that such interventions develop – including a re-analysis of the acceptability of violence, greater empathy, improved communication, and better anger management strategies – do not only reduce violence within relationships, but may also improve parents' relationships with their children.

This provides a glimmer of hope that ultimately, rather than having to try to separately prevent the multiple forms of violence against women, and violence against children, some forms of intervention programming have the potential to have multiple impacts. It is important that future violence prevention research – be it focused on preventing partner violence, strengthening parenting skills, or reducing the use of corporal punishment – explores the potential broader benefits of intervention activities on participants. This evidence could help inform a more joined-up vision for the prevention of violence that seeks to prevent all forms of violence within households, and creates the conditions within which children have the skills to go on to have violence-free, gender equitable, adult relationships.

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