HUMANITARIAN INNOVATION FUND
Development and Implementation Phase Grant Final Report

Organisation Name	Women and Health Alliance (WAHA) International

Project Title	Linking interventions to cultural ceremonies and practices to reduce intimate partner violence among displaced populations in humanitarian crises
Partner(s)	Addis Ababa University (AAU) School of Public Health, Harvard Medical School (HMS), Abdul Latif Jameel Poverty Action Lab (J-PAL), Harvard T.H. Chan School of Public Health
Problem Addressed / Thematic Focus	Intimate partner violence (IPV) / Refugee population
Location	Dollo Ado Refugee Camps, Ethiopia
Start Date	January 1, 2016
End Date	November 30, 2018
Total Funding	149,991 GBP + 9,438 GBP
Total Spent	159,432 GBP

Reporting Period	January 1 2016 – November 30 2018
Type of Innovation	
Project Impact Summary	The project was implemented in Bokolmanyo refugee camp in Dollo Ado, Ethiopia in 2016-2018 and aimed to improve humanitarian practice by developing an innovative intervention to prevent and reduce intimate partner violence (IPV) among a Muslim refugee population and delivered in the context of a cultural practice to increase acceptability, participant engagement, program impacts and scalability to other settings. Qualitative research was conducted in 2016 (n=110) to inform the adaptation of the Unite for a Better Life intervention—an in-person, group-based curriculum that was previously designed and tested for a non-humanitarian setting in Ethiopia. The intervention was adapted in 2017 and comprised 16 sessions and was designed to be delivered to groups of women,

	men, and couples as a tea talk. In 2018, the intervention was piloted in one camp. Households (n=180) with married couples in 6 camp zones were randomly selected for participation in a baseline survey to assess IPV and HIV knowledge and attitudes as well as experience of IPV. Households were randomly assigned to one of four groups: 1) women receive the intervention, 2) men receive the intervention, 3) couples receive the intervention, or 4) a control group. The 16 intervention sessions were delivered to groups of 20 individuals in each arm over 6 weeks. A post-intervention survey was administered to assess acceptability of the intervention and changes in knowledge and attitudes. At baseline, 81% of women (mean age=33 years) reported experiencing physical and/or sexual IPV in their lifetime. The frequency of specific acts of IPV was reported to be higher within the camp than prior to displacement. Of participants, 78% in the women's arm, 68 % in the couples arm and 55% in the men's arm completed at least 70% of sessions. Among participants, 92% were satisfied with the program, 85% would recommend it to a friend, and none reported spousal conflict or violence as a result of participation. Endline data suggest improvements in IPV and HIV knowledge and attitudes.

PROJECT ACTIVITIES AND OUTPUTS

*Please go to **Appendix 1** and attach the final workplan, showing all work that was actually completed.*

1. With reference to the final workplan, what have been the key achievements of the project?

As outlined in the final work plan, key achievements by project phase include: 1) qualitative data on gender, social, cultural, and religious norms that contribute to IPV and on community practices in Dollo Ado camps that may serve as platforms for IPV intervention delivery; 2) an IPV intervention logic model and curricula for three IPV interventions (women, men, and couples) targeted for a Muslim and Somali context; 3) baseline and endline data from the pilot study on feasibility, acceptability, attendance, knowledge and attitudes related to IPV and HIV, and gender and social norms; and 4) lessons learned on the selection of community and cultural practices for IPV intervention delivery, and on the process of adapting an intervention from the non-humanitarian setting, as well as oral dissemination, and preparation of manuscripts for submission to peer-reviewed journals.

INNOVATION OUTCOMES

Whether this innovative project was successful, not successful, or a mix of both, the HIF would like you to report as much detail as possible, so that success can be built on and failures can be learned

from. By 'success' we mean that the innovation has achieved the planned positive impact/outcome, or that it has performed better than the current process, product or system.

2. Has the project demonstrated the success of the innovation? *(Please choose only one answer.)*

☒ Completely successful
☐ Significantly successful
☐ Partially successful
☐ Completely unsuccessful

2b. Please select the successes that your project have achieved:
(You may choose more than one)

☒ There is real evidence that the project achieved the planned outcome(s)
☒ There were perceived contributions or improvements to the planned outcome(s)
☒ Learning was achieved within the project cycle
☒ 'Lessons learned' were gathered and circulated to humanitarian stakeholders and actors
☒The completion of this project has led to another innovation
☐ Other (please comment) _____

2c. Please select the challenges your project has encountered:
(You may choose more than one)

☐ The project did not complete its planned activities
☐ There is no real evidence that the project achieved the planned outcome(s)
☐ There were few perceived contributions or improvements to the planned outcome(s)
☐ Learning was not achieved within the project cycle
☐ 'Lessons learned' were not circulated to humanitarian stakeholders and actors
☒ Other *(please comment)*: The pilot planned in 2017 was postponed and completed in 2018.

2d. If there is any evidence for the successful performance of the innovation, please describe it further:

A pilot study was conducted in 2018 in Dollo Ado to field test the innovation with 180 households randomly assigned to a women's, men's, couples or control group. High attendance rates were achieved despite the challenging setting: 78% of participants in the women's arm and nearly 70 % of couples completed at least 70% of sessions (considered as high exposure to the intervention). Attendance rates in men were slightly lower but lessons learned to increase attendance will improve future implementation. Key indicators demonstrate acceptability, relevance and utility of the intervention. Among participants, 92% were satisfied or very satisfied with the program, 85% would recommend it to a friend, and none reported spousal conflict or violence as a result of participation. Participants demonstrated increased knowledge on violence against women, and less support for gender inequitable attitudes and IPV. Improvements in HIV knowledge and attitudes were observed. While a longer follow-up period (at least one year) is required to assess changes in experience and perpetration of IPV, our pilot data suggest some potential reductions in reported sexual IPV, that should be confirmed via more rigorous evaluation. These findings demonstrate proof of effectiveness and potential to change longer-term outcomes, such as experience of IPV.

3. **Please show the components of the project which contributed the most to any *successes*:**

(where 1 = most influence 3 = least influence)

Component	*1*	*2*	*3*	*N/A*
Design and placement of the innovation	☒	☐	☐	☐
The methodology or approach to collecting evidence	☒	☐	☐	☐
Context	☒	☐	☐	☐
The availability of resources and capacities (financial, human, technical etc.)	☒	☐	☐	☐
Success in identifying and responding to different project and innovation risks	☒	☐	☐	☐
Strength of relationships and collaborations within the team and with other stakeholders	☒	☐	☐	☐
The process was flexible and responsive to emerging results	☒	☐	☐	☐
Ability to draw on experience and expertise of existing practice, codes and standards	☒	☐	☐	☐
Other:	☐	☐	☐	☐
Other:	☐	☐	☐	☐

4. **Please show the components of the project which contributed the most to any unsuccessful elements of the project**

Component	*Yes- contributed to failures*
Weaknesses in the design and placement of the innovation	☐
The methodology or approach to collecting evidence	☐
Context	☐
A lack of access to resources and capacities (financial, human, technical etc.)	☒
Difficulty in identifying and responding to different risks	☒
Lack of good relationships and collaboration within the team and with other stakeholders	☐
Having a process that was not flexible or responsive to emerging results	☐
No ability to draw on experience and expertise of existing practice, codes and standards	☐
Other:	☐
Other:	☐

5. What are the top three, key lessons learnt relating to the innovation? *This should relate to the innovation or the sector in which it operates, rather than project implementation.*

5.1. Intimate partner violence is an important problem to address in this humanitarian setting. Prior to implementation of this project, there were minimal data on intimate partner violence (IPV) among displaced persons originating from Somalia. There were anecdotal data from organisations operating in the refugee camps of Dollo Ado, Ethiopia to suggest that IPV is frequent in this population; but there was a lack of data on IPV to inform programming and policy in this area. Our project helped to fill this gap and provided strong evidence of the widespread nature of IPV in such settings and the urgent need for effective programming relevant and appropriate for humanitarian settings.

Baseline data collected during our pilot study in Bokolmanyo refugee camp in Dollo Ado indicate the pervasive nature of IPV among married couples in the refugee camp. At baseline, 81% of women (mean age=33 years) reported experiencing physical and/or sexual intimate partner violence in their lifetime. The frequency of specific acts of IPV was reported to be higher within the camp than prior to displacement. Based on our expertise and working knowledge of the evidence base, this is one of the highest prevalence rates measured for IPV. The quantitative data from the pilot study collected among men confirm the high rates of IPV, as does the qualitative data which describes the underlying factors and norms related to IPV. These data have been shared with stakeholders and policymakers in Ethiopia (Dollo Ado and Addis Ababa), and there is great interest from stakeholders to implement and scale up the intervention. We have explained more rigorous evaluation on a larger scale is needed prior to scale up and have applied for funding to evaluate the intervention with a randomised controlled trial.

The project findings contribute meaningfully to humanitarian practice as the data indicate that IPV is an important problem to address in this refugee context. Current practice in humanitarian settings is to focus primarily on non-partner violence (such as non-partner sexual violence) and there are few programs directed toward prevention and reduction of IPV. The data also suggest that displacement has led to an increase in IPV among married couples. There are few studies evaluating the impact of displacement on intra-marital stress and conflict, and our data shed new light on what couples experience with displacement. Bringing attention to the issue of IPV within humanitarian settings with robust quantitative and qualitative data has opened up dialogue and has also influenced UNHCR and ARRA programming in Ethiopia.

5.2 The adapted intervention to prevent IPV is feasible, acceptable and has the potential to change long-term outcomes in similar refugee contexts.

The adapted intervention was field tested among 180 randomly selected households within the refugee camp. The pilot study data reveal high feasibility and acceptability of this in-person, group-based, curricular intervention implemented over multiple weeks in a humanitarian context. As indicated in question 2d, the pilot study data revealed high attendance and completion of the intervention among participants. There was also evidence of knowledge and attitudinal change with respect to both IPV and HIV. There was some suggestion of reductions in sexual IPV that need to be confirmed through more rigorous evaluation with a longer follow-up period. Lessons learned related to delivery of the intervention in a camp setting – including timing and frequency of sessions, coordination with existing camp activities, and strategies to improve attendance especially among men were generated and shared with stakeholders. Importantly, among participants completing the intervention, there were no reports of spousal conflict or violence as a result of participation. The innovation is ready for the next stage in the journey to scale – that is more rigorous testing with a randomised controlled trial to measure changes in longer-term outcomes in two additional camps in Dollo Ado (together with UNHCR and ARRA), dissemination and diffusion of the findings and lessons on a much larger scale.

5.3. Importance of integration of IPV and HIV programming

A growing body of evidence has linked IPV with HIV risk; however, there are few IPV prevention programs in humanitarian contexts and few guidelines on the integration of HIV programming into gender-based violence programming in humanitarian contexts. Culturally appropriate, community-based interventions that stimulate behavior change have the potential to prevent IPV and in turn, HIV transmission. The adapted intervention comprised 16 sessions, with 1 session directly targeting HIV called "Communicating with Your Partner about Preventing HIV" and with numerous sessions focused on gender norms, health sexuality, healthy and unhealthy relationships, power in relationships, joint decision making, and setting personal boundaries.

For the pilot study,, households (n=180) with married couples were randomly selected for participation in a baseline survey to assess IPV and HIV knowledge and attitudes as well as experience of IPV. Households were randomly assigned to one of four groups: 1) women receive the intervention, 2) men receive the intervention, 3) couples receive the intervention, or 4) a control group. The 16 intervention sessions were delivered to groups of 20 individuals in each arm over 6 weeks. A post-intervention survey was administered to assess acceptability of the intervention and changes in knowledge and attitudes. In total, 120 individuals (60 women, 60 men) participated in the intervention and 135 women completed the post-intervention questionnaire. Endline data suggest improvements in HIV knowledge and attitudes.

The pilot data suggest that Unite for a Better Life has the potential to reduce IPV and HIV transmission in this population. Rigorous evaluation of the intervention is warranted, but the findings contribute to the humanitarian sector and support integrative programming. It is likely that the factors that contribute to IPV are similar to those that contribute to HIV risk and joint programming may be an important component to programming to prevention of HIV transmission in humanitarian contexts.

6. Do the final outcomes support the initial rationale for the innovation?

☒ Yes, completely
☐ Yes, significantly
☐ Partially
☐ No, not at all

Please describe further:

At the time of the project proposal there were few documented examples of successful and effective IPV prevention interventions tailored for humanitarian contexts, and there was a need for new ideas and innovation in practice to address IPV in these settings. There were some data from other humanitarian settings that IPV is the most common form of GBV in these settings, but there were large evidence gaps around prevalence of IPV and contributing factors in humanitarian settings, and innovative solutions to address it. Our project aimed to fill these gaps, through the collection of qualitative and quantitative data on IPV, and the adaption and field testing of an IPV intervention (Unite for a Better Life) that had been developed for a non-humanitarian setting in Ethiopia and had demonstrated feasibility, acceptability, and behaviour change in that setting.

Our project outcomes support the initial rationale for the innovation – our data demonstrate extremely high prevalence of physical and sexual IPV, a lack of IPV programming in the camp, as well as strong demand from camp administration and other humanitarian organizations for effective IPV programming and guidance for how to implement such programs. Based on initial site visits (prior to the project), discussions with refugees in the camp and other stakeholders, we hypothesized that the innovation adaption process – if evidence-based, informed by data collected within the camp and with significant input from refugee community members and relevant stakeholders, would yield an intervention that would work (both from an implementation standpoint, and also in terms of outcome change) in this setting. Given that we were able to achieve this, it shows that the original premise of the project, as well as the process proposed to develop, test and refine the intervention was appropriate. The innovation itself fills the gap in programming.

7. How has your understanding of the innovation changed through the project period?

Our understanding of the innovation has changed in numerous ways throughout the project period. While there were positive preliminary findings from the implementation of the Unite for a Better Life intervention in Butajira, Ethiopia, we did not know which existing intervention content would be relevant for this refugee setting, and for the Somali culture. We hypothesised that new content may need to be added and developed but did not know at the outset which factors contribute to IPV in this context and which intervention content would need to be added to address IPV in the camps. We hypothesised that displacement may contribute to strain within relationships, but we did not have content in the original intervention to address displacement-related issues. There were also unknowns on how best to deliver the intervention in the camp (i.e. frequency of sessions, type of facilitators and how best to train them, where and when to gather the groups, how to best maintain privacy and confidentiality, how to coordinate with other important camp activities including food distribution).

Through the process of formative research, innovation adaptation, pilot-testing and refinement we have gained knowledge on all of the above and now have a solid understanding of what does and does not work with respect to in-person, group-based IPV interventions implemented in camps. The adapted intervention has demonstrated safety, feasibility, acceptability and potential for long-term outcome change in this setting. **Furthermore, there were numerous lessons learned during the process of adapting the intervention from the non-humanitarian to the humanitarian setting, that will be valuable for other organizations and partners.**

In addition, to the above, we learned that there are harder-to-reach populations in the camp that may not be reached by an in-person intervention that meets 16 times over two months. Building on this new knowledge, together with partners, our team developed a different IPV innovation funded by the World Bank, involving the creation of user-generated podcasts on IPV that will be broadcast in the camp and shared peer-to-peer.

8. Did the innovation lead to any unexpected outcomes or results? How were these identified and managed?

CHANGES IN HIV OUTCOMES

The innovation led to several positive, but unexpected outcomes. First the creation of a new project on podcasts to prevent IPV, funded by the World Bank was an unexpected outcome of the project. It

occurred because of the identification of more mobile populations in the camp who were unlikely to be reached by the innovation.

Second, the innovation piloting demonstrated some changes in HIV-related knowledge and attitudes among participants of the intervention. Only one of the 16 intervention sessions is focused on HIV, thus our team was uncertain as to whether there would be any changes in HIV related knowledge and attitudes. Finally, the qualitative data analysis also revealed that there have been significant changes in marital practices within the camp, including a reduction in early and forced marriages among despite increased poverty and risk of non-partner sexual violence. This was a surprising finding that is different than evidence from other humanitarian settings which demonstrate increased incidence of child marriage during displacement. The reduction in child marriage in Dollo Ado appears to be driven through increased access to education for girls compared to pre-displacement, and to a smaller degree through NGO programming. The identification of this unexpected finding has led to the development of a manuscript focused entirely on displacement-related shifts in marital practices and the implication for IPV programming.

METHODOLOGY

9. Was the methodology successful in producing credible evidence on the performance of the innovation?

☒ Yes, completely
☐ Yes, significantly
☐ Partially
☐ No, not at all

Please describe further:

Yes, the methodology was successful in providing credible evidence of the feasibility, safety and appropriateness of the intervention for this setting, and provides the necessary proof of concept for further evaluation of the intervention to assess longer-term outcomes.

PARTNERSHIPS AND COLLABORATION

10. How and why did the partnership change during the course of the project?

The following changes occurred in organizational partners during the course of the project as compared to the original proposal.

- Over the course of the project, there were no changes to the original team members or organizations involved in the project. The partnership was new at the start of the project, and over the project period, the partnership was solidified. The organizational partners, together, developed new projects and grant applications, including to R2HC to fund further testing of this innovation through an RCT. The R2HC proposal was short-listed and our team received seed funding to further develop the project, as well as the opportunity to participate in a partnership strengthening workshop led by R2HC facilitators. The workshop

brought together all organizational partners (J-PAL, HMS, WAHA International and Addis Ababa University) to discuss strategies to strengthen the partnership.

11. Are there plans to continue your partnership, either while scaling up this innovation or on other projects?

☒ Yes, with this innovation
☒ Yes, with another project
☐ Maybe
☐ No

Please describe further:

Yes, there are plans to continue the partnership in several ways. First, together, we plan to scale up the innovation in two additional refugee camps in Dollo Ado, and conduct an RCT to more rigorously evaluate it in the two new camps. Additionally, the partnership has obtained funding from the World Bank to develop and test a different IPV intervention (described in question 8 above).

DISSEMINATION

12. Please describe any steps taken to disseminate the outcomes of the project.
Please include all completed and forthcoming, as well as all planned and unplanned products (for example, research and policy reports, journal articles, video blogs, evaluations).

Dissemination has taken place locally in Dollo Ado and in Addis Ababa as well as globally in various ways. In Ethiopia, numerous meetings with UNHCR, ARRA and other partners, including at UNHCR convened workshops and working groups has permitted ongoing dissemination of the project progress and findings. Presentations at global conferences related to GBV as well as global health have occurred, and a number of manuscripts are under development. We are currently seeking an HIF diffusion grant to enable wider dissemination of the outcomes of the project including the creation of a policy or practice brief. Examples of products and dissemination events that have been completed and that are forthcoming are listed below.

Completed:

- Project presented at UNHCR Community Based Practice Workshop, Addis Ababa, March 29, 2018.
- **The project and its findings were presented at** Queens University in Kingston, Canada on October 25 2017 and at the Harvard Humanitarian Initiative in Cambridge, USA on June 15 2017.

- Findings from the project were presented at the Sexual Violence Research Initiative (SVRI) Forum in 2017 in Rio de Janeiro, Brazil as an oral poster science pitches on the theme Conflict, post conflict and humanitarian settings**.** The abstract title was:
  Social and cultural influences on intimate partner violence among Somali refugees: findings from a qualitative study in Dollo Ado, Ethiopia
  Sharma V, Tewolde S, Asmara K, Deyessa N, Muleta M, Scott J.

- Findings from the project were presented at the 4th Canadian Conference on Global Health in Conference in Toronto, Ontario, Canada in November 2018. The abstract title was:

Sharma V, Tewolde MA, Asmara K, Deyessa N, Scott J. **Social and cultural influences on intimate partner violence among Somali refugees: Findings from a qualitative study in Dollo Ado, Ethiopia**. 24th Canadian Conference on Global Health, Toronto, November 19-21 2018.

Forthcoming:

- One abstract was submitted to the International AIDS Society 10th IAS Conference on HIV Science to be held in Mexico City, Mexico in July 2019 titled:

  Unite for a Better Life: Piloting a Culturally Appropriate Behavioral Intervention to Decrease Intimate Partner Violence and HIV in among Somali Refugees in Dollo Ado, Ethiopia. Sharma V, Deyessa N, Tewolde S, Scott J.

- Three abstracts were submitted to the SVRI Forum to be held in Cape Town, South Africa in October 2019. These were titled:
  - **A qualitative analysis on khat consumption and its association with intimate partner violence in the refugee camps of Dollo Ado, Ethiopia.** Papaefstathiou S, Sharma V, Tewolde S, Deyessa N, Relyea B, Scott J.
  - **Displacement-related changes in early and forced marriage, power and relationship dynamics and association with intimate partner violence among Somali refugees: A qualitative study in Dollo Ado, Ethiopia.** Sharma V, Amobi A, Tewolde S, Deyessa N, Scott J.
  - **Unite for a Better Life: Piloting a Culturally Appropriate Behavioral Intervention to Decrease Intimate Partner Violence and HIV in among Somali Refugees in Dollo Ado, Ethiopia.** Scott J, Tewolde S, Deyessa N, Sharma V.

- **Manuscripts under development**

  There are a number of manuscripts under development for submission to peer reviewed journals. These include:
  - **Displacement-related changes in early and forced marriage, power and relationship dynamics and association with intimate partner violence among Somali refugees: A qualitative study in Dollo Ado, Ethiopia.** Sharma V, Amobi A, Tewolde S, Deyessa N, Scott J.
  - **Risk and protective factors on intimate partner violence among Somali refugees: Findings from a qualitative study in Dollo Ado, Ethiopia.** Sharma V, Tewolde S, Asmara K, Scott J.
  - **Unite for a Better Life: Piloting a Culturally Appropriate Behavioral Intervention to Decrease Intimate Partner Violence and HIV in among Somali Refugees in Dollo Ado, Ethiopia.** Scott J, Tewolde S, Deyessa N, Sharma V.
  - **A qualitative analysis on khat consumption and its association with intimate partner violence in the refugee camps of Dollo Ado, Ethiopia.** Papaefstathiou S, Sharma V, Tewolde S, Deyessa N, Relyea B, Scott J.
  - **Culture and displacement related moderators of gender based violence in Somali refugee camps in Dollo Ado Ethiopia**. Hanson K, Scott J, Tewolde S, Deyessa N, Sharma V.

13. Has the project received any third party coverage during the project (from news media, third party blogs, researchers or academics etc.)?

At this stage, there has been minimal third party coverage of the project. However, we have applied for an HIF diffusion grant to enable our team to accelerate global diffusion. The proposal included

funds for a social media consultant to help us increase coverage of the project and findings in multiple sources including blogs, news and social media.

SCALE UP AND DIFFUSION – WHAT NEXT?

14. Is the project or innovation to be replicated or scaled up?

□ Yes, we will scale up in the same or similar context
☒ Yes, we will scale up within our organisation (including running more pilots or trials)
□ Yes, we will replicate the innovation/project in another context or country
☒ Yes, the innovation/project will be replicated or scaled up by another organisation or stakeholder
□Yes, other
□ No

If you answered *yes* to question 14, please answer 14b:

14b. What model are you pursuing to scale up or sustain your innovation?

☒ Applying for more donor funding
□ Selling the innovation or patent
□ Cost recovery (for example, selling your service or being paid as a consultant to implement the innovation)
☒ Innovation to be taken up by organisation or government as standard and included in standard planning and core funding by them
□Other_____

Please describe further:

The long-term strategy for scaling the innovation has several components which emphasize end-user needs, evidence and sustainability. We are in the process of seeking additional funds to scale up the innovation and to develop practical, field-friendly tools to facilitate implementation of the innovation by diverse stakeholders. With additional funds, we plan to work with UNHCR and ARRA to implement and evaluate the innovation using an RCT in two additional camps in Dollo Ado to assess effectiveness on long-term outcomes. This evidence will inform decisions about scaling outside of Dollo Ado.

Concurrently, we will engage with stakeholders, disseminate findings generated thus far and during scaling, and explore business models for maximizing sustainability. If the RCT demonstrates effectiveness then implementation tools and adaptation guidance will be intensively disseminated to facilitate innovation uptake. We will also implement capacity building for humanitarian organizations and work with UNHCR to influence guidance documents.

15. If the project or innovation could be replicated or scaled up, please list the three most important issues or actions that will need to be considered:
(where 1 = most important and 3 = least important)

Suggestion/issue	*1*	*2*	*3*
1. Assessing the impact of the innovation on long-term outcomes including experience of intimate partner violence.	☒		
2. The development of field-friendly tools to enable scale up by other partners.		☒	
3. Dissemination of evidence, implementation tools and adaption guidance to influence uptake of the innovation by diverse stakeholders.			☒

Appendix C: Work plan

Name of project: Linking interventions to cultural ceremonies and practices to prevent and reduce intimate partner violence among displaced populations in humanitarian crises

Organisation: WAHA International

Total funds: £149,991 + £9,438

Duration: 35 months

Expected Results	**Main Planned activities**	**Implementation period** Months																																	**Responsible party / person**
		J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	
Complete Pre-Implementation Phase	1. Obtain ethical approval																																				
	2. Hire project staff																																				
	3. Recruit advisory board members																																				
	4. Hold first advisory board																																				

	meeting	Dr. Scott, Dr. Sharma
	5. Resource mapping	
	6. Finalize data collection tools and field protocols	
Complete Phase 1 activities: Formative research on IPV in Dollo Ado camps to inform intervention development	1. Hire and train qualitative enumerators	Dr. Scott, Dr. Sharma
	2. Conduct in-depth interviews and focus group discussions	
	3. Transcribe and translate interviews	
	4. Analyse data	
Complete Phase 2 activities: Intervention development and pre-testing	1. Conduct logic model workshop with EngenderHealth, Development of intervention theory of change,	Dr. Scott, Dr. Sharma
	2. Develop and adapt curricula	
	3. Pre-test intervention	

	4. External review of intervention																																						
	5. Finalize intervention																																						
Complete Phase 3 activities: Pilot testing of the IPV intervention	1. Hire and train facilitators for intervention delivery and enumerators for data collection																																					Dr. Scott, Dr. Sharma
	2. Conduct baseline survey of pilot study participants and control group																																					
	3. Implement adapted intervention and collect ongoing data																																					
	4. Collect endline data from pilot study participants and control group																																					
	5. Analyse data																																					
	6. Preparation of final report and manuscripts for submission to journals																																					
Complete Phase 4 activities:	1. Conduct workshop to																																					

Development of lessons learned for identification and selection of cultural ceremonies and practices, and for adaption of intervention from non-humanitarian to humanitarian settings	develop lessons learned from intervention development and adaption process																																				Dr. Scott, Dr. Sharma
	2. Final manuscript preparation																																				
	3. Dissemination of final report and lessons learned																																				