Effectiveness of Communities Care Scale-up to Change Gender-based Violence Social Norms in Somalia

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Introduction and Background

Gender-based violence (GBV) remains one of the most prevalent and persistent issues facing women and girls globally[1,2]. Women and girls living in conflict and other humanitarian emergencies in Somalia are at increased risk of many forms of GBV[3]. A recent population-based survey on GBV across the three regions of Somalia estimated the prevalence of GBV victimization with 2376 women (15 years and older). Among women, 35.6% reported lifetime experiences of physical or sexual intimate partner violence and 16.5% reported lifetime experience of physical or sexual non-partner violence since the age of 15 years. Women at greatest risk of GBV included membership in a minority clan and displacement from home because of conflict or natural disaster. GBV has negative impacts on physical, mental and reproductive health. However, often these negative health and social consequences are never addressed because women do not disclose GBV to providers or access health care or other services (e.g., protection, legal, traditional authorities) because of social norms that blame the woman for the assault and prioritize protecting family honor over safety of the survivor, and institutional acceptance of GBV as a normal and expected part of displacement and conflict[4].

Social norms are contextually and socially derived collective expectations of appropriate behaviors. Communities have shared beliefs and unspoken rules that convey that GBV is acceptable, even normal. This includes social norms pertaining to family honor, men's authority over women and children and blaming woman when they experience GBV. Community leaders, institutions, and service providers (health care, traditional elders and justice system) can reinforce harmful social norms by justifying a husband's use of physical violence as a means to discipline his wife and not responding in a caring way to women who have experienced GBV. Different theories to explain the complexity of social norms and their influence on behavior exist. In this context, social norm can be conceptualized as beliefs of two types: 1) a descriptive norm which is an individual's beliefs about what others typically do in a given situation; and 2) an injunctive norm which are their beliefs about what others expect them to do in a given situation. When evaluating effectiveness of programs to change social norms the sustain GBV, the focus is on injunctive norms or beliefs about what influential others (e.g., parents, siblings, peers, religious leaders, teachers) expect individuals to do when cases of GBV occur.

Acknowledging the potential of the humanitarian setting as an opportunity for primary prevention programming and recognizing the need to strengthen GBV response systems, the United Nations Children's Fund (UNICEF) developed the Communities Care Program (CC). The goal of CC is to create safer communities for women and girls by challenging social norms that sustain GBV and catalyzing new norms that uphold women and girls' equality, safety, and dignity. The CC program aims to increase quality and access to care, support for women who experience GBV and to change harmful social norms that sustain GBV in communities. The program consists of service provider training on compassionate care for GBV survivors across sectors (police, justice system, healthcare providers, psychosocial providers, and community health workers), 15 weeks of structured community discussions

groups led by trained discussion leaders from the community and community actions determined by and enacted by the community discussion participants. The program implementation is guided by a toolkit developed by UNICEF (https://www.unicef.org/documents/communities-care). The toolkit consists or four parts – Building knowledge and awareness; Programme planning and monitoring; Strengthening community-based care, and Catalyzing change. Originally the program was implemented in Mogadishu, Somalia by Comitato Internazionale per lo Sviluppo dei Popoli (CISP) an NGO with a long history working in Somalia and evaluated by Johns Hopkins University. The program was found to be effective at changing social norms and improving confidence in providers in a randomized evaluation comparing districts that received CC with control districts[5]. CC districts had improved social norms from prior to the program start to 24 months after the Communities Care was implemented compared to control districts among randomly selected general community members who did not participate directly in the discussion groups illustrating the spread of the CC messages throughout the community.

To scale-up CC, CISP has partnered with local NGOs is 9 areas of Somalia to implement the CC program with funding provided by UNICEF. In order to evaluate the feasibility and effectiveness of the scale-up, the local implementing partners also conducted surveys with CC participants and general community members pre- and post-implementation. The areas for scale-up varied across locations throughout Somalia and varied in setting (rural/urban), population size and degree of ongoing conflict. This paper presents the evaluation of the scale-up examining change in personal beliefs and social norms among CC participants and general community members. We also examine change over time in confidence in service providers across the 9 scale-up sites.

Methods

Study setting

CC was implemented in 9 areas of Somalia – Quardho Puntland, Garowe Puntland, Bardhere Jubaland, Dhobley Jubaland, Dollow Jubaland, Dharkenley Mogadishu, Baidoa South West, Bual Burte - Hirshabelle and Waberi - Mogadishu. Each of the areas have local and/or international NGOs with the capacity to provide services for survivors of GBV.

Communities Care scale-up implementation process

The CC program was implemented by local implementing partners (Shilale Rehabilitation and Ecological Concern- (SHILCON), Tadamun Social Society – (TASS), Social-Economic Development and Human Rights Organization (SEDHURU), Community Empowernment and Development Action (CEDA), Somali Children Welfare Rights Watch SCWRW), Humanitarian Integrity for Women Action(HIWA), Somali Women Development Centre (SWDC), with support from CISP. The scale-up of the Communities Care (CC) program was a comprehensive initiative that leveraged both physical and virtual resources. Leading this effort, CISP played a pivotal role in providing mentorship and support to the local UNICEF partners responsible for implementing the CC program across various regions. This collaborative approach aimed to create safer communities for women and girls by challenging and transforming the prevailing social norms that sustained gender-based violence (GBV).

Implementing Partner Training and Support. The implementation process began with a 15-days training program training component for the local NGO partners. The primary objective of this training was to empower implementing partners with the knowledge, skills, and tools needed to scale up the CC program. This comprehensive training support was instrumental in ensuring the successful expansion of

the CC program and its positive impact on communities. The training curriculum emphasized the foundational elements required for addressing GBV comprehensively. It covered topics ranging from understanding sexual violence, the dynamics of social norms, fostering self-awareness, and using the CC Toolkit. A central component of the CC program is the Toolkit which serves as a comprehensive resource with practical guidance on how to implement the program effectively and detailed dialogue guide that provided step-by-step instructions for conducting each of the dialogue sessions. This guide was instrumental in ensuring that the discussions were focused, informative, and aligned with the program's goals.

Community Discussion Leaders Training and Support. The partners then transferred their newly acquired knowledge and skills to individuals selected to lead the discussion groups, known as Community Discussion Leaders (CDLs). These CDLs served as the frontline facilitators of the CC program within their communities. They were entrusted with the responsibility of guiding community members through structured discussions outlined in the CC Toolkit aimed at challenging existing norms and promoting positive change with respect to GBV. The training program spanned a period of 14 days, ensuring that participants had ample time to absorb and internalize the knowledge and skills required for their roles. The initial three days were dedicated to establishing a strong foundation on the core concepts of the CC program. Participants engaged in immersive sessions that explored the intricacies of societal norms, delved into the sensitive topic of sexual violence, and fostered self-awareness among those involved. These foundational elements were crucial in setting the stage for the subsequent phases of the training. The remaining eleven days of the training were strategically focused on honing the participants' abilities in facilitating group discussions within their respective communities. This part of the training encompassed various essential components, including the development of effective facilitation skills. Participants learned how to create an inclusive and open environment for discussions, encouraging community members to actively engage in conversations about GBV and related social norms. In addition they were introduced to reporting and monitoring tools designed to ensure that CDL's were prepared to track and evaluate the progress of their activities.

Dialogue session support. Throughout the implementation of the community dialogues, the partners received extensive support from CISP to ensure the effectiveness of the dialogue sessions. This support was designed to serve as a continuous feedback loop, allowing for ongoing monitoring of the program's progress and addressing any challenges or concerns that the partners might encounter. One key focus of the support was on effective utilization of the dialogue guide. Partners were provided with detailed guidance on how to make the best use of this resource. They were encouraged to explore the intricacies of the dialogue guide, understanding how it could serve as a valuable tool for facilitating meaningful conversations within the community. This included insights into structuring the discussions, framing questions effectively, and creating an environment conducive to open dialogue. Partners were also introduced to the importance of distinguishing between content and process within the dialogue sessions. This distinction was essential in ensuring that the discussions remained focused on the program's objectives while allowing for the natural flow of conversation. Partners were guided on how to strike the right balance between steering the dialogue toward relevant topics and allowing community members to express their thoughts and experiences. Importantly, the support provided to CC partners was not solely focused on programmatic aspects but also extended to addressing any personal challenges or concerns they might encounter. This personalized assistance ensured that partners felt supported and equipped to navigate any issues that arose during the dialogue sessions.

Support for Community Action Plans. After the completion of the community dialogue meetings, the partners received mentoring on developing action plans including developing information, education, and communication (IEC) materials and messages tailored to the specific needs of different dialogue groups and communities. Each group comes up with a summery captioning what they have learned through the dialogues, CISP staff support the partner in development of messages and dissemination to the wider communities. The groups public events use different means such as poems, songs, and plays. They also use visibility materials such as hats, scarfs, and posters. Event participants are drawn from different stakeholders including local authorities, religious leaders, women and youth group leaders and the event are captured on live on local radio stations.

Communities Care Evaluation

The scale-up evaluation uses a longitudinal design (baseline and endline) with two samples. The evaluation with CC program participants examines if the program changed personal beliefs and social norms of the people who participated in the community dialogues and community actions. All program participants (~100 per area) completed a survey prior to the start of CC and again 1-year later after full implementation of the program. In addition, a random sample of 120 general community members in each area who did not directly participate in the CC program were surveyed prior to the CC implementation and 1-year later to evaluate if the CC messages spread from the program participants into the general community.

Data Collection Methods

Data was gathered by surveys administered in-person. RAs from each of the implementing partners were trained by CISP and JHU on interviewing skills, ensuring privacy during the interview, and data security. Inter-rater reliability was assessed and RAs had to achieve >95% agreement before beginning data collection in the field. Female interviewers interviewed female survey participants and male interviewers interviewed male survey participants, privately. The recruitment target for the general community members in each community was stratified by gender and age (18-24, 25-44, 45+). The random sampling procedure instructed the research assistant (RA) to start from a central point and knock on the door of every 3rd house/buul/tent. The houses/tents were counted on both sides of the street/walk pathways. If the person who answered the door was not willing to answer the survey or did not match the sampling target, the RA went to the next house. Only one interview was carried out in each household. CC participants were contacted by the RA who arranged a time and private place to meet them and complete the survey at baseline and endline.

Personal Belief and Social Norms Measures

The Social Norms and Beliefs about GBV Violence Scale was used to evaluate people's personal beliefs and social norms towards GBV in the domains of Response to Sexual Violence, Husband's Right to Use Violence Against his Wife, Protecting Family Honour[6]. This scale was the basis of study that examined the effectiveness of CC compared to control areas in Mogadishu[5]. For Personal Beliefs the questions were asked on a 4-point scale of "tell us if you strongly disagree, disagree, agree, or strongly agree with each statement". Higher scores represent more negative personal beliefs or beliefs that sustain GBV. For Social Norms were phrased "how many people in your community think…" with a 4-item response scale of "none, few, many, most or all". Higher scores reflect that more people in the community endorse social norms that sustain GBV. Three additional sets of items were included to capture personal beliefs and social norms about gender equality (2 items, personal beliefs only), female genital mutilation (FGM) (4 items) and child marriage (6 items).

Confidence in GBV Service Providers

Since one important component of CC is training of service providers to improve providers response to GBV, we also examined change over time in confidence in service providers using 17 items on a 4-point scale (strongly disagree to strongly agree). Items asked about police/justice system, Elders, healthcare/psychosocial providers, and community health workers.

Statistical Analysis

We examined change from baseline to endline in personal beliefs and harmful social norms that sustain violence against women using t-tests separately for CC participants and general community members. The evaluation with general community members used a panel design where a random sample of community at each time point is taken so that surveys were completed by different people at baseline and endline representing the community at that time. CC participants also could change over time as people come and go from the program. Data was collected anomalously from the CC participants to protect confidentially especially when the community was small.

Results

Table 1 presents the demographic characteristics of the two samples. The sampling frame achieved an approximately equal number of males and females with ¼ of respondents from each age group for the general community members. CC participants were also approximately 50% female with the majority of people participating in CC being in the age range of 25-44 years. Nearly ¾ of those participating in CC had never been displaced whereas approximately ½ of the general community member sample had never been displaced. Over 2/3 of people were married with the majority having children. Approximately 40% of the general community members did not complete primary school and slightly over a ¼ of CC participants did not complete primary education. Over 67% of general community members and 55% of CC participants were unemployed and the majority never have enough money to meet the basic needs of their family every month.

Table 1. Demographic characteristics for CC participants and general community members

	CC Participants		General Community Members	
	Baseline N=933	Endline N=943	Baseline N=1096	Endline N=1125
Gender				
Female	53%	52%	50%	49%
Male	47%	48%	50%	51%
Age				
18-24	26%	22%	25%	25%
25-44	44%	43%	26%	25%
45-60	23%	27%	25%	25%
Over 60	7.3%	7.5%	23%	25%
Displacement				
Currently Displaced	6.5%	6.4%	16%	18%
Previously Displaced	23%	20%	30%	35%
Never Displaced	71%	74%	55%	47%
Married	65%	69%	67%	68%
Have children	66%	75%	74%	72%
Education				
Did not complete primary/none	30%	25%	42%	37%

Completed primary	11%	14%	7.8%	7.6%
Did not complete secondary	7.7%	9.3%	4.3%	6.8%
Completed secondary or above	29%	32%	19%	23%
Attended Madrasa	22%	20%	27%	26%
Employment				
Does not work	56%	55%	67%	68%
Full-time	12%	11%	6.6%	6.8%
Part-time	32%	34%	26%	25%
Financial Status – Have enough money to meet basic needs of family …				
For most or all of the month	27%	25%	18%	18%
For about 1/2 of the month	16%	15%	14%	9.8%
For less than 1/2 the month	16%	15%	16%	12%
Never have enough money to meet the basic needs of your family	40%	45%	52%	60%

Changes in Personal Beliefs, Social Norms, and Confidence in Service Providers

Overall the people who participated in the CC community dialogues and enacted the community action plans had significant positive changes from baseline to endline (Table 2). At endline, CC participants were more likely to have a supportive response when someone experiences sexual violence ($p<.001$), reject husbands' right to use violence against his wife ($p<.001$), not endorse protecting family honor over reporting sexual violence ($p<.001$), be more supportive of gender equality ($p<.001$), and reject the practices of FGM ($p<.001$) and child marriage ($p<.001$). The Cohen's d' effect sizes presented in the last column of Tables 2 and 3 is a measure of the amount of change from baseline to endline. Values <0.20 are consider small, 0.35 moderate, and >0.80 large[7]. The observed effect sizes in Tables 2 and 3 are negative which means there was a reduction over time in the scores indicating more positive beliefs and social norms. The CC participants also saw a change in how the community responds to GBV with fewer people in the community endorsing harmful social norms that sustain GBV in their community ($p<.001$ for all subscales). Small to moderate effect sizes in the range of 0.22 to 0.24 were seen for personal beliefs about husbands' right to use violence against his wife, gender equality, and FGM indicating these are the areas where CC participants should the least improvement in personal beliefs. Moderate effect sizes (0.37 to 0.57) were observed for personal beliefs about response to sexual violence, protecting family honor and child marriage as well as social norms about husbands' right to use violence and FGM. The greatest improvements with moderate to large effect sizes (0.60 to 0.90) were in the areas of social norms for response to sexual violence, protecting family honor and child marriage.

Table 2. Personal beliefs and social norms across time for CC participants (higher score reflect more negative personal beliefs or social norms that sustain GBV)

	Baseline CC Participants	**Endline CC Participants**	**p-value**	**Effect Size**
Personal Beliefs (1-strongly disagree to 4-strongly agree)				
Response to sexual violence	2.00	1.80	<0.001	-0.53
Husbands' right to violence	2.26	2.15	<0.001	-0.24
Protecting family honor	2.39	2.13	<0.001	-0.57
Gender Equality	2.27	2.10	<0.001	-0.30
FGM	2.65	2.56	<0.001	-0.22

Child marriage	2.44	2.25	<0.001	-0.42
Social Norms (1-none of them to 4-all of them)				
Response to sexual violence	2.25	1.89	<0.001	-0.90
Husbands' right to violence	2.36	2.17	<0.001	-0.37
Protecting family honor	2.38	1.99	<0.001	-0.71
FGM	2.65	2.49	<0.001	-0.40
Child marriage	2.45	2.20	<0.001	-0.60

The CC messages reached those that did not directly participate in CC. The messages were spread into the general community with only 19% reporting that they heard messages about GBV at baseline and 41% hearing GBV messages at endline (p<.001). Overall, community members felt more people in the community think that sexual violence a problem at endline (p<.001) with more members of the community speaking out against GBV at endline compared to baseline (p<.001). Table 3 illustrates the positive changes in the general community members in personal beliefs and social norms. Personal beliefs improved in all areas (p<.002 for all) except for husbands' right to use violence against his wife (p=.196). Small but significant effect sizes were observed for general community member's personal beliefs about response to sexual violence, gender equality, FGM and child marriage. Greater change was seen for personal beliefs about protecting family honor with a small to moderate effect size. At endline, general community members were more likely to have a supportive response when someone experiences sexual violence, not endorse protecting family honor over reporting sexual violence, be more supportive of gender equality, and reject the practices of FGM and child marriage. Not only did community members personal beliefs improve at endline, so did harmful so social norms that sustain GBV (p<.005 for all). There was greater change in community member's perception of social norms than their personal beliefs with moderate to large effect size for response to sexual violence and moderate effect sizes for protecting family honor and child marriage. Social norms for husbands' right to use violence and FGM had small associated effect sizes.

Table 3. Personal beliefs and social norms across time for the general community members (higher score reflect more negative personal beliefs or social norms that sustain GBV)

	Baseline General Community	**Endline General Community**	**p-value**	**Effect Size**
Personal Beliefs (1-strongly disagree to 4-strong agree)				
Response to sexual violence	1.92	1.85	<0.001	-0.18
Husbands' right to violence	2.28	2.25	0.196	-0.06
Protecting family honor	2.37	2.25	<0.001	-0.26
Gender Equality	2.27	2.15	<0.001	-0.20
FGM	2.64	2.59	0.002	-0.11
Child marriage	2.41	2.31	<0.001	-0.22
Social Norms (1-none of them to 4-all of them)				
Response to sexual violence	2.21	1.96	<0.001	-0.66
Husbands' right to violence	2.34	2.27	<0.001	-0.13
Protecting family honor	2.32	2.14	<0.001	-0.37
FGM	2.64	2.58	0.005	-0.13
Child marriage	2.43	2.28	<0.001	-0.34

At endline, both CC participants and members of the general community had more confidence in service providers to help women who experience GBV. There was a significant improvement in

confidence in service providers among the CC participants (p<.001 for all). The greatest improvement was for the police/justice system (effect size=0.56) and healthcare and psychosocial providers (effect size=0.53), followed by community health worker (effect size=0.43) and elders (effect size=0.39) Confidence in all service providers also increased significantly (p<.001 for all) among general community members. The largest improvement in confidence was seen for police/justice system (effect size=.40), healthcare and psychosocial providers (effect size=0.39) and community health workers (effect size=0.32) with less improvement for confidence in elders (effect size=0.28).

Scale-up differences by site

The success of the implementation in changing personal beliefs and social norms varied across the 9 sites. Table 4 summarizes the pattern of findings when comparing the baseline and endline for the CC discussion participants and the general community members. A check (✓) represents a statistically significant improvement over time among CC discussion participants and a plus (+) denotes a significant improvement in the general community members personal beliefs and social norms. The intervention had a substantial impact on CC participants in Dollow, Dhobley, Qardho, Waberi, Garowe and Baidoa with improvements seen in nearly all areas. The spread of CC into the general community was successful for Dollow, Qardho and Waberi. Although there was change in CC participants in Dhobley, and Garowe, the community action plans did not appear to have a strong impact on the general community as there was little change in the general community members. Garowe had delays due to elections and difficulty getting religious leaders to support the program. Bulla Burte that experienced a high level of insecurity in the area had mixed success in changing CC participants personal beliefs and social norms, while Dharkenley had little impact on CC participants but there was positive change in the general community members. Dharkenley is located right next to Bondheere District which previously implemented CC. The discussion leaders and CC participants likely selected from people who had previous engagement in activities promoting change who could be seen as role models, so they had more positive beliefs at baseline with less room for improvement. In Bardhere which encountered challenges due to insecurity in conducting the public events had little success in changing personal beliefs for the CC participants and almost no change in the generally community members.

Table 4. Significant improvement from baseline to endline in the CC discussion participants

	Dollow	Bardhere	Dhobley	Qardho	Waberi	Garowe	Dharkenley	Baidoa	Bulla Burte
Thinks sexual violence in a problem	✓ +	+	✓ +	✓ +	✓ +	✓ +			✓ +
People speak out against sexual violence	✓ +	✓	✓	✓ +	+	✓	+	✓ +	+
Heard messages about GBV	✓ +	✓ +		✓ +	✓ +	✓	✓ +	✓ +	✓ +
Personal Beliefs									
Response to sexual violence	✓ +		✓ +	✓ +	✓ +	✓			
Husband's Right to Use Violence	✓ +				✓ +			✓	✓ +
Protecting Family Honor	✓ +	✓	✓	✓ +	✓ +	✓		✓	
Gender Equality	✓ +		✓	✓ +	✓ +		+	✓	
Child Marriage	✓ +		✓	✓ +	✓ +	✓	✓ +	✓ +	

FGM			✓	✓ +	✓ +	✓ +		✓	✓ +
Social Norms								✓	
Response to sexual violence	✓ +		✓ +	✓ +	✓ +	✓ +	✓ +	✓	
Husband's Right to Use Violence	✓ +			✓	✓ +		✓ +	✓	✓ +
Protecting Family Honor	✓ +		+	✓ +	✓ +	✓ +	✓	✓	
FGM		✓		✓ +	✓ +	✓ +	✓	✓	✓ +
Child Marriage	✓ +		✓	✓ +	✓ +	✓ +	✓ +	✓	
Confidence in Service Providers									
Police/justice system	✓ +		✓ +	✓ +	✓ +	✓	✓ +	✓	✓
Elders	✓ +		+	✓ +	✓ +		✓ +	✓	
Healthcare /psychosocial providers	✓ +		✓ +	✓ +	✓ +	✓	✓ +	✓ +	+
Community health workers	✓ +		✓	✓ +	✓ +		✓ +	✓	

Discussion

The scale-up of Communities Care in nine sites implemented by seven different implementing partners was successful in improving personnel beliefs and social norms about GBV across several different regions of Somalia. An important aspect of the success of the scale-up is mentorship from an organization that has extensive experience in implementing and monitoring the CC program.

Among CC discussion participants, the greatest positive change was seen for personal beliefs about response to sexual violence, protecting family honor and child marriage. Similarly, the CC discussions participants report substantial improvement in social norms for all of these areas. Significant, but smaller improvements were seen for husbands' right to use violence and FGM. FGM is a deep-rooted cultural practice in many settings tied to women being respected and eligible for marriage[8]. Families may practice FGM to avoid stigma and communication on the topic of FGM is not widely accepted[9]. Greater focus on improving knowledge about the consequences of FGM for the woman may be need in the community discussion guides. Over 35% of women in Somalia have experienced violence from a husband in her lifetime[3]. It is not surprising that change is not as great for IPV as likely, the majority of these acts occur in private making it harder for others to observes changes in social norms around husbands' right to use violence against his wife.

Significant but smaller improvements were seen among the general community members with the greatest positive change seen in community members perception of social norms and less change in their personnel beliefs. Attending the CC community action events illustrates that support of community members to eliminate GBV which general community members perceive as a shift in social norms in their community. Changing individual's personal beliefs may be slower requiring more time and discussions before general community members internalize the messages.

The communities where we found the greatest improvement were those sites that were able to implement strong community action plans and had support from local authorities and religious leaders. When general community members were asked about where they heard message about GBV violence most (80%) said through community events organized by local NGO (the local implementing partner). Over 70% heard the messages on the radio and 68% at social gatherings. The public declarations focused on eliminating GBV in the community appear to be a key component to change social norms among community members. This is likely because they are observing others in their community

publicly denouncing harmful social norms that enforce violence against women and girls. These findings are congruent with other research that illustrates that community dialogues can enact change and organized diffusion to spread the dialogue group messages to the broader community is an effective strategy to expand the effect and achieve sustainable social norms change[10].

Communities that experienced security concerns due to violence by groups such as Al Shabab were unable to hold large gatherings and enact their action plans. Although CC participants did door-to-door awareness raising, the impact on changing personal beliefs and social norms was minimal. Door-to-door awareness doesn't provide an opportunity for the people to see that many in their community support the elimination of gender based violence and hence see a shift in community social norms. Although 55% present of the community members said a community member had visited their home to talk about GBV, in sites where this was the main activity for the CC action plans, the change was not as strong as those with public declarations.

Some implementing partners described difficulties in engaging religious leader in the CC discussion group and public actions and others encountered difficulties with government officials joining these events. In the original CC effectiveness, the participation of religious leaders was seen as a key component in improving social norms. Only 18% of the scale-up community members reported hearing messages in mosques and 19% from government officials. Increasing buy-in and participating from religious and government officials could greatly strengthen the impact of the CC program.

Social norms change is a progressively slow process that gradually changes over time. This evaluation examined the impact of a single implementation of the CC program. As CC discussion participants become new champions of ending GBV, they can become CDL's for future discussion groups and community actions propelling further progress of social norms change.

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