World Vision Kenya
World Vision International

Funded through the Sexual Violence Research Initiative (SVRI) and World Bank Development Marketplace Innovations Grants 2016/2017 for preventing Gender Based Violence. The SVRI is an initiative hosted by the South Africa Medical Research Council.

Pilot Process Evaluation
Grant/Project #: K206078- Reducing incidences of violence against women in two peri-urban communities in Kenya.

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Pilot evaluation: November 2017
Report completed: August 2018
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<tr>
<td>ADP</td>
<td>Area Development Program</td>
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<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CBT</td>
<td>Cognitive Behavioural Treatments</td>
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<td>CHV</td>
<td>Community Health Volunteers</td>
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<td>CHW</td>
<td>Community Health Workers</td>
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<td>CTS2S</td>
<td>Conflict Tactics Scale (Version 2) Shortform</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>FIDA</td>
<td>Federation of Women Lawyers in Kenya</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>GHQ</td>
<td>General Health Questionnaire</td>
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<td>GPM+</td>
<td>Group Problem Management Plus</td>
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<td>IPV</td>
<td>Intimate Partner Violence</td>
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<td>Kenya MoH</td>
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<td>KIIs</td>
<td>Key Informant Interviews</td>
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<td>KNH-UON ERC</td>
<td>Kenyatta National Hospital-University of Nairobi Ethics Research Committee</td>
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<td>LAMIC</td>
<td>Low-Middle Income Country</td>
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<td>LEC</td>
<td>Life Events Checklist</td>
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<tr>
<td>mhGAP</td>
<td>Mental Health GAP Action Programme</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>PCL-5</td>
<td>Posttraumatic Stress Disorder Version 5</td>
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<td>PFA</td>
<td>Psychological First Aid</td>
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<tr>
<td>PHC</td>
<td>Primary Health Centre/Clinic</td>
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<tr>
<td>PI</td>
<td>Principle Investigator (Co-PI=Co-Principal Investigator)</td>
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<td>PM+</td>
<td>Problem Management Plus</td>
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<td>PSYCHLOPS</td>
<td>Psychological Outcomes Profile</td>
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<td>Posttraumatic Stress Disorder</td>
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<td>RCT</td>
<td>Randomized Control Trail</td>
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<td>SGBV</td>
<td>Sexual and Gender Based Violence</td>
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<td>Sexual Intimate Partner Violence</td>
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<td>SVRI</td>
<td>Sexual Violence Research Initiative</td>
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<td>VAW</td>
<td>Violence Against Women</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WHO ASSIST</td>
<td>World Health Organisation Alcohol, Smoking and Substance Involvement Screening Test</td>
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<td>World Health Organization Disability Assessment Schedule</td>
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<td>WHO-SRI</td>
<td>World Health Organization Services Receipt Inventory</td>
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<td>World Vision International</td>
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Acknowledgements

This pilot process evaluation was led by Dr. Alison Schafer (Principle Investigator; PI) Global Technical Advisor Mental Health and Psychosocial Support World Vision International. However, this could have never taken place without the input and support of many other people, including: World Vision Kenya: Phiona Koyiet, National Coordinator for Gender, Disability, Mental Health and Psychosocial Support, Jacinta Sila, Clinical Supervisor, Vane Nyamweya, Project Officer Data Management & Community Mobilization, Kenya Ministry of Health: Dr. Simon Njuguna (Co-PI), Director of Mental Health and Substance Use, Dr. Salim Hussein (research collaborator), Head of Community Health and Development, Dr. Catherine Mutisya (research collaborator); all of whom were active participants in reviewing process evaluation methods, quantitative and qualitative data entry and analyses and report write-up.

During the process evaluation, our thanks go to Esther Mueni, Veronica Koimburi and Robert Gitau who conducted and transcribed key informant interviews. Michael Mungai, Nancy Wambui, Irene Maina and Jane Thige who mobilized the clients/men for interviews.

Process for thematic analyses were drawn from prior project experiences that had been supported by Dr. Anna Chiumento and Prof. Atif Rahman from University of Liverpool. PM+ material was drawn from the WHO PM+ Manual, plus group variations provided by and with direct inputs from Dr. Katie Dawson from University of NSW.


For feedback or information about this report and its project: Contact Phiona Koyiet: phiona_koyiet@wvi.org
Abstract / Executive Summary

**Background:** Statistics indicate Kenya has some of the highest rates of sexual and intimate partner violence in the world. Using global research about violence against women (VAW) as a foundation and rationale, Word Vision Kenya has implemented a pilot study to explore the potential of reducing incidences of VAW in the Waithaka and Mutuini communities of Kenya’s peri-urban Dagoretti District. The theory of change suggests that by supporting men with common mental health problems, alcohol use may decrease and subsequently, incidences of VAW also reduce. The pilot study intended to examine measurement tools, procedures, and a 6-session Group Problem Management Plus (GPM+) format for adult men and ascertain if patterns were suggestive that this theory of change warranted further exploration in a definitive feasibility study.

**Methods:** A mixed methods research design was applied to evaluate results of the pilot study. Primary quantitative measures included two screening instruments for inclusion to the study; the General Health Questionnaire to assess psychological distress and the World Health Organization (WHO) Disability Assessment Schedule to assess functional impairment. Secondary measures included the WHO Services Receipt Inventory, Psychological Outcomes Profile, Posttraumatic Stress Disorder (PTSD) Checklist, WHO Alcohol, Smoking and Substance Involvement Screening Test and the Conflict Tactics Scale (Version 2 Short form) to assess perpetration and experiences of violence with a partner. Qualitative assessment comprised three focus group discussions and ten key informant interviews, with transcribed data thematically analysed.

**Results Summary:** The pilot 193 men of whom 62%, met criteria for inclusion to GPM+. This suggested a high percentage of men in Mutuini (n=66; 52%) and Waithaka (n=53; 42%) experiencing substantial psychological distress and impaired functioning. Of the men included in the study, 91 men participated in a pre-assessment, of whom 24 men were recorded as having attended between 4 and 6 of the GPM+ sessions and participated in post-assessment. Qualitative and quantitative data were consistent in showing that men attending GPM+ reported overall improved wellbeing, reduced psychological distress, impaired functioning and symptoms of PTSD. They also reported reduced days of productivity lost due to illness. While the qualitative data revealed high satisfaction with male clients and expressions of reduced alcohol use and improved family relationships, the quantitative data did not support this; however, the data did suggest men may not have been honest during pre-assessment data collection which likely influenced these results. The findings showed that getting men to attend GPM+ at the outset was challenging without material incentives. Nonetheless, for those who did attend GPM+, they reported the intervention to be acceptable and beneficial.

**Conclusion:** Despite several study limitations, the data showed that the proposed theory of change shows promise and with strengthened research methods, a definitive feasibility study is likely to shed further light on these patterns and approach towards reducing incidences of VAW.
Project Rationale

Statistics indicate Kenya has some of the highest rates of sexual and intimate partner violence (SIPV) in the world. More than 41% of Kenyan women experience sexual and/or physical violence by intimate partners in their lifetime, while in a 12-month period, 31% of women are living with active violence in their homes\(^1\). Statistics reveal that women are most commonly victims of SIPV and men the perpetrators; although the incidences of violence against men, perpetrated by women, is believed to be largely underreported. The Government of Kenya has committed to addressing SIPV (locally referred to as GBV) using various approaches and partnerships\(^2\).

Since 2013, World Vision Kenya (WVK) has been working in partnership with Kenya’s Ministry of Health (MoH), University of New South Wales (UNSW) and WHO to research a mental health intervention to support women affected by violence. The pilot and randomised control trial (RCT) studied the effectiveness of WHOs manual, “Problem Management Plus (PM+)”. PM+ is a brief (5-session) Cognitive Behavioural Treatment (CBT) to address common mental health problems, such as depression, anxiety, suicidal ideation and posttraumatic symptoms that are known impacts of GBV\(^3\). The pilot determined PM+ as a treatment for women was locally feasible and acceptable\(^4\); and final data from the RCT confirmed that PM+ supported significant reductions of symptoms of depression, anxiety, posttraumatic stress and functional impairment when compared with women treated under an enhanced treatment as usual condition\(^5\). WHO has now released both a generic and a Kenya-specific version of the PM+ manual for treatment of individuals with common mental problems\(^6\).

During WVKs work with women and the PM+ intervention, community consultations commonly stressed the importance of (primarily) preventing and (secondarily) reducing violence by addressing common mental health issues. The World Health Organization (WHO) defines interpersonal violence as “violence that occurs between family members, intimate partners, friends, acquaintances and strangers, and includes child maltreatment, youth violence, intimate partner violence, sexual violence and elder abuse \(^(*)\).” Regarding Gender Based Violence (GBV) there is no universal definition \(^(*)\). GBV can mean different things according to culture, language and context; and it can incorporate subsets or types of violence and directions of victimisation/perpetration \(^(*)\). Nonetheless, GBV it is a term generally accepted to feature violence against women, on the basis that women are more likely to be victims of interpersonal violence perpetrated by men\(^(*)\). In turn, GBV may include (but is not limited to) sexual gender based violence (SGBV), intimate partner violence (IPV) and sexual IPV (SIPV) or generally violence against women (VAW). For the purposes of this report, the terms of GBV, IPV, SIPV and VAW is used interchangeably.

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problems amongst men. They reported men’s alcohol consumption, drug use, lack of employment and poverty-related stressors to be core contributors to GBV and believed supporting men’s mental health needs may help prevent or reduce GBV. This rationale has growing support in GBV literature, particularly in relation to reducing harmful alcohol consumption.

In 2015, UN Women devised a framework to underpin action to prevent VAW. It highlights risk factors for perpetration, including mental health problems such as depression/low life satisfaction, individual experiences or witness to violence, alcohol use, marital discord and low social connectedness. The framework suggests emerging evidence and practice for support of both perpetrators and victims of violence against women may help prevent violence as well as stem the flow of victimisation for those who already experienced abuse. The framework acknowledges caring for the mental health needs of current and potential perpetrators as well as victims of GBV is a key entry point for intervention: “Poor mental health is a risk for both victimization and perpetration, suggesting the importance of integrating strategies to prevent VAW into programmes to prevent and respond to poor mental health” (p.41). This idea for integration for GBV response and prevention, in line with mental health services, was echoed in WHO’s Global Status Report on Violence Prevention, 2014.

In Kenya, one of the most challenging mental health concerns is heavy alcohol consumption and abuse, where Men are reported to be more at risk of alcohol-related mental health concerns than women. Alcohol abuse and mental health problems often go hand in hand forming a negative cycle; individuals with common mental health problems use alcohol as a coping strategy, which worsens mental health, social and family problems. This is a cycle also shown to perpetuate cycles of violence.

In Kenya’s health surveys conducted in 2009, findings revealed a strong positive relationship between men taking alcohol and tendencies towards violence. Analyses indicated that women whose husbands were often drunk were twice as likely to experience emotional, physical, or sexual violence (79%) compared to women whose spouses did not consume alcohol (39%). A logical step might be to solely address harmful alcohol use, but global mental health research stipulates singular mental health interventions for singular mental disorders/problems is not sustainable, scalable or effective in addressing the myriad common mental problems in LAMIC. Therefore, WHO’s Problem

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Management Plus (PM+) program was designed to be transdiagnostic (addressing multiple common mental health concerns), brief (5-sessions), practical (using CBT/Behavioural strategies) and potentially scalable by using locally trained para-professionals (E.g., CHWs) to deliver the intervention, built from expert consensus and evidence informed components. WVKs work with women affected by violence using PM+ has been a starting point. Evidence on preventing revictimization did not form part of the original research design, but it is anticipated this may be a positive unmeasured outcome given feedback from the project’s pilot process evaluation and GBV literature. However, based on community consultations and experience throughout this project, WVK has identified two important innovations necessary for PM+ to be examined as a targeted prevention and reduction strategy against GBV: (1) the approach needs to be scalable to reach more survivors of GBV; and (2) the approach needs to also work with GBV perpetrators (be they current perpetrators or those at risk of perpetration/re-perpetration). Communities may also benefit from the promising evidence that engaging in reflection and discussion about local social norms that link with mental health and violence against women. It is these elements that formed the basis of the project design, its aim to reduce incidences of VAW in peri-urban Kenya, and it’s four project objectives. An overarching theory of change was developed for the project (refer to Annex A) showing how this project rationale links with proposed intervention areas, project outcomes and ultimate impacts.

About Problem Management Plus (PM+) and Group Problem Management Plus (GPM+)

- PM+ is a brief (5 x 90 minute) evidence-based intervention, published under World Health Organization’s mhGAP Programme.
- PM+ is shown in two randomized control trials to reduce symptoms of common mental health problems, such as depression, anxiety and posttraumatic stress disorder.
- PM+ helps people to self-manage practical (e.g. unemployment, interpersonal conflict) and common mental health problems (e.g. depression, anxiety, stress, grief).
- PM+ strategies include approaches for managing stress, managing problems, behavioral activation and strengthening social supports. Additional components include psychoeducation, motivational interviewing and relapse prevention.
- PM+ is ‘transdiagnostic’, meaning it can be used to treat different symptoms and mental health problems without clinical diagnosis.
- PM+ was specifically designed to be delivered by non-professional mental health workers, such as trained and supervised Community Health Volunteers.
- World Vision Kenya has adapted the PM+ intervention to a group format for the purposes of this study.
- The GPM+ format has been extended to 6 x 2-hour sessions (weekly) to allow for more speaking time during groups and additional time on the management problems strategy (sessions 2 and 3) in the anticipation that this will require more focus for men and enable the topic of alcohol use to be addressed.
- The GPM+ intervention has been adapted from the draft WHO GPM+ intervention (currently in trial in Nepal) and uses a central “character” as the way to show the group how an individual can implement the different PM+ strategies. For this study, that “character” was named “Otieno”.

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Project Details

**Project Title:** Grant/Project #: K206078- Reducing incidences of violence against women in two peri-urban communities in Kenya

**Project duration:** October 2016 to June 2018

**Setting:** Peri-urban Kenya, specifically the Dagoretti district and two primary health clinics (PHC) within its region; Waithaka PHC and Mutuini PHC. Project implementation was supported through World Vision Kenya’s (WVK) Riruta Area Development Program (ADP) and the cooperation of the Kenya Ministry of Health at Dagoretti District and National government levels.

**Funding partner:** This project was funded through the Sexual Violence Research Initiative and World Bank Development Marketplace for preventing gender based violence. The SVRI is an initiative hosted by the South Africa Medical Research Council.

**Ethics Approval:** Ethics was approval for the pilot and definitive feasibility studies was provided by the Kenyatta National Hospital-University of Nairobi Ethics Research Committee (KNH-UON ERC) on 26th April 2016. Application Number: KNH-ERC/A/142 (P830/11/2016) under the research heading: “Assessing the feasibility of Problem Management Plus (PM+) for men with common mental health problems (including alcohol and substance use) as a means for reducing violence against women in the Waithaka and Mutuini communities of Dagoretti Sub-County, Nairobi County, Kenya”

**Project aim and objectives:** The project aim was to reduce incidences of violence against women in two peri-urban communities in Kenya. It was intended that this be achieved via the following four objectives:

- **Objective 1:** The feasibility, acceptability and effects of reducing violence using Group Problem Management Plus (GPM+) for men with common mental health problems in Waithaka and Mutuini is assessed.
- **Objective 2:** Inclusion of community messages about VAW is piloted in one of the two research sites and examined for possible additive effects to reduce VAW when combined with individual mental health support for men.
- **Objective 3:** Feasibility of PM+ Community Based Organisations (CBOs) to establishing alternative income generation initiatives allowing them to provide PM+/GPM+ for Kenya MoH at scale is assessed.
- **Objective 4:** Kenya MoH establishes a model for PM+/GPM+ scale-up.

**Project process:** The project has two major elements. Objectives one and two seek to research the impacts of Group Problem Management Plus (GPM+) for men with common mental health problems, and whether the inclusion of community messages about violence against women (VAW) enhances the impacts of the GPM+ intervention to contribute towards reducing incidences of VAW in the communities. The first task of these two objectives was to undertake a rapid ethnographic study. This was completed in June 2016, with outcomes and results soon to be published20. Next, was to undertake a pilot process and evaluation, which forms the basis of this report. The final two objectives (project objectives 3 and 4) seek to actively explore ways for the sustainability and scale up of PM+ as a psychological intervention to become included in the spectrum of community mental health services. Details about these aspects of the project are reported in generic project management documentation.

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Introduction to the report

This report focuses on one element of the project’s first objective: To assess the feasibility, acceptability and effects of reducing violence using GPM+ for men with common mental health problems (including excessive alcohol consumption) in Waithaka and Mutuini. Prior to the project undertaking its definitive feasibility study, a pilot study was implemented. This supported optimal training of GPM+ facilitators, explored potential challenges the definitive study may face and was a starting point to examine possible trends as to the likely outcomes of the GPM+ intervention; including whether GPM+ might help reduce harmful alcohol consumption and subsequently, VAW. Furthermore, the pilot enabled the project team to determine the acceptability and relevance of proposed study measures.

This report documents findings from the process evaluation of the PM+ pilot trial. It covers issues related to research process in addition to the qualitative outcomes (feasibility and acceptability) of the PM+ intervention; and to ascertain considerations pertinent to the conduct of a definitive RCT on the PM+ intervention. Such process evaluations have been recommended for pilot trails involving psychological interventions (Leon et al, 2001) to examine the acceptability of the intervention to both clients and its delivery agents (in this instance, Community Health Volunteers, (CHVs). This phase of the research is considered especially critical when a psychological intervention is adapted to a new setting and/or using a non-traditional mode of delivery.

Process evaluation of pilot implementation: research questions

This process evaluation of the pilot implementation of the GPM+ intervention with men was intended to assess four key areas, intending to inform and support refinement of the methodology for the definitive feasibility study. These were to:

1. Assess the face-validity of existing PM+ measures, and new measures in the research design, notably the Conflict Tactics Scale, Version 2, Shortform (CTS2S) and the WHO ASSIST tool (refer to Methodology chapter for details of quantitative measures);
2. Determine if procedures for GPM+ screening, recruitment, GPM+ sessions and post assessment were sufficient to meet research criteria for the feasibility study;
3. Assess the format and acceptability of GPM+ with men; and
4. Assess if GPM+ was showing favourable patterns towards helping men to improve mental health outcomes, reduce harmful alcohol consumption and reduce VAW; thus providing a suggestion about feasibility of the project’s theory of the change (refer to Annex A, specifically the ultimate impacts of “reducing prevalence of common mental health problems” and “reduced incidences of SIPV in Kenya”).

Methodology

To respond to the pilot questions, a two-part mixed methods research design was applied with different measures used for different elements of the pilot research questions. Refer to Annex B for a summary flow-chart of the pilot (and definitive) feasibility study data collection processes for quantitative data collection.

For screening and assessing men for the GPM+ program, 15 enumerators were hired by World Vision for data collection. They comprised 8 men who had never worked with World Vision or PM+ before, plus 7 experienced PM+ data collectors who had previously worked in the World Vision Kenya PM+ Randomised Control Trial. They received 3-days of enumerator training in November 2016. The 3-day training was a participatory (e.g., group work) and experiential (e.g., role plays with case examples) and included the following topics:

- Introduction to the research/Enumerators role
Due to delays with ethics approval, screening did not begin until May 2017 (6-months post-enumerator training). By this time, an additional training with new enumerators was undertaken, however the format of new male enumerators and experienced female enumerators was maintained. Screening was eventually undertaken by 12 enumerators – 6 males and 6 females who formed 6 x 2-person pairs.

Through World Vision Kenya’s long-standing presence in the Mutuini and Waithaka communities, staff advised the local administration about the research being undertaken and proceeded with their blessing. Sampling methodology followed that recommended by Onwuegbuzie and Collins (2007) for mixed methods non-probability sampling. Specifically, the sampling methodology used mixed sampling approaches that were purposeful (i.e., in Mutuini and Waithaka and for men only), convenient (i.e., men conveniently available in the communities) and based on quota (i.e., to reach the number of required participants that screen positive for GPM+ in this pilot process. An element of randomisation was employed, by selecting a random direction from which to begin approaching individuals for participation and then moving to every 8th household or nearby area (as determined in the previous Kenya PM+ RCT). Being a pilot feasibility study further sampling rigor was not deemed necessary to meet the objectives of the research.

Quantitative measures were administered with men in the communities. First, men were screened for prospective inclusion to the GPM+ program. Screening took approximately 15 minutes per participant. Inclusion criteria to GPM+ was in accordance with the Kenya PM+ Randomised Control Trial, as follows:

- Aged 18 years or above, plus other demographic data collected including age, education, marital status, work status, and living situation;
- Psychological distress as determined by General Health Questionnaire (GHQ), with scores of >=3;
- Impaired functioning as determined by the WHO Disability Assessment Schedule (WHODAS), with scores of >=17;
- No signs of observable cognitive impairment (e.g., psychosis, dementia, intellectual disability); and
- No indications of imminent suicide risk (e.g., no direct plans to end one’s life in the proceeding 2-weeks)

Screening scores were immediately assessed by enumerators who provided men with feedback about whether they met inclusion criteria for GPM+. For those who did, they received information about the research and GPM+. An appointment was scheduled for them to participate in a pre-assessment, which took approximately 90 minutes. Pre-Assessment included the following qualitative and quantitative tools, which were then re-administered (called Post-
Assessment) after the men had participated in the GPM+ program. The Pre and Post Assessment comprised the following:

- An assessment of potentially traumatic life-experiences using the Life Events Checklist (LEC)\(^{27}\);
- The usage of local health services using WHO Services Receipt Inventory (WHO-SRI)\(^{28}\);
- Symptoms of Posttraumatic Stress Disorder, based on the Posttraumatic Stress Disorder Checklist (PCL-5)\(^{29}\);
- Alcohol and substance use, based on the WHO Alcohol, Smoking and Substance Involvement Screening Test (WHO-ASSIST)\(^{30}\);
- Experiences of intimate partner violence, both perpetration and victimisation, based on the Conflict Tactics Scale (Version 2) Shortform (CTS2S)\(^{31}\) (translated and used with permission; see Annex C); and
- The pre-treatment and post-treatment Psychological Outcomes Profile (PSYCHLOPS)\(^{32}\). Note: a during-treatment PSYCHLOPS measure was also used each week for men attending the 6 x GPM+ sessions.

After implementation of the men’s GPM+ sessions, post-assessment quantitative data was collected between May and June 2018. In August 2018, a qualitative exploration of GPM+ was applied. Targeted semi-structured Key Informant Interviews (KII) and three Focus Group Discussions (FGD) were held. These included:

- 1 x FGD with 9 men who attended three different GPM+ groups;
- 1 x FGD with 11 community health volunteers (CHV) who had been trained and were facilitating GPM+ sessions (6 male / 5 female);
- 1 x FGD with 7 (3 male / 4 female) project enumerators who collected screening, pre and post assessment data;
- 4 x KIIs with CHV who had been trained and facilitated GPM+ sessions. The interviews included 1 male CHV from each of the Waithaka and Mutuini communities plus 1 female CHV from each community;
- 1 x KII with a male client who attended all 6 GPM+ sessions;
- 1 x KII with a male client who did not attend GPM+ sessions (this client only attended the first 5 minutes of GPM+ Session 1);
- 3 x KIIs with enumerators from the Mutuini area (2 male / 1 female); and
- 1 x KII with an enumerator from Waithaka (male)

For a copy of the interview schedules followed during KIIs and FGDs, refer to Annex G. KIIs were conducted by three enumerators employed and briefed specifically for this task. KIIs were held in local, Swahili and English language, with notes and transcripts recorded in English. FGDs were led by Dr. Alison Schafer, with support from co-authors Jacinta Sila and Vane Nyamweya. FGDs were conducted in English only, although local staff (Jacinta and Vane) assisted with key terms where participants had difficulty describing their experiences in English. FGD notes were recorded and transcribed in English.


Data treatment

Once transcribed, qualitative data from KII s and FGDs were combined and thematically analysed. Five of the authors of this report held a workshop, over 2½ days, to systematically analyse qualitative data and relevant themes. A thematic analysis approach, as per procedures set out by Braun and Clarke (2006\(^{33}\)) was used to organise common themes and categories. These themes and categories were later refined for increased transparency using the Framework Approach, as set out by Smith and Firth (2011\(^{34}\)) and to ensure all data received had reached saturation.

All four authors read over each of the transcripts twice, taking note of emerging themes and prominent ideas. From this, an initial coding matrix was established. Data was extracted from the transcripts and entered to the coding matrix. This was further analysed to check that information was appropriately represented. A further analysis initial themes, and sub themes were refined, along with categories under (either themes without sub-themes, or under sub-themes). Extracted data from the coding matrix was re-organised accordingly and examples of these qualitative excerpts were highlighted for inclusion in this final report. Refer to Annex H for a full outline of the thematic codes and relevant qualitative data.

Qualitative themes were identified first, followed by the summary data analysis of the quantitative data. Data from the screening, pre and post assessments, along with during-treatment PSYCHLOPS information was entered to SPSS for analysis.

During this pilot, a non-random sample was applied at screening. The skills of enumerators and CHVs during the screening, pre, during and post-assessment procedures were still being refined. Also, the pilot process showed that there were high attrition rates among men in the GPM+ sessions, which meant final client outcome data was not powered for rigorous statistical analysis. Furthermore, missing data was common. Based on these limitations of this pilot study, quantitative data was only explored at summary level with comparisons of pre-post treatment outcomes indicative of patterns observed. Additionally, due to missing data, not all measures were analysed; only those with adequate responses to offer meaningful summary level information.

Pilot Study Results

The results presented first summarise the qualitative thematic analyses, examining the emergent themes, subthemes and categories. Next the results consider the men screened for inclusion to the GPM+ program and then proceed to explore outcomes of pre, during and post assessment data. Mostly, the results reported combined findings of the quantitative and qualitative results. These results may be presented as unique quantitative or qualitative outcomes; or as data where one offers (e.g., the qualitative data) offers more depth of explanation or interpretation of results to the other (e.g., the quantitative data). At the conclusion of this chapter, a summary of research findings as they relate specifically to the pilot study questions is provided.

Quantitative analysis: Demographic data during screening and pre-assessment

Offering a snapshot of the community studied, the pilot screened 193 men of whom 124 came from Mutuini and 70 from Waithaka. Of the total men screened, they were aged between 18 and 81 years ($M=37.1$ years; $SD=15.6$ years) with the majority living independently (94%). Thirty-nine percent (39%) of men reported having never been married and 35% currently married. Nearly 17% were either separated or divorced. Most men indicated they were in paid work (37%) or self-employed (28%), while 17% reported being unemployed.

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Based on GHQ and WHODAS scores, 119 men screened, or 62%, met criteria for inclusion to GPM+. This suggested a high percentage of men in Mutuini (n=66; 52%) and Waithaka (n=53; 42%) were experiencing substantial psychological distress and impaired functioning. On the GHQ measure, with possible scores ranging from 0 to 12 and an inclusion cut-off score of >=3, men included in the study scored an average of 6.3 (SD=7.1). WHODAS scores, ranging from 12 to 60 and an inclusion cut-off score of >=17, showed men included in the study with average scores of 25.5 (SD=6.2). Every man screened who reported being unemployed also met inclusion criteria. Of those who met inclusion to the study, 12% had reported having previously taken actions to end their life.

Of the men included in the study, 36 declined participation in the pre-assessment. Other men did not complete the pre-assessment or declined responses to multiple questions warranting their exclusion from the analysis. Pre-assessment data is therefore based on 91 men who met criteria for inclusion to GPM+. As shown in Table 1, these men reported high use of smoking, alcohol and other substances, considerable exposure to traumatic life events, but surprisingly, quite moderate symptoms of Posttraumatic Stress Disorder (PTSD). The measure of VAW, the Conflict Tactics Scale (Version 2) Shortform (CTS2S), suggested men perpetrated minimal violence against partners and had few experiences as victims of domestic violence. Men reported that they had been totally unable to carry out their usual activities or work for an average of 5 days of the previous 30 days. Further explanation of these results follows Table 1.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Possible Range of Scores</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO-ASSIST</td>
<td>0–20 (high scores represent high smoking, alcohol and substance use)</td>
<td>91</td>
<td>15.8</td>
<td>3.2</td>
<td>16</td>
</tr>
<tr>
<td>LEC</td>
<td>16–80 (high scores represent less exposure to traumatic events)</td>
<td>91</td>
<td>41.6</td>
<td>9.8</td>
<td>42</td>
</tr>
<tr>
<td>PCL-5</td>
<td>0–80 (high scores represent higher numbers of PTSD symptoms)</td>
<td>90</td>
<td>26.0</td>
<td>14.8</td>
<td>24</td>
</tr>
<tr>
<td>CTS2S – Perpetration</td>
<td>10–80 (high scores represent less violence perpetrated)</td>
<td>90</td>
<td>52.8</td>
<td>31.5</td>
<td>69</td>
</tr>
<tr>
<td>CTS2S - Victim</td>
<td>10–80 (high scores represent less violence experienced)</td>
<td>91</td>
<td>53.9</td>
<td>32.0</td>
<td>70</td>
</tr>
<tr>
<td>DAYS</td>
<td>Number of days in the past 30-days where men were totally unable to carry out their usual activities or work</td>
<td>87</td>
<td>4.7</td>
<td>7.5</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 1. Summary results of pre-assessment measurement data

**Pre-Assessment: The WHO Alcohol, Smoking and Substance Involvement Screening Test (WHO-ASSIST)**

Among men in this study group, the WHO-ASSIST measure indicated extensive drug and alcohol use. The total WHO-ASSIST score is a cumulative score that adds the results about the use of tobacco, alcohol, cannabis, cocaine, amphetamine stimulants, inhalants, sedatives, hallucinogens, opioids and other medications (excluding prescribed medications taken at the appropriate dose). In this group of 90 men, tobacco, alcohol and cannabis were the most used substances with each of these sub scores falling within the “moderate risk” range. Moderate risk is where WHO recommends brief interventions because individuals scoring at these levels are likely experiencing risks for health and other (e.g., employment, mental and psychosocial) problems based current patterns of use. Seven (7%) of the sample group showed high alcohol use, indicative of more intensive treatment needed (e.g., suggesting possible alcohol dependence). Cannabis use was commonly tried by participants, but 69% showed only low risk for health or other problems based on current usage patterns, with WHO suggesting no intervention being needed. However, with 31% of men still showing moderate risk from cannabis use and 40% a moderate risk for health problems associated with alcohol consumption, there is an emerging pattern potentially linking this drug and alcohol use and psychological distress/impaired functioning.
Pre-Assessment: Life Events Checklist (LEC)

Responses to the LEC indicated that men who participated in the pre-assessment had personally experienced (“It happened to me”) and/or directly witnessed (“I witnessed it”) multiple traumatic events in their lives, showing the extent of adversity as well as exposure to violence in the communities of this sample group. Some of the reported exposures included:

- 66% having been exposed to natural disaster;
- 60% experiencing transport accidents;
- 76% exposed to physical assault of which, 58% reported “it happened to me”;
- 60% having experienced or witnessed an assault with a weapon;
- 13% reported sexual assault (“it happened to me”) and a further 25% indicated they had witnessed sexual assault. 16% of men reported having directly experienced another unwanted or uncomfortable sexual experience;
- 39% witnessed a violent death (e.g., homicide or suicide); and
- 7% of men reported having caused serious injury, harm or death to someone else.

Pre-Assessment: Symptoms of Posttraumatic Stress Disorder Checklist (PCL-5)

Despite the substantial LEC scores and extremely high number of traumatic life experiences in this cohort, PTSD symptom scores were quite low. An estimated score of 33 for the PCL-5 is believed to be indicative of PTSD diagnoses and yet this groups mean score was 26.0 (SD=14.8). In this data set (n=90), only 30% of men would have been likely to meet diagnostic criteria for PTSD. This suggests that ‘other’ mental health problems were the basis for men’s psychological distress and impaired functioning, such as alcohol and substance use, unemployment, depression, anxiety and stress, as opposed to trauma exposure or posttraumatic stress.

Pre-Assessment: Conflict Tactics Scale (Version 2) Shortform (CTS2S)

The CTS2S was reported as the most challenging measure to administer by enumerator staff, which featured prominently in the qualitative feedback from staff and clients. One enumerator said “It was basically hard to ask some of the questions contained in the CTS2S, especially those that contained intimacy questions because most men shy off to such questions. “They felt uneasy and uncomfortable answering…” Some clients also reported feeling shocked or embarrassed to be directly asked questions about violence in the home: “Will I share my experience, my inner things, with a stranger?”; “I was shocked to be asked about these issues”. In contrast, some clients also said they appreciated being asked these questions, including about suicide, because it was easier to speak to a stranger than friends or other men in the community (i.e., “Men are reluctant to say they have problems because they are supposed to be strong”; “Sometimes it is easier because you are talking to a stranger”; and “The things that were being asked were things I thought of doing and wanted help. I had thought of taking my life and killing my wife.”)

During the pilot process evaluation, many enumerators reported men not answering the questions of the CTS2S, preferring to skip over them. The quantitative analysis showed that 75% of men responded to every item of the CTS2S and approximately 80% responded to most questions. Overall, however, the CTS2S data suggested there was very little domestic violence – either perpetrated or experienced – among this group. Figures showed that:

- Up to 9% of respondents had verbally abused their partners 3 or more times in the past 1-month;
- 8% of respondents reported that they had “pushed, shoved, or slapped my partner” one or more times in the past month;

This estimated cut-off score for PTSD diagnoses is taken from: Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for DSM-5 (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov. However, it is noted that this is not valid specifically for Kenya and these mean scores are not powered for significance. As such, this cut-off score is being used only as an indication of a possible pattern and cannot be deemed as statistically significant (or valid or reliable) results.
– Up to 5% reported having “destroyed something belonging to my partner or threatened to hit my partner” one or more times in the past month; and
– Using “force (like hitting, holding down, or using a weapon) to make my partner have sex” was reported as occurring twice in the past month by 2 individuals; and
– One individual in the dataset reported perpetration of verbal, emotional, physical and sexual abuse towards their partner more than 5 times in the past month.

Compared with data from national Kenya statistics (where 31% of women are living with active violence in their homes) these reports of active violence among this cohort were low. However, of additional interest was respondents indicating that while not having occurred in the past month, 20% men reported perpetrating verbal abuse, 8% physical abuse and 10% sexual violence at some point before the past one-month. Interestingly, no more than 55% of men reported these perpetraions as never having occurred and only 71% of respondents stated that forced sexual encounters had “never” occurred. This is in contrast to Kenya statistics that suggest nearly 50% of women experience sexual abuse in their lifetimes.

In relation to being victims of violence from a partner, 42% of men reported never having been victim of verbal abuse, 66% not having been physically abused and 71% never having been forced to have sex when they did not want to. Men did report having experienced violence in the home, however rates were still much lower than reports of violent perpetration. For example:
– 9% of men reported verbal abuse at least 3 times in the past 1-month;
– 3% of men reported being pushed, shoved, or slapped by their partner at least once in the past month; and
– One individual reported sexual abuse and being forced (like hitting, holding down, or using a weapon) by their partner to have sex.

Data of the CTS2S showed inconsistent results with other previous Kenya surveys and studies. The qualitative analysis helped to explain this mismaching data, with several clients stating they were deliberately dishonest in the pre-assessment because they did not wish to admit such things. E.g., “Yes; some responses I made were not 100% genuine because I was still suspicious of the enumerators so some I answered correctly and some I didn’t because this are situations that had or have been happening in my life and I don’t like people knowing what am going through, especially if am not familiar with those people. So I decided to cover my true self….” and “This first day I didn’t give the full information”.

Qualitative thematic analysis: Results
Main and sub themes identified in the qualitative analysis are summarised in Table 2. It shows that 5 main themes emerged, some of which focus more on experiences reported by GPM+ facilitators (CHVs) and enumerators, while others focused on client perspectives about the program. The subthemes begin to reflect the range of experiences reported by those engaged in the pilot GPM+ implementation. These subthemes were further analyzed to categories (for a full listing and examples, refer to Annex H), which are explained in more detail below.

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### Main Themes and Subthemes

<table>
<thead>
<tr>
<th>Main Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enumerators and CHV Competency</td>
<td>N/a</td>
</tr>
<tr>
<td>Defined identified gaps in competency of enumerators and CHVs</td>
<td></td>
</tr>
<tr>
<td>2. Client Recruitment</td>
<td>Screening and pre-assessment questions identified challenges during screening and pre-assessments</td>
</tr>
<tr>
<td>Defined factors that contributed to or hindered the recruitment of clients to GPM+</td>
<td>Engaging clients reported challenges accessing men and benefits that enhanced clients' attendance</td>
</tr>
<tr>
<td></td>
<td>Community awareness of GPM+ - challenges related to the understanding about GPM+</td>
</tr>
<tr>
<td>3. Hindrances to GPM+ Success</td>
<td>Group Composition reported issues that hindered effective group therapy</td>
</tr>
<tr>
<td>Defined as factors that hindered GPM+ from being successfully implemented</td>
<td>Severe Drug and Alcohol intake reported cases of inability to be attentive and participate in sessions as a result of high intake of alcohol</td>
</tr>
<tr>
<td></td>
<td>Unmet/Inaccurate expectations reported expectations from clients that were not within the GPM+ intervention</td>
</tr>
<tr>
<td></td>
<td>Timing of sessions reported clients missing out on sessions because of competing priorities</td>
</tr>
<tr>
<td></td>
<td>Low client engagement reported incidences of men not attending and dropping out of the sessions</td>
</tr>
<tr>
<td>4. Key aspects that enhanced GPM+ sessions</td>
<td>Execution reported motivation among men to contribute to GPM+ based on the nature of execution during session 1 (one)</td>
</tr>
<tr>
<td>Defined as factors that contributed to the successful implementation of GPM+</td>
<td>Effective Facilitation reported enhanced group participation and attendance as a result of good facilitation techniques and skills</td>
</tr>
<tr>
<td></td>
<td>Conducive environment for group sessions reported benefits for men as a result of being in a group that is safe and their wellbeing attended to</td>
</tr>
<tr>
<td>5. Psychological Outcomes of GPM+ for men</td>
<td>Reduced alcohol and drug intake reported cases of reduced alcohol and drug intake</td>
</tr>
<tr>
<td>Defined as the reported successes of GPM+ for men with common mental health issues, alcohol and substance abuse</td>
<td>Enhanced social support and family reintegration reported feelings of increased social support and cases of family reunion</td>
</tr>
<tr>
<td></td>
<td>Improved wellbeing and attitudes to problems reported cases of men becoming happier and more focused in life</td>
</tr>
<tr>
<td></td>
<td>Employment, functioning and hygiene reported cases of men securing jobs and improving grooming</td>
</tr>
<tr>
<td></td>
<td>Effectiveness of GPM+ strategies reported benefits of GPM+ as an effective therapeutic intervention</td>
</tr>
</tbody>
</table>

Table 2. Summary of KII main themes and sub themes

**Qualitative Theme 1: Enumerators / CHV Competency**

The first theme emerging in the qualitative analysis related to the skills and competency of the enumerators and CHVs involved in the study. Most categories related to the capacity and experiences of the enumerators. This included enumerators expressing difficulty finding men to interview for screening, including a report of men sometimes becoming aggressive when approached. Enumerators reported that sometimes, the men shared a lot of information and it was difficult to contain them, in contrast to other men who did not “open up” or asked many questions about what the survey was about. Enumerators also expressed concerns about the length and
repetitiveness of the pre-assessment package. These factors suggested that greater enumerator competency and training may support them to manage and respond in more appropriate ways to men during screening; and to become more efficient (faster) in administering the pre-assessment.

In this theme, clients sometimes commented that CHVs had disclosed personal experiences with their GPM+ clients, which despite being viewed as helpful, indicated to program staff that this practice needed to be emphasised to helpers as being inappropriate. “The facilitator shared his personal struggles and stories. He opened up to us, which really made some of us to open up and share our stories as well.” Further, there was some suggestion that CHVs may have been lapsing towards providing GPM+ clients direct advice, which hinted to the need for CHV skills to be further refined.

Both enumerators and CHVs reported that the process for referring individuals for specialist services related to drug and alcohol dependence needed strengthening in the project protocols; and these staff better trained to manage the referral processes. “If you tell some of them to attend to a rehab they found avenues of denying by telling you how expensive it was and couldn’t afford it.”

Qualitative Theme 2: Client Recruitment
The client recruitment theme identified numerous factors that contributed to or hindered the recruitment process of clients to GPM+. This was an important feature to explore in the qualitative process evaluation because project team members were aware that getting men to attend GPM+ sessions, and completed all 6 x GPM+ sessions was extremely difficult during the pilot study. The project team were cognisant that majority of men did not engage between pre-assessment and GPM+.

The first main contributor to client attrition identified was the screening and pre-assessment questions. Men tended to be pre-occupied with their daily tasks to take time out to respond to enumerators for screening and the pre-assessment, they complained about being asked a lot of questions, including intimate questions, and found it difficult to commit to the time needed to complete the pre-assessment.

- “During pre-assessment… others backed out during pre-assessment because the questions were too many for them.”
- “The pack is very bulky and some questions are very personal and intimate”
- “Most work as casuals and getting them to answer the pre-assessment pack was quite a challenge since you could agree to interview them at a certain day, only to call them and they tell you they are at work and can’t be available until evening. And when you call them at the evening as agreed, they will skip to the day after.”

It is already reported above that many men expressed feelings of embarrassment or shame to answer some questions, particularly intimate questions about violence at home and/or suicide. From the enumerator’s perspectives, they also viewed the suicide and CTS2S questions as the hardest to administer. “The CTS2S was probably very difficult to ask, especially to the old men. I found it hard asking the man if there was any incidence where the wife had beaten him to make love, this is a rare case. In most of the Kenyan communities and most of the men found the questions to be too personal and some declined answering.” The consequence of this challenge was that many men did not respond honestly to all questions (particularly during pre-assessment), making it difficult for the pilot study to
glean a clear picture of the extent of VAW among this cohort. Project staff were cognisant that many men did not re-engage after pre-assessment, with the highest participant attrition occurring between pre-assessment and GPM+ Session 1. Therefore, the qualitative methods actively sought to understand how clients became more engaged in GPM+ and what might have been reasons for disengagement. Some of the barriers to client engagement were:

- Fear of non-confidentiality. Men indicated that confidentiality was important to them and they liked when this was emphasised; “As long as they keep the things confidential; so I decided to leave my story with them.”
- Being suspicious of enumerators and their data collection, worried about them possibly reporting violence to others or that World Vision was taking advantage of them; “Some said you’re using us to get what you want. You, you’re working, others are working. You just want information from us”; and “Some of the clients feel like they are being asked too many questions and also feel like they are being investigated to be reported to FIDA37. “Why do you want to know that about me? Are you investigating me?”
- Language (with packs translated from English to Kiswahili). Some enumerators reporting the need to use local language or English, or mixed language (e.g., local, English & Kiswahili) to assess clients; “… so one can choose which language he would prefer to be interviewed.”
- Contacting men to complete the pre-assessment, with many not being reached on their phones, missing scheduled appointments or simply changing schedules at the last moment. This was why so many men who screened for inclusion to the project were not, eventually, pre-assessed. Further to this, by the time pre-assessment concluded, men felt the project might not be relevant for them anymore and thus did not engage in the first GPM+ group session. E.g., “Communicating to some included clients was a problem since their phones were off and locating them became an issue”; and “Getting these clients [for pre-assessment] was hectic, especially those who lacked mobile phones. You would wait for them at their homes, only to find out they had shifted to other areas. Others came up with excuses that they had gone to work …. They were sick and couldn’t be available … casual labourers … they worked for late hours.”

One element viewed by enumerators as being key to them eventually getting the data they required was working in male/female pairs for data collection. “At first I was a bit uneasy introducing myself to total strangers especially men. Most of them were arrogant and hostile but having a co facilitator who was a man I felt safe I gained confidence and was able to walk out there and look for people in need of this program”.

The qualitative data showed mixed results about World Vision’s reputation in the community sometimes being a benefit to client engagement and other times a hindrance, depending on the experience individuals may (or may not) have had with World Vision in the past. They also confused this project with other World Vision initiatives in the area and often expected material support, expressing disappointment about the GPM+ intervention being a “talking therapy”: “They were confusing us about something for other issues and other projects in the past. It was hard to convince

37 FIDA = The Kenya Federation of Women’s Lawyers, a women’s rights organisation that offers legal aid and assistance to women and children

Many men declined participation in the study between the pre-assessment and first session of GPM+. Thereafter, there was a slight attrition observed in the group over the 6-weekly GPM+ sessions.

- 32 men attended GPM+ Session 1; 
  Mutuini n=15; Waitaha n=17
- 29 men attended GPM+ Session 2; 
  Mutuini n=15; Waitaha n=14
- 31 men attended GPM+ Session 3; 
  Mutuini n=17; Waitaha n=14
- 29 men attended GPM+ Session 4; 
  Mutuini n=16; Waitaha n=13
- 28 men attended GPM+ Session 5; 
  Mutuini n=15; Waitaha n=13
- 25 men attended GPM+ Session 6; 
  Mutuini n=12; Waitaha n=13

Session 3 in the Mutuini group increased in numbers because men were insisting on having friends attend because they believed their friends would also benefit from the program.
them to do an emotional program”. Further, CHVs felt Enumerators needed to be more emphatic about describing GPM+ to clients to ensure they were not attending GPM+ sessions with unrealistic expectations for handouts: “The enumerators need to emphasise on the money issue, encouraging the clients to attend but informing them that no money will be offered.” Some individuals in the program saw the lack of financial or material support as the projects greatest weakness; and there lacked understanding that an approach such as GPM+ might reduce stress rather than directly providing what men often believed to be the solution (i.e., to be offered jobs or money):

- “Most men refused to be interviewed because there were no reimbursements provided.”
- “Others requested for jobs and material things to boost their lives since they didn’t fully understand how the program would empower them…”
- “They want money, entrepreneur or training courses. They feel it’s a waste of time…”
- “Due to lack of finance this causes problems (GBV). Most men said that if they could be given money their other problems will be sorted.”

One identified way around this desire for material support could be to promote the idea of learning new skills among men, which was well-received by clients: “clients felt good that they could get skills to deal with their problems”;

- “Some said they felt good they’ll receive the skills from the CHVs”. Another suggestion was to increase community engagement before project activities, to strengthen GPM+ recruitment and retention: “There is need and desire for more engagement people need to be told everything about this program wholesome information is key. They should also create awareness on the importance of this program and how exactly how one can benefit from it.”

**Qualitative Theme 3: Hindrances to GPM+ Success**

Throughout the exploration of factors that enhanced or hindered GPM+ implementation, learnings included the importance of ensuring attention to group composition. For example, trying to organise men’s groups into those of similar ages, culture, or even similar degrees of problems, such as those with/without high alcohol/drug problems: “Compatibility of clients. Some clients had some very deep problems, like substance abuse and others have regular lifestyle, so when you mix those two characters, some of these are most likely to feel out of place. It’s like they didn’t belong.” It was also noted by CHVs that some men’s alcohol problems were so severe that they could not participate fully in sessions and it created a negative influence to group cohesion: “Some clients were very high and could not continue with sessions. Communication was a problem and the other clients couldn’t go together with them.”

The issue of expectations of material support was a continuous theme, with many CHVs viewing this as one of the primary reasons men dropped out of groups and discontinued sessions. They reported that such expectations were prominent throughout the entire GPM+ program, despite regular efforts of project staff advising men of the different nature of the program: “They had expectations. We emphasised they will not get material support, but even at the last session they asked for money or capital.”; “Some clients dropped because they had hoped there was some reimbursements.” The process evaluation also showed that this desire was something often believed necessary among helpers themselves (enumerators and CHVs): “Most clients had financial problems so we suggest, if possible, clients should be offered a small token to help them attend to their family needs, even if it was a one day token”. This belief revealed itself in the process evaluation to be a barrier for many men who resisted working through their various problems, believing that receiving cash from World Vision or the CHVs would resolve all their problems: “They would open up to basic problems but conceal their inner problems which trouble them the most. Thus, most didn’t give definite problems, they would talk of money challenges while there was underlying issues”.

The logistics of the timing of group sessions proved to be another hindrance. Session times were difficult for day-labourers who needed to take daily work when it was available, or the time in the sessions was believed to prevent men from seeking work. This was made worse by some men frequently arriving to GPM+ sessions late and causing the groups to go beyond its intended 2-hours. If men missed one GPM+ session (maybe due to illness, work or other reasons) there was no opportunity for them to learn about the PM+ strategy discussed that day. Men also requested group sessions to be held at times (e.g., evenings) which were inconvenient for the GPM+ facilitators,
particularly female CHVs. Lack of material support was again referenced as a rationale for men not attending sessions regularly, citing that they could not justify spending time in a group program if they were not being provided something in return for their families.

- “Casual labourers with no definite time for reporting to work, thus you could find some would agree to come for sessions, but when the day to report came, they couldn’t be found since they had reported to work”
- “You will also find those whom reported are those who had accommodative work routines, therefore time was a big challenge”
- “There was this issue on lateness, some clients were unable to keep time”
- “If one misses a session you feel for them because you can’t repeat.”
- “The challenge is they have no jobs so they have nothing to take home to their families after attending sessions”

Lack of clients attending sessions also led to much greater work required for CHVs. For instance, when clients did not attend sessions, they had to phone or visit clients and speak with them. This was especially difficult for the many clients who did not attend GPM+ Session 1, since the rapport and understanding of the program was not yet realised by the clients. Sometimes, lack of attendance also meant a CHV might need to cancel sessions; effectively ‘wasting’ their time and sometimes that of the one or two who may have shown up. Commonly, CHVs found this disappointing and demotivating and they felt powerless when men sometimes said they would only attend the groups if they were reimbursed.

- “My [CHV] disappointment was when one client came for one session and could not come for the next session”
- “We called them and they said they are coming, but wouldn’t turn up”
- “Some clients said if only they could be compensated they would come for the next sessions”

**Qualitative Theme 4: Key Aspects that Enhanced GPM+ Sessions**

Factors that appeared to enhance GPM+ and encourage client engagement were divided into three subthemes:

- Execution, where the motivation among men to continue with GPM+ seemed to be based on the way GPM+ Session 1 was executed;
- Effective Facilitation, where group participation was optimised and there was evidence of strong facilitation skills by CHVs; and
- A Conducive Environment for the group sessions supported men in the groups to share more and feel well-supported by other group members and facilitators.

Many clients reported feeling curious about GPM+, which motivated them to attend the first session. This curiosity was piqued following the assessment process and a desire to take the opportunity to improve themselves: “It was out of curiosity [to attend the first session]. I wanted to know if it was what I had been told was true.”; “After giving my information to a stranger, I wanted to know if those guys were serious.”; “The things that were being asked were things I thought of doing and I needed help. I had thought of taking my life and killing myself”.

Aspects of execution that encouraged men to continue with GPM+ included facilitators placing strong emphasis on group respect and support so that the men felt they were there for themselves, as well as others. This included facilitators being strong on the need for attendance to all group sessions, ensuring confidentiality of client information and setting goals from the outset:

- “We used a string to emphasize the importance of sticking together (created a bond amongst them). And telling them our “string” needs to stay tight.”
- “The way we introduced ourselves, assuring them of confidentiality and emphasising the need of attending the six sessions”
- “Having been invited to the 1st session we were received very well by the facilitators, they told us that all we were to share was to remain confidential”
- “The goals we set on day one, we started getting casual jobs, reduced alcohol intake.”
Reports of effective facilitation appeared to include CHVs taking strong advantage of the co-facilitation approach, including an effective use of the male/female facilitation “pairs”. Indeed, CHVs and clients both reported benefits and satisfaction having at least one female presence in the group. Client relationships, or rapport between facilitators and group members also proved a key element for those groups which were successful in completing the GPM+ sessions.

- “We [the CHV facilitators] used to help each other a lot when offering sessions for when I got stuck she could engage and take over the session and we ended up having an amazing time with the clients and delivered what was expected of us.”
- “The presence of a female co-facilitator really made the clients to open up because I believe if it was a man to man thing some couldn’t agree to talk about their innermost issues troubling them physiologically because most men believe that emotional topics women are able to handle them well than men can.”
- “The family figure [the woman] was important. Male clients used to talk about their wives whereby we would help them understand why their wives would react in a certain manner and how they could avoid arguments and violence.”
- “There was good coordination between the facilitators and clients”
- “Having been invited to the 1st session we were received very well by the facilitators…”

Factors that supported a conducive environment for the group sessions included a focus on group cohesion and teamwork and encouraging the group as a form of social support for the men: “in the first session we didn’t know each other and were a bit uncomfortable with each other but with time when we gathered together and became one class we created friendship whereby we exchanged phone numbers and would call each other whenever we had issues concerning stress the bond was tight in such a way that after the six sessions we still continued to communicate, it was more of a family at the end of it all.”; “Men could also support each other during the sessions. Being as group they were helping others. They could listen and help each other.”; “So they felt acknowledged, accepted and there was a sense of belonging in the session also; it played a huge part in keeping them to continue, so it was all about a joint effort and making the clients feel appreciated.”

Contributing to group cohesion, being flexible with all members about session times, keeping time, maintaining confidentiality, feeling safe and not judged by facilitators and receiving tea and snacks during the group sessions all played a role for the groups that successfully completed the GPM+ program. There was also a desire for men to bring their friends and at times self-select their groups. This appeared to encourage even greater social support:

- “My group had seven members and refused to be separated showing the great bond between them. The clients were also from the same locality. They were friends before with a car wash.”
- “For some they were friends already, but others; their friendship came from the group.”
- “I was given hope”;
- “I felt cared and loved”;
- “Snacks and tea was a good motivation also”

**Qualitative Theme 5: Psychological Outcomes of GPM+ for men**

The final theme that emerged in the qualitative data was the clear finding that for the men who did attend the GPM+ sessions, they found the program offered them multiple benefits and improved psychological outcomes. These included many reports of having reduced alcohol and drug intake (irrespective of whether they sometimes attended the sessions when high or sleepy) and viewing alcohol and drug use differently (i.e., as an unhelpful coping approach compared with alternative problem-management approaches). The men reported reduced feelings of social isolation and increased belonging and improved or restored family relationships. Men described overall feelings of improved well-being, ranging from improved self-perception (e.g., self-esteem, power, hopefulness) and changed attitudes and outlooks in life and toward their problems. The men stated their appreciation for and acceptance of the GPM+ program, particularly its focus on the “boy-child” and they believed that having received support and help motivated
them to support and help others. The following series of statements provides snapshots of the improvements observed by CHVs and/or clients themselves:

- “Other times I was using Bhang [Cannabis] and I am not using it now”;
- “I was taking alcohol from morning to evening and I could even sleep in the bar. But since I started the session I only take alcohol in the evenings”;
- “A client reduced his alcohol intake from 5 bottles to one. Another had a goal of stopping drinking and he thought it was impossible, but he was able to reduce his alcohol intake”;
- “Some of us used to sleep in the sessions but now we are awake because we have reduced our drug intake.”
- “Men really go through stressful situations that make some of them bitter and result to alcohol as a stress reliever that is where they go wrong alcohol can make you forget just for a short time about your problem but it cannot help one solve his problems in fact it makes them worse.”;
- “From the sessions I could learn that drugs was about peer pressure. Alcohol too.”
- “We [group members] are still in contact with group members and if he [a fellow group member] does not turn up for work, we go and pull him out of bed so he is not isolated and tempted to use drugs again.”;
- “They were very happy they were out of a cocoon. They got a group where they could share.”
- “We solved some problems. Like quarrelling with my wife and making sure it does not get too bad.”
- “Before the sessions I was separated from my wife because of drugs. But now I’m sober and thinking to bring her home.”
- “After joining the PM+ session my stress reduced and now I can cope with my problems”
- “I used to hate myself but when I came to this session I felt loved and cared for”
- “By coming together and sharing we can get some peace of mind.”
- “I think you should take people like us out there to state our testimony and tell the community how this program has changed our lives.”
- “In managing stress, we are teachers now to others in the community”;  
- “Most men don’t have forums when it comes to managing stress due to lack of accepting themselves and agreeing to opening up.”;
- “Men are considered to be left out in such programs whereby most organisations focus on women and bringing this program to men, they felt cared for and wanted to play a role in it as well.”;
- “Money comes and money goes but having a positive mind full of knowledge on how to manage your stress that is something that is there to stay and one will forever benefit from it. It is important for people to understand that this program is worth more than money because it can change one’s life for better even without having money.”

In addition to reduced alcohol/drug intake and subjective feelings of wellbeing having improved, many men also reported functional improvements, including getting (or re-engaging in) work, increased attention to personal hygiene and becoming more organised:

- “Before coming to the sessions we had stopped our car washing business in the community but after learning the strategy of get going keep doing we started again.”
- “One man was homeless. Stop drinking and a job were his goals. He got a house and in the 6th session he has been employed.”
- “I am now well cleaned and dressed and now I can get a girl! I have got hope.”
- “It has helped me in stress management because I have changed I can now relate better with whatever situation comes my way. I feel different and more easily and calmer than I used to before. I am now focused despite my worries. When I include the breathing exercise I can control myself.”

The GPM+ strategies were all very well received. Although some CHVs had different opinions about whether the program should include 5, 6 or more sessions was debated, the strategies themselves were deemed effective. Managing problems and strengthening social support appeared to play a crucial role in the group process and support to the men. Stress management was also an easily implemented strategy for the men. The one GPM+ strategy that
showed mixed results, from the CHVs perspective, was the Get Going Keep Doing strategy. CHVs reflected that this was more challenging for this male-specific cohort. They reflected that in prior experience with women, where female clients had many chores or household tasks to complete, the men tended to have fewer “daily activities” to draw on for the get going keep doing homework tasks. Nonetheless, the overall feedback and qualitative analysis suggested that the GPM+ strategies were well accepted, workable in the group delivery format and easily implemented by male clients.

- “I would say all the sessions have been of great benefit to me, they have really changed me. All sessions (stress management, problem management, get going keep doing, strengthening social support, staying well moving forward, closing ceremony) but when it comes to stress management especially the breathing exercise was my favourite and it helped me to be calm and compose myself. When I needed to talk to people social support definitely worked very well for me at some point your able to communicate with them and some will give you hope and from there you’re able to focus and proceed with life.”;

- “Managing problems worked wonders because we were taught how to identify solvable and unsolvable problems and how to relate with them. By identifying these problems he now has a sure way of how he can be able to curb them without this problems bringing him down to a point of him been hopeless with his life. For instance could apply problem management when he found two of his friends were sick and by applying solvable and unsolvable problems tactics he was able to let go of things beyond his control.”;

- “With the get going, keep doing strategy I started talking to people. I used to sleep the whole day and now I am happy.”

- “In my group, the get going keep doing was a challenge. They did not understand it. Even the words was confusing for them “get going keep doing”. Men only hustle for their families and therefore they could not get it and we therefore need to brainstorm on activities that are common to men.”

- “All in all the program was a success”;

- “All in all it was a good journey which brought a positive change”.
Quantitative Analysis: Post-Assessment

Quantitative post-assessments and analyses were based solely on men who (a) attended at least 4 or the 6 GPM+ Sessions; and (b) were reachable for the post-assessment process (n=24). As a pilot, only summary data was analysed based on average scores and outcomes. Table 3 summarises post-assessment outcomes for primary and secondary measures. It can be noted and is further depicted in Figure 1 that outcomes of men’s mental psychological distress improved substantially, as did their symptoms of PTSD. While functioning improved slightly, there was still a major improvement in men attending to their daily activities or work, given less days lost due to poor functioning. The total ASSIST measure scores reduced only slightly; due to reportedly less use of tobacco and cannibals, while alcohol consumption appeared to remain steady. On the CTS2S measure, men at post-assessment reported higher incidences of perpetration and experiences of violence compared with pre-assessment, which is shown in Figure 2.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Possible Range of Scores</th>
<th>M</th>
<th>SD</th>
<th>Median</th>
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<tbody>
<tr>
<td>GHQ</td>
<td>0-12 (high scores represent higher psychological distress)</td>
<td>0.6</td>
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<td>WHODAS</td>
<td>12-60 (high scores represent greater impaired functioning)</td>
<td>23.8</td>
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<td>WHO-ASSIST</td>
<td>0-20 (high scores represent high smoking, alcohol and substance use)</td>
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<td>PCL-5</td>
<td>0-80 (high scores represent higher numbers of PTSD symptoms)</td>
<td>7.0</td>
<td>7.5</td>
<td>5.5</td>
</tr>
<tr>
<td>CTS2S – Perpetration</td>
<td>10-80 (high scores represent less violence perpetrated)</td>
<td>61.5</td>
<td>30.3</td>
<td>76.5</td>
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<tr>
<td>CTS2S - Victim</td>
<td>10-80 (high scores represent less violence experienced)</td>
<td>61.2</td>
<td>30.1</td>
<td>77</td>
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<tr>
<td>DAYS</td>
<td>Number of days in the past 30-days where men were totally unable to carry out their usual activities or work</td>
<td>0.8</td>
<td>1.4</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3. Summary scores of post-assessment data (n=24).
Figure 1. Men’s pre-post assessment comparison mean scores for primary and secondary measures.

![Graph showing mean scores pre and post assessment for various measures, including PCL-S, TOTAL Alcohol, TOTAL Tobacco, TOTAL Cannabis, TOTAL WHO-ASSIST, WHODAS, GHQ, and DASS activities.]  

Figure 2. Men’s pre-post assessment comparison mean scores for the Conflict Tactics Scale Version 2, Shortform, showing a slight increase in reported perpetration and experiences of violence.

![Graph showing mean scores for Conflict Tactics Scale, pre and post assessment.]  

Further explanation about these mixed results from the pre-post assessment measures is provided in the following chapters. However, it is also important to note that on the final measure of the post-assessment PSYCHLOPS, nearly all men who participated in the GPM+ sessions reported feeling a little, a lot or much better than when they first began the program. This is perhaps a clear overall assessment, matching reports in the qualitative analyses that GPM+ was generally beneficial for them men who participated, as shown in Figure 3.
Discussion

This process evaluation of the pilot implementation of the GPM+ intervention with men was designed to examine four key areas. These were to: Assess the face-validity of existing PM+ measures, and new measures in the research design, notably the Conflict Tactics Scale, Version 2, Shortform (CTS2S) and the WHO ASSIST tool; Determine if procedures for GPM+ screening, recruitment, GPM+ sessions and post assessment were sufficient to meet research criteria for the feasibility study; Assess the format and acceptability of GPM+ with men; and assess if GPM+ was showing favourable patterns towards helping men to improve mental health outcomes, reduce harmful alcohol consumption and reduce VAW. The ultimate goal was to ascertain if this approach warranted further study – a full feasibility study – and to offer recommendations as to how such a study, or future research about this theory of change could be strengthened.

Most measures used in this study were previously tested for reliability and validity with Kenyan women in a randomised control trial, for individual PM+ in Kenya. This included all measures (namely GHQ and WHODAS) in the screening pack (refer to Annex D) and the following measures from the pre-post assessment packs (refer to Annex E): LEC, WHO-SRI, PCL-5 and PSYCHLOPS. Based on the combined quantitative and qualitative findings of this pilot, these measures suggested a likely equivalency of face-validity, relevance and acceptability for men. The GHQ and WHODAS appeared to adequately differentiate men with psychological distress and impaired functioning, while the LEC in the pre-assessment appeared to reflect common traumatic and adverse experiences well-known to affect urban communities in Kenya. Results that showed reduced psychological distress (GHQ), improved functioning (WHODAS and productivity days lost due to illness), and reduced symptoms of PTSD (PCL) all suggest these tools were measuring something meaningful; which was further reflected in the qualitative themes of men obtaining work, returning to work, improving personal hygiene and feeling more cared for and supported. It was

Figure 3. Men’s post-assessment Psychological Outcomes Profile (PSYCHLOPS) response to the question: “Compared to when you started [the GPM+ program], how do you feel now?”
also reflected in the subjective outcome of the post-assessment PSYCHLOPS where most men who participated in GPM+ reported feeling generally “better”.

The difficult tools in the pre-post assessment pack were the CTS2S and WHO ASSIST. It was evident that enumerators felt awkward or anxious to ask questions in the CTS2S, particularly as it related to sexual violence. They also expressed concerns about the pre-post assessment packs being long and uninteresting to men. Consistent with these sentiments, men also reported the assessments being long and highly “intimate”. Some expressed feelings of shock or embarrassment to respond to all the questions. Consequently, some men admitted to not being truthful in their responses. Some men also admitted to being deceptive about the extent of their behaviour, which may have included alcohol use. The outcomes of these two measures indicated there may be acceptability concerns about their use in these communities, and this would likely influence their validity.

It was an interesting finding that the quantitative data suggested men in this program had increased their perpetration of violence, experienced more violence from their partners and reported their alcohol use to be much the same at the end of the program as it was at the beginning. This contrasted with qualitative data which suggested many men had substantially reduced their alcohol and substance use and were experiencing less conflict with their partners. Some men reported improvements where they felt they could now be trusted for their families to be reunited.

A possible explanation for these disparate findings on the CTS2S and WHO ASSIST measures and the qualitative data was that by post-assessment, men felt more trusting and less suspicious about answering questions honestly. After being in GPM+ for 4-6 sessions, men will have better understood the purpose of the questions and appreciated the need to be forthcoming about the realities of their situations. This may not mean the measures are not entirely valid or reliable, but that enumerators may need more training to better explain and prepare men for the nature of the questions during pre-assessment; thus, allowing for potentially more consistent results at post-assessment.

Suggestions made by the men, enumerators and CHVs for greater community mobilisation and preparedness for this work might also prove beneficial. Based on this pilot evaluation, it cannot be categorically indicated that these two measures would not yield more valid and reliable results if approached differently in future studies. This also relates to whether the piloted approaches for the screening, recruitment, pre and post assessment processes are sufficient to meet research requirements in a larger-scale study.

The sampling approach was suitable for a pilot study although future studies may take heed of enumerator feedback that approaching men was challenging and following them up for pre (and post) assessment more so. The nature of men’s activities and work in the communities make it difficult for them to spare time to participate in such initiatives and there was a strong call for “incentives” for future research, which would likely encourage greater participation of men. This may also be the case for men to attend GPM+. The qualitative themes showed a clear desire for men to be receiving some type of material support as an accompaniment to the emotional support of GPM+. For future research, incentives may be necessary to ensure good research design and methodology; although it must be noted that implementation of incentives may prove problematic for scalability and sustainability. Suggestions made of promoting GPM+ as a learning or education experience may be an alternative way to attract men’s interest and participation. This might be especially important during the phase between pre-assessment and the first GPM+ session. The current data showed this was the highest time of attrition of participants.

The data also showed that the ways the facilitators engaged men during the first GPM+ session was critical to them returning for future sessions. This included emphasising the importance of group cohesion, assuring men of confidentiality and reminding them of the goals which they could offer support for men to improve. It further seemed important for groups to be appropriate, by way of age, culture and level of difficulties among group members.

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Feedback about the format of GPM+ was mixed. The group format and the inclusion of snacks were valued by men. The combination of having one male and one female facilitator was another benefit to the program, which was noted...
by both facilitators and clients. However, the timing of the groups may demand greater flexibility to allow for men’s work commitments and for them to be able to take advantage of daily work opportunities. This may require “out of hours” times and/or approaches where men might be able to “make up” a session if they miss one. Incentives and material support to attend weekly sessions was again emphasised by both GPM+ facilitators and clients. There may be opportunities to integrate GPM+ with other programs, such as livelihoods activities or cash-based programs, which may provide a stronger motivation for men’s attendance to all GPM+ sessions.

GPM+ itself was shown to be well-accepted and beneficial to men who attended the program. Results showed that for men who attended at least 4 to 6 GPM+ sessions, on average, reduced their psychological distress and improved their functioning. Qualitatively, they also reported feelings of stronger social support, less alcohol and drug use and improved family relationships, even though this was difficult to measure in pre-post format. The men could recall various PM+ strategies, such as managing stress, managing problems, get going keep doing and strengthening social support. Men seemed to mostly value the strategies of managing problems and strengthening social support, although various clients reported individual differences in which PM+ strategies were most useful to them. These findings suggest that GPM+, as a six-session group format for men, with fidelity to the original PM+ approaches were relevant, acceptable, and beneficial. It also suggests that there is encouraging prospects for the theory of change on which this project and research is built.

Recommendations from pilot study for the definitive feasibility study

In preparation for the definitive feasibility study, some practical recommendations can be gleaned from this pilot process and evaluation, as well as unique options for consideration.

- Many approaches used in the pilot study should be maintained in the definitive feasibility study. This includes the male-female paired enumerators and CHVs, the 6-session GPM+ format and PM+ strategies and screening instruments. Pre-post assessment instruments are also recommended to remain the same, but the ways these are implemented need refining. Snacks for men during GPM+ will be important to maintain, along with agreement for men to meet in groups with friends, or invite new friends to existing groups (presuming this will not disrupt dynamics for other group members). Men who attend GPM+ sessions under mild intoxication might also benefit from continuing to be permitted to attend sessions.

- Enumerators would benefit from additional, refresher training. They need to become more confident approaching men to be screened for the study, better explain the nature and benefits of the program despite it not being about material assistance, and to prepare men for the sensitive nature of the pre-assessment questions. They need to find words and approaches that encourage men at the pre-assessment phase to be unashamed and honest in their responses. In doing so, a greater assessment of the capacity of the WHO ASSIST and CTS2S measures and their appropriateness for measuring the theory of change this project is based on and whether such measures might be usable in any future randomised control trials. Refresher training with enumerators should also use this opportunity for enumerators to become familiar with the pre-post assessment packs and work towards reducing the time it takes for them to go over the material with participants. On a practical note, pre-post assessment packs should be condensed to less numbers of pages to make them less bulky and overwhelming for enumerators and clients.

- GPM+ facilitators would also benefit from refresher training. This would be to further to strengthen group dynamics during session 1 and emphasise confidentiality and the benefits of the program, beyond material support.

- The program, overall, would likely offer greater acceptability to men if both enumerators and CHVs could be further swayed to understand and value the benefits of a non-material assistance program.

- The definitive feasibility study will likely benefit from community mobilisation and awareness raising about this specific project and what it involves. This may help pave the way for enumerators to screen men for
participation, reduce expectations of material assistance and prepare men and women for the sensitive nature of the VAW questions – as well as men as it relates to alcohol substance and tobacco use.

- There is an opportunity from this pilot process to harness the goodwill and success of the men who benefited from the GPM+. Their stories could be recorded in simply format and presented to men after the pre-assessment, which may encourage them to attend the first GPM+ session.
- The planned design of the definitive feasibility study, which includes measuring VAW with women in the community and a 3-month follow-up assessment of men who complete the GPM+ remains sound and is consistent with the need to strengthen findings in this pilot report. To assess men at pre-post and follow up assessment, it may be necessary to explore the option of incentives to encourage greater participation in the research. To do this, an ethics update will need to be submitted and budget allocated. Should this not be viable, greater efforts will be essential for follow up assessments and enumerator competence to be able to persuade men of the benefits of their participation. Also, the research team may need to reconsider analysis approaches should inadequate comparative data (pre-post and GPM+ participants and control) be unavailable. Any future RCT on this topic may need to include the costs and ethics of using incentives as a means to better quality data.
- If possible, enable some GPM+ groups to meet outside of traditional daily work hours to determine if this helps to improve regular GPM+ attendance. Naturally, this will be dependent on safety and availability of the CHV facilitators to do this.
- Closer attention to data collection entry will be important for the future feasibility study. The current data was adequate for this evaluation, however reducing missing data and ensuring greater consistency of information between pre and post assessment will support stronger quantitative analyses.
- Methodology for the definitive feasibility study should maintain the mixed methods design of data collection and analyses, given how well the quantitative and qualitative data of this pilot study supplemented each other and offered explanations for interpretation that may have been difficult with a qualitative or quantitative only research design.

Pilot Feasibility Study Limitations

The results, outcomes and interpretations of these pilot study results should be used with caution. While results from this pilot are promising, the following design and methodological limitations must be considered when interpreting the findings.

It is important to note this pilot study was only one part of a wider feasibility study seeking to examine the theory that supporting men with common mental health problems, including excessive alcohol use, may reduce their psychological distress, improve their functioning and subsequently reduce incidences of violence against women. However, not all elements of this theory were tested in the current pilot. The most notable measure not included in this pilot study was experiences of violence against women from the reports and perspectives of women themselves. Only men's subjective reports of violence they perpetrated or experienced as victims was assessed. Further, while alcohol use was measured in this study using the WHO ASSIST tool, it did not examine any causal links between alcohol use and violence against women in this community. Although alcohol use and VAW is a reasonably well-established global phenomenon, it cannot be directly correlated based on findings of this study.

Sampling methods used for quantitative results were not rigorous and based on purposive and convenience methods, thus indicating results may not be representative of the wider Kenya population. Consequently, quantitative analyses were also based only on summary descriptive data and could not be tested for statistical significance. Another quantitative data limitation of this pilot study was missing data, which meant all measures could not be reliably analysed. For instance, little data from the PSYCHLOPS (pre-during and post) could be assessed. The lack of a powered and random sample also meant none of the quantitative measures could not be stipulated as statistically reliable. Nonetheless, the qualitative data that was carefully analysed did offer support to some quantitative findings,
such as overall feelings of improved wellbeing and reduced mean scores for GHQ and PTSD symptoms, as well as improved functioning and less days of productivity lost due to illness.

While the qualitative analyses showed greater analytic rigor than the quantitative findings, it is critical to note that the data collection, thematic analyses and write-up of this evaluation report was managed and authored by an individual stakeholder with close connections to the project, while co-authors were also heavily invested in the project as employees. This may have introduced some bias to the interpretation of the results and thematic analyses. Nonetheless, employment of independent data collectors of the KIIIs and transcripts of interviews may have helped to mitigate this bias. A further bias was the purposive sampling for KIIIs and documentation that comprised the process monitoring and evaluation data.

Translations of data and verbatim recording of KIIIs may have also missed potentially important information. The challenges of translation during KIIIs, transcripts and data interpretation, coupled with the limitations of note-takers being unable to record complete conversations verbatim, all point towards the probability that some information may have been overlooked. Whilst the approach of written transcripts does have these limitations, it was however felt to be the most appropriate and feasible in the study context.

Findings outlined in this research are also not inclusive of comparative data; this being men who did not participate in GPM+. It was evident that while many men participated were successfully screened for inclusion to GPM+, fewer participated in the pre-assessment while very few actually attended 4 or more GPM+ sessions. As such, the post-assessment quantitative results not only compare a disparity of respondents from pre-to-post assessment, but also, it does not shed light on whether the men who did participate in GPM+ may have improved irrespective of the intervention.

Despite these important study limitations, the results of this mixed methods pilot evaluation cannot overlook the important patterns emerging in the data. Nor can they overlook the potential findings a more well designed and methodologically rigorous feasibility, or even randomised control trial, might lend to inform this theory of change, which is showing strong potential and warrants ongoing investigation. Recommendations from this pilot evaluation may further help inform such research design.

Conclusion

Pilot process evaluation findings of the men’s GPM+ program in the Waithaka and Mutuini communities of Kenya’s urban Dagoretti district has shown that a more detailed GPM+ feasibility study as being workable and acceptable to the context and target population. This is based on primary findings that show patterns of men’s improved wellbeing because of their involvement with the GPM+ intervention, including suggestions of reduced alcohol and drug use and improved family relationships. To ascertain if the theory of change that this leads to reduced VAW, stronger management during data collection will be essential to gather more accurate pre and post data. Despite several limitations to the current study, the overall outcome of this pilot study indicates that the proposed theory of change is promising. With strengthened research methods and approaches, it suitable that the idea of improving men’s mental health to reduce alcohol use and subsequently reduce incidences of VAW is justified.
Annex A – Project Theory of Change

Risks Factors as They Relate to Mental Health

- Lack of community awareness about the mental health implications of violence against women
- Poor mental health (including harmful alcohol use) is a risk factor for victimisation and perpetration of IPV
- Poor mental health perpetuates and increases incidences of IPV
- Kenya MoH lacks resources to meet the mental health treatment gap

Interventions for Individuals and Health Structures

- Monthly community dialogues for health are used (every 2nd month) as a community forum to raise awareness about issues related to violence against women, including mental health implications for men and women
- A generic and feasible low-intensity intervention (including harmful alcohol use) that is brief and can be delivered by trained para-professionals is adapted (P+). P+ reduces risks for re-victimisation of women and male perpetration/re-perpetration of violence against women.
- Paraprofessionals trained to treat men with common mental health problems form CBOs
- CBOs establish income generation initiatives that will enable them to provide treatment within the community

Protective Outcomes as They Relate to Mental Health

- Women receive treatment for common mental health problems
- Men receive treatment for common mental health problems
- Kenya MoH and CBOs partner to scale up interventions for individuals affected by violence and living with common mental health problems
- Kenya MoH improves access to services to treat individuals with common mental health problems

Impacts

- Increased community awareness about the mental health implications of violence against women
- Women experience improved mental health and are protected from re-victimisation
- Men experience improved mental health and are protected from perpetrating/re-perpetrating IPV
- Reduced incidents of IPV in Kenya

Legend:
- Current Situation
- Key Interventions
- Process Outcomes
- Ultimate aims/impacts

Rationale:
- Findings indicating that treatment for the mental health and wellbeing of individuals both at risk of victimisation/re-victimisation and perpetration/re-perpetration of violence against women can positively influence a reduction and/or prevention of incidences of sexual and intimate partner violence (IPV) in Kenya and such an approach can be implemented at scale.

Assumptions (A):  
1. Ethics approval for feasibility study is approved and men and women agree to participate
2. Trained para-professionals are agreeable to establishing CBOs and can establish formal, functional structures that actively engage in income generation initiatives
3. CBOs establish enough alternative income generation to be able to facilitate ongoing treatment for women affected by violence
4. Men agree to and actively attend all Group P+ (P+M) sessions
5. Kenya MoH accept P+M/GPM+ for scalability and are open to negotiate potential partnerships with CBOs
6. Women and men who benefi from treatment AND/OR awareness raising key messages experiential change that reduces their risks in relation to IPV over time
7. Kenya MoH is committed to the roll out of scalable treatments and models for treatment of individuals with common mental health problems
8. Awareness about the mental health implications of violence against women translates to potential help-seeking behaviours
Annex B – Flow chart data collection processes for the GPM+ program


**PILOT FEASIBILITY STUDY**

- Screening (n=Approx. 150*)
- Pre-Assessment (n=50**)
- Pilot Implementation GPM+ 6 x 2 hour sessions held over 3 weeks
- Post-Assessment

**DEFINITIVE FEASIBILITY STUDY**

- Screening (n=Approx. 960*)
- Pre-Assessment (n=320**)
- Definitive Implementation GPM+ 6 x 2 hour weekly sessions
- Post-Assessment
- 3-Month Post-Assessment

*Estimated one in three will meet criteria but screening figures may be higher or lower until the quota of included participants is reached
**The study will recruit 50 men for the pilot study plus 320 men for the definitive feasibility study; however, it is anticipated there will be some attrition of participants throughout the process; an important phenomenon to assess in and of itself.
Annex C – Permission for translation and use of the Conflict Assessment Scale (version 2) Shortform
Annex D – English version of the GPM+ Screening Pack, including informed consent

**SCREENING PACK for MEN ONLY**

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<td>2</td>
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</table>
| 5       | Suicide Risk Assessment  
            (Including additional guidelines and script) |
| 6       | Severe Mental Disorder & Cognitive Impairment |
| 7       | Scoring Summary Form  
            (Including exclusion criteria check) |
| 8       | Giving People Feedback |
| 10      | Information & Consent Form #1:  
            Phases 1 and 3 Trial Screening Form  
            (To participate in screening interview) |
| 11      | Information & Consent Form #2:  
            Phases 1 and 3 Trial Consent Form  
            (For included clients only) |
I) INTRODUCTIONS & VERBAL CONSENT

- Hello, my name is ............ I am from World Vision Kenya, and I would like to ask you whether you are willing to participate in a project.
- I’d like to tell you more about the project. I expect we will need to spend no more than 30 minutes together.

===== Note: if the participant has no time, ask whether you may come back at a later time =====

- Some people experience stress that may affect their ability to carry out day to day tasks. A program has been developed that teaches people skills to cope better with stress. This program will take 6 weeks and would be delivered to participants by Community Health Volunteers. We will be testing whether this program helps men with stress-related difficulties in your community.
- What we hope you will get out of the program are skills to deal with stress. So the program is not about providing direct material support or money, but teaching important skills.
- I’d like to interview you now about your stress.
- If this interview indicates that the program might help you, you will most likely be invited for the next part of the project. You will not be invited for the next part of the program if this interview indicates that this program is not right for you. If the program is right for you I will explain the procedures for the next part of the study in more detail later.
- Everybody included will receive the program at different times. Half of the participants will be offered the program immediately, and half of the participants will be offered the program at a later time. All participants will also be interviewed three times. You are free to decide to participate in this brief interview now. You may decide to stop at any stage during this brief interview.
- Everything you tell us during the interviews, or during the project, is kept confidential. I will write down your responses to the interview and only take your name for purposes of generating a case ID after which the name will be deleted from the forms. The responses are then stored behind locks in the World Vision building

- Everything I just told you is in this letter. You may read it yourself if you would like more information. The letter also contains the name of the contact person you may contact if you have questions.

====Hand over the Phases 1 and 3 Screening Informed Consent form to the man – separate consent form available for participants to keep====

- Would you like to participate in this study? You do not have to decide today, I can come back later if that is better for you.

[If the man agrees to participate, hand over the Certificate of Consent form for a signature or a witnessed fingerprint.

- Now with your consent I would like to interview you by asking you some questions; OR
- [If the man does not agree to participate, thank her, tell him that he may always change his mind, and say goodbye.]
2) **DEMOGRAPHIC INFORMATION**

Thank you for participating in the interview. Let me ask you the questions now. Please note that there is no right or wrong answers to these questions. Just be honest about how things are right now. I will start with some background questions.

<table>
<thead>
<tr>
<th></th>
<th>Record gender as observed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Female 1 Male 2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>How old are you?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>_______ years</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>How many years in all did you spend studying in school, college or university?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>_______ years</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>What is your current marital status? (Select the single best option)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Never married 1 Currently married 2 Separated 3 Divorced 4 Widowed 5 Cohabitating 6</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Which describes your main work status best? (Select the single best option)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Paid work (see 5b) 1 Self-employed, such as own your business or farming (see 5b) 2 Non-paid work, such as volunteer or charity 3 Student 4 Keeping house/homemaker 5 Retired 6 Unemployed (health reasons) 7 Unemployed (other reasons) 8 Other (specify)___________ 9</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>If they are in paid work or self-employed ask: What is your job? (What do you do for work?) (Write answer exactly in space provided)</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Living situation at time of interview Record as observed (circle only one)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Independent in community 1 Assisted living 2 Hospitalized 3</td>
<td></td>
</tr>
</tbody>
</table>
3) WHO-DAS

Instructions to the interviewer are written in bold and italics – do not read these aloud

Text for the respondent to hear is written in standard print in blue. Read this text aloud

This interview has been developed by the World Health Organization (WHO) to better understand the difficulties people may have due to their health conditions. The information that you provide in this interview is confidential and will be used only for research. The interview will take 5–10 minutes to complete.

Even if you are healthy and have no difficulties, I need to ask all of the questions so that the survey is complete.

The interview is about difficulties people have because of health conditions.

Hand flashcard #1 to respondent

By health condition, I mean diseases or illnesses, or other health problems that may be short or long lasting; injuries; mental or emotional problems; and problems with alcohol or drugs.

Remember to keep all of your health problems in mind as you answer the questions. When I ask you about difficulties in doing an activity think about...

Point to flashcard #1

• Increased effort
• Discomfort or pain
• Slowness
• Changes in the way you do the activity.

When answering, I’d like you to think back over the past 30 days. I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30 days, while doing the activity as you usually do it.

Hand flashcard #2 to respondent

Use this scale when responding.

Read scale aloud:

None, mild, moderate, severe, extreme or cannot do.
Ensure that the respondent can easily see flashcards #1 and #2 throughout the interview

Section 4 Core questions

**Show flashcard #2**

<table>
<thead>
<tr>
<th>In the past 30 days, how much difficulty did you have in:</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme or cannot do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S1</strong> Standing for <strong>long periods</strong> such as 30 minutes?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>S2</strong> Taking care of your <strong>household responsibilities</strong>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>S3</strong> Learning a <strong>new task</strong>, for example learning how to get to a new place</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>S4</strong> How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>S5</strong> How much have you been <strong>emotionally affected</strong> by your health problems?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the past 30 days, how much difficulty did you have in:</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme or cannot do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S6</strong> Concentrating on doing something for <strong>ten minutes</strong>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>S7</td>
<td>Walking a long distance such as a kilometre (or equivalent)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>S8</td>
<td>Washing your whole body?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>S9</td>
<td>Getting dressed?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>S10</td>
<td>Dealing with people you do not know?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>S11</td>
<td>Maintaining a friendship?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>S12</td>
<td>Your day-to-day work/school?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**H1** Overall, in the past 30 days, how many days were these difficulties present? **Record number of days ________**

**H2** In the past 30 days, how many days were you totally unable to carry out your usual activities or work because of any health condition? **Record number of days ________**

**H3** In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition? **Record number of days ________**

*Calculate total score immediately*

<table>
<thead>
<tr>
<th>TOTAL SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count the numbers from S1-S12</td>
</tr>
</tbody>
</table>

**IS THE TOTAL SCORE equal to or BELOW 16?** **YES / NO**
4) GENERAL HEALTH QUESTIONNAIRE

Say to the client:

*We want to know how your health has been in general over the last few weeks. I will read the questions below to you and each of the four possible answers, which are also here (point to GHQ Flashcard 3). Tell me the response that best applies to from this card.*

You will read each item, point to the corresponding scale on the flashcard as you read it out and circle the appropriate number based on the client’s response.

The third line of numbers (e.g. 0, 0, 1, 1) is counted for scoring and should not be shown to the client.

*Have you recently:*

1. Been able to concentrate on what you’re doing?

<table>
<thead>
<tr>
<th>Better than usual</th>
<th>Same as usual</th>
<th>Less than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

2. Lost much sleep over worry?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>No more than usual</th>
<th>Rather more than usual</th>
<th>Much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

3. Felt that you are playing a useful part in things?

<table>
<thead>
<tr>
<th>More so than usual</th>
<th>Same as usual</th>
<th>Less so than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

4. Felt capable of making decisions about things?

<table>
<thead>
<tr>
<th>More so than usual</th>
<th>Same as usual</th>
<th>Less so than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
5. Felt constantly under strain?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>No more than usual</th>
<th>Rather more than usual</th>
<th>Much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Felt constantly</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>under strain?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Felt you couldn’t overcome your difficulties?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>No more than usual</th>
<th>Rather more than usual</th>
<th>Much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Felt you couldn’t</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>overcome your</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>difficulties?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Been able to enjoy your normal day to day activities?

<table>
<thead>
<tr>
<th></th>
<th>More so than usual</th>
<th>Same as usual</th>
<th>Less so than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Been able to enjoy</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>your normal day to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>day activities?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Been able to face up to your problems?

<table>
<thead>
<tr>
<th></th>
<th>More so than usual</th>
<th>Same as usual</th>
<th>Less so than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Been able to face</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>up to your problems?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Been feeling unhappy or depressed?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>No more than usual</th>
<th>Rather more than usual</th>
<th>Much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Been feeling</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>unhappy or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>depressed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10. Been losing confidence in yourself?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>No more than usual</th>
<th>Rather more than usual</th>
<th>Much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

11. Been thinking of yourself as a worthless person?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>No more than usual</th>
<th>Rather more than usual</th>
<th>Much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

12. Been feeling reasonably happy, all things considered?

<table>
<thead>
<tr>
<th>More so than usual</th>
<th>Same as usual</th>
<th>Less so than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*Calculate total score immediately*

<table>
<thead>
<tr>
<th>TOTAL SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Count the numbers from the 3rd line that are in <strong>bold</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IS THE TOTAL SCORE <strong>equal to or less than 2?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>YES / NO</td>
</tr>
</tbody>
</table>
5) SUICIDE RISK ASSESSMENT

The following questions will assist you in assessing imminent suicide risk in participants. By imminent risk of suicide, we mean those participants whose current safety you cannot guarantee and you need to help keep them safe. Be familiar with the Additional Guidelines below and ensure you remember them as you go on with the questions.

Additional guidelines when assessing suicide risk in participants:

Ask direct, clear questions:

- When asking questions about suicide, avoid using less direct words that could potentially be misunderstood
- Direct questions help participants feel like they are not being judged by having suicidal thoughts, plans or attempts
- Some people may feel uncomfortable talking with you about suicide but you can tell them that it is very important for you to clearly understand their level of safety
- Asking questions about suicide will not put ideas in a person’s head to end their life if they had not thought about this before

Look for extreme emotions or behaviours:

- Severe emotional distress
- Hopelessness
- Extreme agitation
- Violence
- Uncommunicative behaviour
- Severe social isolation

Responding to imminent suicide risk:

- Always contact your supervisor
- Remove means of self-harm if possible
- Create a secure and supportive environment; if possible, offer separate, quiet room while waiting
- Do not leave the person alone if possible
- Supervise and assign a named staff member or family member to ensure safety if available.
- Attend to mental state and emotional distress with your basic helping skills and PFA if needed
Say to the client:
We have just been talking about different emotional difficulties people can experience. Sometimes when people feel very sad and hopeless about their life, they have thoughts about their own death or even ending their own life. These thoughts are not uncommon and you should not feel ashamed about having such thoughts if you do. The following questions I have for you are about these kinds of thoughts. Is that okay with you? Can we continue with the interview?

1. In the past month have you had serious thoughts or a plan to end your life?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, ask the participant to describe their thoughts or plans. Write details here:</td>
<td></td>
</tr>
</tbody>
</table>

If the participant responded ‘no’ to question 1, thank the client for answering your questions and you can end the assessment.

If the participant responded ‘yes’ to question 1 please continue with question 2.

2. Have you taken any actions to end your life?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, ask what actions they have taken and write details here:</td>
<td></td>
</tr>
</tbody>
</table>

3. Do you plan to end your life in the next two weeks

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>UNSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes or unsure, ask participant to describe their plan to you. Write details here:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the participant says ‘yes’ to question 3 they are at imminent suicide risk and you must contact your supervisor immediately. Stay with the person while you do this. (See script below if needed.)

If you are unsure whether the participant is at imminent risk of harm tell the participant you would like to contact your supervisor to ask them follow-up questions.

Script for people with imminent risk of suicide:

“If from what you have described to me, I am concerned about your safety. As I mentioned at the beginning of this interview, if I believe you are at risk of (say which is appropriate: harming yourself, being harmed by someone else, or harming someone else) I must contact my supervisor. This is very important so we can get you the best kind of treatment for these problems as soon as possible. I am going to do this now, okay?”
6) **SEVERE MENTAL DISORDERS & COGNITIVE IMPAIRMENT**

The following behaviours should be considered when assessing severe mental health or cognitive impairment. The following items are based on your observations and judgment of the client’s behaviours. **Do not ask the client any questions here.** Circle yes or no to indicate your judgment and give details if needed.

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1 Does the client understand you (even though they speak the same dialect)?</td>
<td>If no, give details: YES / NO</td>
</tr>
<tr>
<td>(E.g. can they understand basic words, questions or follow the instructions?)</td>
<td></td>
</tr>
<tr>
<td>8.2 Is the client able to follow what is happening in the assessment?</td>
<td>If no, give details: YES / NO</td>
</tr>
<tr>
<td>(Please consider if the client is so drunk or high they cannot follow what is happening- then circle NO)</td>
<td></td>
</tr>
<tr>
<td>8.3 Are the client’s responses bizarre and/or highly unusual?</td>
<td>If yes, give details: YES / NO</td>
</tr>
<tr>
<td>(E.g. uses made-up words, long periods of staring into space, talks to him/her-self, stories are very bizarre and unbelievable)</td>
<td></td>
</tr>
<tr>
<td>8.4 From the client’s responses and behaviours does it appear that they are not in touch with reality or what is happening in the assessment?</td>
<td>If yes, give details: YES / NO</td>
</tr>
<tr>
<td>(E.g. Delusions or firmly held beliefs or suspicions that do not make sense (they are bizarre) or are not realistic in the person’s local context, unrealistic paranoia, such as a highly unrealistic belief that someone is trying to harm them)</td>
<td></td>
</tr>
</tbody>
</table>

Consider excluding a client if you answered **NO** on 8.1 or 8.2, or **YES** on 8.3 or 8.4
## 7) SUMMARY PAGE

Complete the summary table before deciding whether the client is to be included in or excluded from the study.

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RESPONSE/SCORE</th>
<th>EXCLUSION (Tick if response to any is YES)</th>
<th>RESPONSE FOR EXCLUDED CLIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO-DAS Total Score</td>
<td>________</td>
<td>If YES, Give feedback for negative screen (p.16)</td>
<td></td>
</tr>
<tr>
<td>Is the WHO-DAS Score equal to or less than 16?</td>
<td>YES / NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GHQ Total Score</td>
<td>________</td>
<td>If YES, Give feedback for negative screen (p.16)</td>
<td></td>
</tr>
<tr>
<td>Is the GHQ Score equal to or less than 2?</td>
<td>YES / NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the client under 18 years?</td>
<td>YES / NO</td>
<td>IF YES, If person shows signs of mental health problems, link with a child/adolescent mental health service</td>
<td></td>
</tr>
<tr>
<td>Is the client at imminent risk of suicide?</td>
<td>YES / NO</td>
<td>IF YES, Call your supervisor. Link in with more appropriate treatment</td>
<td></td>
</tr>
<tr>
<td>Does the client have a severe mental disorder? (From clinical observation-items 8.1-8.4)</td>
<td>YES / NO</td>
<td>If YES, Link in with more appropriate treatment</td>
<td></td>
</tr>
<tr>
<td>Does the client have a severe cognitive impairment? (From clinical observation-item 8.1)</td>
<td>YES / NO</td>
<td>If YES, Link in with more appropriate treatment</td>
<td></td>
</tr>
<tr>
<td>Does the client only want treatment for seizures?</td>
<td>YES / NO</td>
<td>If YES, Link in with more appropriate treatment</td>
<td></td>
</tr>
</tbody>
</table>

Circle the appropriate decision based on the summary table above

**INCLUDED**

Give feedback (scripts below)

**EXCLUDED**

Give feedback and refer on if necessary
8) GIVING FEEDBACK TO CLIENTS

1. Feedback for Participants with **Negative Screen**

   a. **Participants not distressed** (i.e. WHO-DAS is equal to or less than 16; and/or GHQ is equal to or less than 3)
      
      ➢ Thank you for these answers. It seems that you are coping well with things at the moment, and so this programme is not really something you need. I am very grateful for giving me your time and for being so honest with your answers.

   b. **Participants with problems not suited to this programme** (i.e. excluded due to severe mental health disorder or severe cognitive impairment, or wants treatment for seizures)
      
      • Thank you for your time and honest answers.
      • It seems you are experiencing difficulties that this programme would not be able to help you with (name difficulty- e.g. hearing voices, very severe problems with drinking/drugs).
      • I would like to link you in with a service that would be better suited to helping you with these problems. Would that be okay?
      • Explain clearly what you will do- e.g. call the service to make an appointment for the client now or later, talk with your supervisor, call or revisit the client at a different time etc.

2. Feedback for Participants with **Positive Screen** (i.e. client meets all inclusion criteria)

   ➢ Thanks for these answers. It seems that you are having some problems with coping with the situations (as mentioned) at the moment, and so this programme may help you. Therefore, I invite you to take part in the next part of our project.
   
   ➢ I would like to tell you more about it during the next 10 minutes. Would you agree with that?

   **[Note: if the participant has no time, ask whether you may come back at a later time.]**

   ➢ We will test the usefulness of a new program, called Group Problem Management Plus (GPM+). This program will be delivered by Community Health Volunteers.

   ➢ This program will consist of 6 weekly meetings of approximately 90 minutes each with the Community Health Volunteers and other men who have also shown distress from this survey.

   ➢ What we hope you will get out of the program are skills to deal with stress. So the program is not about providing direct material support or money, but teaching important skills.

   ➢ Everybody included will receive the program at different times.
➢ To be fair, participants who will receive the program now, and who will receive it later, will be decided by chance, as if by tossing a coin. You will be phoned by my colleague Vane Nyamweya with more information about where you will meet and when.

➢ After today’s interview, you will be interviewed three times by me irrespective of whether you are receiving the program or not. These interviews focus on feelings of distress, and your experiences with stressful events. They take approximately one hour and will take place at your home. The first interview will be held this week, the second interview will be 6 weeks later, and the final interview will be 4 months later.

➢ As I previously mentioned, you are free to decide to participate in the project. You may decide to stop at any stage.

➢ Everything you tell us during the interviews or during the project is kept confidential. I will write down your responses to the interview, but without your name on the form, only a number and these responses will be kept behind locks in the World Vision building.

➢ Everything I just told you is also written down in this letter. You may read it yourself if you would like more information. The letter also contains the name of the contact person you may contact of you have questions.

[Hand over the Consent Form #2: Phases 1 and 3 Trial Consent form to the woman. This is on page 26 and should be separated from the assessment pack.]

➢ Would you like to participate in this study? You do not have to decide today, I can come back later if that is better for you.

PHASES 1 AND 3 SCREENING CONSENT FORM (Version 1)

Informed Consent form

This Informed Consent Form is for men in Dagoretti Sub County of Nairobi, and who we are inviting to participate in research on the feasibility of administering Group Problem Management Plus (PM+) for use in Nairobi, Kenya. The title of our research project is “GPM+ in the treatment of common mental health problems amongst men in urban Kenya”.

This Informed Consent Form has two parts:

- Information Sheet (to share information about the research with you)
- Certificate of Consent (for signatures if you agree to take part)

You will be given a copy of the full Informed Consent Form

PART I: Information Sheet

Introduction

We are a group of researchers from World Vision Kenya. We are interested in studying the feasibility of new support program for distressed men. This program is called “Problem Management Plus for Groups (GPM+)”. I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

If I use some words that you do not understand, please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask either me, the community health worker or other colleagues involved in the project.

Purpose of the research

Emotional problems, such as feelings of extreme sadness and extreme anxiety are very common. These may affect the ability of people to carry out day to day tasks, or tempt people to turn to unhelpful coping strategies, such as drinking alcohol. Many people with such problems do not get effective help. In this research, we aim to find out whether a support program called “Group Problem Management Plus (PM+)” is useful and acceptable in reducing such problems amongst men in this community.

Type of Research Intervention

This research involves an interview about feelings and emotions to find out if you meet the criteria for inclusion in the study. This will take approximately 20 minutes of your time. If your responses indicate that you might be stressed or depressed, we will provide you with more information and invite you to take part in our study.

Participant selection

We are inviting a sample of men from this community to participate in this research.
Clarifying question: Do you know why we are asking you to take part in this study? Do you know what the study is about?

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. Whether you choose to participate or not, all the services you receive at this primary healthcare centre will continue and nothing will change. You may change your mind at any time and stop participating, even if you agreed earlier. If you stop, your responses will be destroyed.

Clarifying question: Do you know that you do not have to take part in this research study, if you do not wish to? Do you have any questions?

B. Description of the Process

- If you agree, I will ask you questions about your well-being, about feelings and emotions, and difficulties you are experiencing and daily activities. This takes approximately 20 minutes. If your responses indicate that you are probably distressed, we will invite you to take part in our study. If your responses indicate that you are probably not distressed, your participation in the research ends. If indicated and if you agree, you may be referred for additional support.

Clarifying question: Do you have any questions? Do you want me to go through the procedures again?

Risks

It is possible that talking about your feelings and emotions will make you more stressed, fearful or tense for a little while. Talking about your feelings or emotional topics may be difficult for some people, and cause emotional upset in some. You may always skip any questions which make you feel uncomfortable. If you become upset, you will be able to speak with [INSERT NAME OF COMMUNITY MOBILISER – TO BE CONFIRMED], whose contact details we will give to you. Our staff are trained in helping you to cope with such feelings. If you or our staff become seriously concerned about your mental wellbeing or symptoms of distress, we will assist you to receive specialised care at the Mbagathi District Hospital

Reimbursements

No compensation will be offered for participating in today’s interview.

Clarifying question: Do you have any questions?

Confidentiality
We and any researchers working on this study ensure privacy and confidentiality for all study-related data, documents, and findings. It is possible that if others in the community are aware that you are participating, they may ask you questions. But we will not be sharing the identity of who is participating in the research.

All information collected about you will be kept strictly confidential. The results of all assessments and tests will never be linked to yourself. Any information about you will have a number on it instead of your name. Data will be stored in a document on a computer at World Vision Kenya that can only be opened by the researcher. Only group results will be reported that cannot be linked to yourself to protect confidentiality. No one else except direct members of our research team will have access to the information documented during your interview. The interviews will be destroyed after five years.

➢ **Clarifying question:** Did you understand the procedures that we will be using to make sure that any information that we as researchers collect about you will remain confidential? Do you have any questions about them?

**Sharing the Results**

The knowledge that we gain during this research will be shared with you through community meetings before it is made widely available to the public. Nothing that identifies you will be shared at these meetings or at any point during this study, and we will not tell anybody that you have contributed to this research. Meetings in the community to share research findings will be announced. After these meetings, we will publish what we have learnt so that other interested people may learn from this research.

**Right to Refuse or Withdraw**

You do not have to take part in this research if you do not wish to do so. Refusing to participate will not affect your support from the community health volunteers or other treatment by medical staff at this primary health centre in any way. You will still have all the benefits that you would otherwise have in your community. You may also stop participating in the research at any time you choose without losing any of your rights as a patient.

**Who to Contact**

If you have questions now you can ask me. We will also give you the name and phone number of a study team member to contact if you have questions later. This person is:

Project manager Title: [TO BE CONFIRMED]

Physical address: Equity Building, Kawangware, Nairobi
This protocol has been reviewed and approved by the Kenyatta National Hospital Ethics and Research Internal Review Board. Whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the ethical approval, contact KNH-UoN ERC, P.O BOX 20723-00202.

**Clarifying questions:**
- Do you know that you do not have to take part in this study if you do not wish to? You can say No if you wish to? Do you know that you can ask me questions later, if you wish to? Do you know that I have given the contact details of the person who can give you more information about the study?
- You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?
PART II: Certificate of Consent

Literate participant:

I have read and understood the above information, or it has been read to me. I have had the opportunity to ask questions, and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this research.

Print Name of Participant__________________________________________

Signature of Participant ___________________________________________

Date ___________________________  
   Day/month/year

Illiterate participant:

I have witnessed the accurate reading of the consent form to the participant, and the participant has had the opportunity to ask questions and these have been answered to the participant’s satisfaction. I confirm that the individual has given consent freely.

Thumb print of participant

Print Name of Witness__________________________________________

Signature of Witness ___________________________________________

Date ___________________________  
   Day/month/year
Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the purpose and process of the study.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this informed consent form has been provided to the participant.

Print Name of Researcher/person taking the consent _______________________________

Signature of Researcher /person taking the consent _______________________________

Date ___________________________

Day/month/year

CONSENT FORM #2 on the following page

Give clients who are included in the research project the form (next page) to keep and read. This form will be completed before pre-assessment.
Informed Consent form

This Informed Consent Form is for men in the Dagoretti Sub County of Nairobi, and who we are inviting to participate in research on the feasibility of administering Group Problem Management Plus (GPM+) for use in Nairobi, Kenya. The title of our research project is “Group Problem Management Plus (GPM+) in the treatment of common mental problems amongst men in urban Kenya”.


This Informed Consent Form has two parts:

- Information Sheet (to share information about the research with you)
- Certificate of Consent (for signatures if you agree to take part)

You will be given a copy of the full Informed Consent Form
PART I: Information Sheet

Introduction

We are a group of researchers from World Vision Kenya studying a new support program for distressed individuals. This program is called “Group Problem Management Plus (GPM+)”.

You were interviewed by a research assistant of our research team and your responses indicated that you are probably distressed. Therefore, we invite you to take part in the next part of our study. In this part, we will test the feasibility GPM+ program in reducing these feelings of distress.

I am going to give you information and invite you to be part of this part of the research. You do not have to decide today whether or not you will participate. Before you decide, you can talk to anyone you feel comfortable with about the research.

I may use some words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask me, the interviewer, service provider or other staff members involved in the project.

Purpose of the research

Emotional problems, such as feelings of sadness and anxiety are very common. These may affect the ability of people to carry out day to day tasks. Many people with such problems do not get effective help and they may turn to unhelpful behaviours, such as drinking alcohol in order to cope. In this research, we aim to find out whether a support program called “Group Problem Management Plus (GPM+)” is useful and effective in reducing such problems.

GPM+ consists of 6 group sessions with about 7 other men. Each session will run around 2 hours. During these sessions, a two group facilitators (one man and one woman) will listen to you and the other men in the group. The whole group will discuss issues related to your problems and emotions. You will also be given advice on ways you can address problems that cause distress. Research in other countries suggests that this program may reduce stress-related problems. We now want to find out whether it is useful and acceptable for men in Kenya.

Type of Research Intervention

This type of research study means all participants to can be included GPM+ will be offered treatment, though some may be offered treatment a few weeks before or after others. All the men involved in the groups will be similar to you, in that they too will have shown signs that they may be distressed or not functioning very well.

➤ *Clarifying questions:* Do you know why we are asking you to take part in this study? Do you know what the study is about?

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. Whether you choose to participate or not, all the services you receive in the community will continue and nothing will change. You may change your mind at any time and stop participating, even if you agreed earlier. If you stop, your responses will be destroyed.
Clarifying questions: If you decide not to take part in this research study, do you know what will happen? Do you know that you do not have to take part in this research study, if you do not wish to? Do you have any questions?

A. Description of the Process

- You will be interviewed again. The interviewer will ask you some additional questions on adverse events and reactions related to these events, and other difficulties concerning your health. This will take approximately 50 minutes. Finally, another research assistant will tell you to which group you are assigned – when and where they will be meeting. The group are assigned will be run by one male and one female facilitator and one of these two individuals will contact you to confirm your attendance at the first and subsequent group sessions.

- GPM+ will consist of you attending 6 weekly group sessions, each lasting about 2 hours. This will provide you a chance to share your challenges with others, as well as trained facilitators who will help teach you skills and offer advice on ways you can address problems that cause distress.

- At the second assessment, seven weeks after the first, all participants will again be asked questions, which are similar to the first assessment. This assessment will take approximately 60 minutes

- At the final assessment, four months after the first, all participants will again be asked questions similar to the first assessment. This assessment takes approximately 60 minutes. This helps us measure how well you have benefited from the GPM+ program over time.

Clarifying questions: Can you tell me if you remember the number of times that we are asking you to complete questions for our research project? And how many sessions does the PM+ program have? Do you have any other questions? Do you want me to go through the procedures again?

Risks

We do not expect that GPM+ will have any negative effects. However, it is possible that talking about your feelings and emotions will make you more stressed, fearful or tense for a little while. Talking about your feelings or emotional topics may be difficult for some people, and cause emotional upset in some. You may always skip any questions which make you feel uncomfortable. If you become upset, you will be able to speak to the person whose contact details we will give to you. Our staff is trained in helping you to cope with such feelings. If you or our staff becomes seriously concerned about your mental wellbeing or symptoms of distress, we will assist you to receive specialized care at the Mbagathi District Hospital.

Benefits

We expect that the programme might be helpful to people experiencing distress. If the study shows that GPM+ is helpful for men, then additional service providers in your area will be trained to deliver GPM+ so that other people who experience stress-related problems may benefit from it too.

Reimbursements

We will not offer compensation for your time to take GPM+ sessions; although we will offer refreshments you (drinks and a small snack at each meeting.)

Clarifying questions: Can you tell me if you have understood correctly the benefits that you will have if you take part in the study? Do you have any other questions?
Confidentiality

We and any researchers working on this study ensure privacy and confidentiality for all study-related data, documents, and findings. It is possible that if others in the community are aware that you are participating, they may ask you questions. But we will not be sharing the identity of who is participating in the research. All information collected about you will be kept strictly confidential. The results of all assessments and tests will never be linked to yourself. Any information about you will have a number on it instead of your name. Data will be stored in a document on a computer at the Office of World Vision Kenya, which can only be opened by the researcher. Only group results will be reported that cannot be linked to yourself to protect confidentiality. No one else except the lead research team at World Vision will have access to the information documented during your interviews. The interviews will be destroyed after five years.

Clarifying questions: Did you understand the procedures that we will be using to make sure that any information that we as researchers collect about you will remain confidential? Do you have any questions about them?

Sharing the Results

The knowledge that we gain during this research will be shared with you through community meetings before it is made widely available to the public. Nothing that identifies you will be shared at these meetings or at any point during this study, and we will not tell anybody that you have contributed to this research. Meetings in the community to share research findings will be announced. After these meetings, we will publish what we have learnt so that other interested people may learn from this research.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so. Refusing to participate will not affect your treatment from the community health worker or medical staff the primary health centre in any way. You will still have all the benefits that you would otherwise have at your primary healthcare centre and any other healthcare facility you may wish to visit. You may also stop participating in the research at any time you choose without losing any of your rights as a patient.

Who to Contact

If you have questions now you can ask me. We will also give you the name and phone number of a study team member to contact if you have questions later. This person is:

Project manager Title: Jacinta Sila –Clinical Supervisor

Physical address: Equity Building, Kawangware, Nairobi

This protocol has been reviewed and approved by the Kenyatta National Hospital Ethics and Research Internal Review Board whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the ethical approval, contact Dr Guantai, KNH-UoN Ethics and Research Committee.

Clarifying questions: Do you know that you do not have to take part in this study if you do not wish to? You can say No if you wish to? Do you know that you can ask me questions later, if you wish to? Do you know that I have given the contact details of the person who can give you more information about the study?

Question: You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?
PART II: Certificate of Consent

Literate participant:

I have read and understood the above information, or it has been read to me. I have had the opportunity to ask questions, and any questions that I have asked have been answered to my satisfaction. I consent voluntarily be a participant in this research.

Print Name of Participant__________________________________________

Signature of Participant ___________________________________________

Date ___________________________

Day/month/year

Illiterate participant:

I have witnessed the accurate reading of the consent form to the participant, and the participant has had the opportunity to ask questions and these have been answered to the participant’s satisfaction. I confirm that the individual has given consent freely.

Thumb print of participant

Print Name of Witness__________________________________________

Signature of Witness ___________________________________________

Date ___________________________

Day/month/year
Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the purpose and process of the study.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this informed consent form has been provided to the participant.

Print Name of Researcher/person taking the consent_______________________________

Signature of Researcher /person taking the consent_______________________________

Date ___________________________

Day/month/year
### Annex E – English version of the Pre-and-Post Assessment Pack, including informed consent

**PRE-ASSESSMENT PACK for MEN ONLY**

<table>
<thead>
<tr>
<th>Section</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introductions &amp; Verbal Consent</td>
</tr>
</tbody>
</table>
| 2       | PSYCHLOPS (PRE Assessment)  
          | PSYCHLOPA (POST Assessment) |
| 3       | Life Events Checklist (LEC) |
| 4       | PTSD Checklist (PCL-5) |
| 5       | Conflict Tactics Scale, Version 2, Shortform (CTS2S) |
| 6       | WHO Alcohol, Smoking and Substance Involvement Screening Test (WHO-ASSIST), Version 3.1 |
| 7       | Cost Effectiveness Questions |
| 8       | Scoring Summary Form |
| 9       | Copy of Trial Consent Forms (To be detached) |
1) INTRODUCTIONS

- Greet the man again and thank him for your time
- Tell him you will be talking about the consent form first to make sure he is happy to be interviewed again. Then you will begin the second interview.

VERBAL CONSENT FORM #2

The following should have been read at the end of the screening interview. However, be sure the client understood everything that was said to them about the programme last time you visited. If they cannot remember what was said, read the following again.

- During our previous interview, your responses indicated that the program might help you. Therefore, I invited you to take part in the next part of our project.

- We will test the usefulness of a new program, called Group Problem Management Plus (GPM+). This program will be delivered by a Community Health Workers.

- This program will consist of 6 meetings of approximately 2 hours each with the Community Health Worker. The groups will run once per week for 6 weeks.

- What we hope you will get out of the program are skills to deal with stress. So the program is not about providing direct material support or money, but teaching important skills.

- After today, you will be phoned by my colleague Vane Nyamweya who will tell you about which group you will meet in and where and when. Everybody included will receive the program at different times. Half of the participants will be offered the program immediately, and half of the participants will be offered the program at a later time.

- All participants will also be interviewed three times. These interviews focus on feelings of distress, and your experiences with stressful events. They take approximately one hour and will take place at your home. The first interview will be held this week, the second interview will be after you complete the group program; and the final interview will be 4 months late. We are asking for your participation voluntarily and will not be able to offer you any reimbursement for your time. However, we do anticipate that being part of this program will be helpful to you in learning new skills to manage problems and stress.

- As I previously mentioned, you are free to decide to participate in the project. You may decide to stop at any stage.
- Everything you tell us during the interviews or during the project is kept confidential. I will write down your responses to the interview, but without your name on the form, only a number, and these responses will be kept behind locks in the World Vision building.

- Everything I just told you is also written down in this letter. You may read it yourself if you would like more information. The letter also contains the name of the contact person you may contact if you have questions.

[Handover the Phases 1 and 3 Trial Consent form to the man if he does not have a copy. This should be separated from the assessment pack.]

- Would you like to participate in this study? You do not have to decide today, I can come back later if that is better for you.

[If the man agrees to participate, hand over the Certificate of Consent form for a signature or a witnessed fingerprint.

If the man does not agree to participate, thank him, tell him that he may always change his mind, and say goodbye.]

Additional script if partner is present or participant requests their partner to be present

If you would like your partner (or other family member) to be present for this interview, this is okay. If they would like more information about the program I would be happy to share this with them too.

- Information about the program given to partner or family members is the same as information given above.
- If the partner or family member would like more information you can give them the field coordinator’s contact information. Tell them to contact this person who can provide them with more information about the project.
2) A. Psychological Outcome Profiles Questionnaire

(PSYCHLOPS – Before version – PRE Assessment) \(^{38}\)

Instructions in **bold** are to be read to the client. Instructions in *italics* are for the assessor only.

The following is a questionnaire about you and how you are feeling. First, I will ask you some questions about the problems you are currently experiencing. Please think about these problems no matter how big or small they may be.

Question 1.1

a. **Choose the problem that troubles you most.** Record a brief summary of the client’s description of the problem. If necessary, ask: “Can you describe the problem to me?” (Please write it in the box below.)

b. **How much has it affected you over the last week?** (Please tick one box below.)

0 1 2 3 4 5

Not at all affected

Severely affected

Question 1.2

a. **Choose another problem that troubles you.** Record a brief summary of the client’s description of the problem. If necessary, ask: “Can you describe the problem to me?” (Please write it in the box below.)

---

\(^{38}\) The questionnaire, reproduced with permission, is an adapted version of Pre-therapy Version 5 of the PSYCHLOPS. See www.psychlops.org. All rights reserved © 2010, Department of Primary Care and Public Health Sciences, King’s College London. The adapted version is different in that (a) it does not ask when the person became concerned about the problem, (b) it asks how people have felt this last week rather than how people have felt in themselves this last week (Q1.4), (c) it probes for a problem description (Q1.1a and Q1.2a), (d) it has additional questions on coping (Q1.1c-1f and Q1.2c-2f).
b. **How much has it affected you over the last week? (Please tick one box below.)**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all affected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Question 1.3**

a. **Choose one thing that is hard to do because of your problem (or problems). (Please write it in the box below.)**

b. **How hard has it been to do this thing over the last week? (Please tick one box below.)**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all hard</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Question 1.4**

**How have you felt this last week? (Please tick one box below.)**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Scoring PSYCHLOPS

- PSYCHLOPS has been designed as a mental health outcome measure. As such, the pre-intervention score is compared with later scores (during- and post-intervention). The difference is the ‘change score’.

- All of the responses in PSYCHLOPS are scored on a six point scale ranging from zero to five. The higher the value, the more severely the person is affected.

- Not every question in PSYCHLOPS is used for scoring. Only the questions relating to Problems (Questions 1.1b and 1.2b), Functioning (Question 3b) and Wellbeing (Question 4) are scored.

- Other questions provide useful information but do not contribute to the change score. PSYCHLOPS therefore consists of three domains (Problems, Functioning and Wellbeing) and four questions which are scored.

- The maximum PSYCHLOPS score is 20

- The maximum score for each question is 5.

- If both Q1.1 (Problem 1) and Q1.2 (Problem 2) have been completed, the total score is: Q1.1b + Q1.2b + Q1.3b + Q1.4.

- If Q1.1 (Problem 1) has been completed and Q1.2 (Problem 2) has been omitted, the total score is: (Q1.1b x 2) + Q1.3b + Q1.4. In other words, the score of Q1.1b (Problem 1) is doubled. This ensures that the maximum PSYCHLOPS score remains 20.

Total PSYCHLOPS Before score: ________
B. Psychological Outcome Profiles Questionnaire

(PSYCHLOPS – Post version POST Assessment) 

Instructions in bold are to be read to the client. Instructions in italics are for the assessor only.

The following is a questionnaire about you and how you are feeling

Question 1.1

a. This is the problem you said troubled you the most when we first asked.
   (Enumerator - please write it in the box below before the assessment.)

b. How much has it affected you over the last week? (Please tick one box below.)

   0                     1                     2                     3                     4                     5                     
   Not at all affected   □                     □                     □                     □                     □                     □                     
   SeVERELY affected    □

Question 1.2

a. This is the other problem you said troubled you when we first asked.
   (Enumerator - please write it in the box below before the assessment.)

b. How much has it affected you over the last week? (Please tick one box below.)

   0                     1                     2                     3                     4                     5                     
   Not at all affected   □                     □                     □                     □                     □                     □                     
   SeVERELY affected    □

39 The questionnaire, reproduced with permission, is an adapted version of Pre-therapy Version 5 of the PSYCHLOPS. See www.psychlops.org. All rights reserved © 2010, Department of Primary Care and Public Health Sciences, King’s College London. The adapted version is different in that (a) it does not ask when the person became concerned about the problem, (b) it asks how people have felt this last week rather than how people have felt in themselves this last week (Q1.4), (c) it probes for a problem description (Q1.1a and Q1.2a), (d) it has additional questions on coping (Q1.1c-1f and Q1.2c-2f).
Question 1.3
a. **This is the thing you said was hard to do when we first asked.**
   *(Enumerator - please write it in the box below before the assessment.)*


b. **How hard has it been to do this thing over the last week?** *(Please tick one box below.)*

   Not at all hard: [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
   Very hard: [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

Question 1.4

a. **How have you felt this last week?** *(Please tick one box below.)*

   Very good: [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
   Very bad: [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

Question 1.5

During the program, you may have found that other problems became important. If so, how much have these problems affected you over the last week?

*(Please tick one box below, or leave blank if no other problems have become important.)*

Not at all affected: [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
Severely affected: [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

Question 1.6

Compared to when you started the program, how do you feel now? *(Please tick one box below.)*

Much better: [ ]
Quite a lot better: [ ]
A little better: [ ]
About the same: [ ]
A little worse: [ ]
Much worse: [ ]
Scoring PSYCHLOPS

- All of the responses in PSYCHLOPS are scored on a six point scale ranging from zero to five. The higher the value, the more severely the person is affected.

- Not every question in PSYCHLOPS is used for scoring. Only the questions relating to Problems (Questions 1.1b and 1.2b), Functioning (Question 3b) and Wellbeing (Question 4) are scored.

- Other questions provide useful information but do not contribute to the change score. PSYCHLOPS therefore consists of three domains (Problems, Functioning and Wellbeing) and four questions which are scored.

- The maximum PSYCHLOPS score is 20

- The maximum score for each question is 5.

- If both Q1.1 (Problem 1) and Q1.2 (Problem 2) have been completed, the total score is: Q1.1b + Q1.2b + Q1.3b + Q1.4.

- If Q1.1 (Problem 1) has been completed and Q1.2 (Problem 2) has been omitted, the total score is: (Q1.1b x 2) + Q1.3b + Q1.4. In other words, the score of Q1.1b (Problem 1) is doubled. This ensures that the maximum PSYCHLOPS score remains 20.

- Note that the score on Q1.5 - Q1.6 are not used to calculate the total score.

Total PSYCHLOPS Post score: _______
3) LIFE EVENTS CHECKLIST

You can show the client the form (next page) as you read each of the items and tick the appropriate responses.

(There is not a Flashcard for this measure.)

You may tick more than one response to each event. That is, a client may have experienced, witnessed and learned of different physical assaults. You would then tick all three columns for this event.

Please avoid ticking “not sure” option. The “Does not apply” option is when the client has not been exposed to this event in their lifetime.

Say to the client: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event that I read to you, tell me whether (a) it happened to you personally, (b) you witnessed it happen to someone else, (c) you learned about it happening to someone close to you, (d) you’re not sure if it fits, or (e) it doesn’t apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as we go through the list of events.

<table>
<thead>
<tr>
<th>Event</th>
<th>Happened to me</th>
<th>Witnessed it</th>
<th>Learned about it</th>
<th>Not sure</th>
<th>Doesn’t apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Natural disaster (for example, flood, famine, drought, earthquake)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Fire or explosion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Transportation accident (for example, car, vehicle or other road or pedestrian accident)</td>
<td></td>
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<tr>
<td>4. Serious accident at work, home, or during recreational activity</td>
<td></td>
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<tr>
<td>5. Accidental exposure to toxic substance (for example, dangerous chemicals)</td>
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<tr>
<td>6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Event Description</td>
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<td>-------------------</td>
<td></td>
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</tr>
<tr>
<td>7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)</td>
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<td></td>
</tr>
<tr>
<td>8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Other unwanted or uncomfortable sexual experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Combat or exposure to a war-zone (in the military or as a civilian)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Life-threatening illness, injury or serious complications during childbirth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Sudden, violent death (for example, homicide, suicide)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Sudden, unexpected death of someone close to you</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Serious injury, harm, or death you caused to someone else</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Any other very stressful event or experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

73
4) **PTSD CHECKLIST - 5**

Say to the client:

*I will read to you a list of problems that people sometimes have in response to a very stressful experience, such as the ones we have just talked about. Please listen to each problem carefully and then tell me one of the numbers on this card (show PCL Flashcard) to indicate how much you have been bothered by that problem in the past week.*

<table>
<thead>
<tr>
<th>In the past week, how much were you bothered by:</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Repeated, disturbing, and unwanted memories of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Repeated, disturbing dreams of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Suddenly feeling or acting as if the stressful experience were actually happening again <em>(as if you were actually back there reliving it)</em>?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Feeling very upset when something reminded you of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Having strong physical reactions when something reminded you of the stressful experience <em>(for example, heart pounding, trouble breathing, sweating)</em>?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Avoiding memories, thoughts, or feelings related to the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Avoiding external reminders of the stressful experience <em>(for example, people, places, conversations, activities, objects, or situations)</em>?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Trouble remembering important parts of the stressful experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
In the past week, how much were you bothered by:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Blaming yourself or someone else for the stressful experience or what happened after it?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Loss of interest in activities that you used to enjoy?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Feeling distant or cut off from other people?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. Irritable behavior, angry outbursts, or acting aggressively?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. Taking too many risks or doing things that could cause you harm?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. Being &quot;super alert&quot; or watchful or on guard?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. Feeling jumpy or easily startled?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. Having difficulty concentrating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. Trouble falling or staying asleep?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
**CONFLICT TACTICS SCALE, SHORTFORM (V.2)**

Tell a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or because they are in a bad mood, are tired or for some other reason. Couples also have many different ways of trying to settle their differences. This is a measure when you have differences. Please mark how many times you did each of these things in the past month, and how many times your partner did them in the past month. If you or your partner did not do one of these things in the past month, but it happened before that, indicate a number “7” if it never happened, tell me to mark an “8” as your answer. Here are the response options (show CTS2S Flashcard). Tell me which number best describes your experiences:

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I explained my side or suggested a compromise for a disagreement with my partner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>My partner explained his or her side or suggested a compromise for a disagreement</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>I insulted or swore or shouted or yelled at my partner</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>My partner insulted or swore or shouted or yelled at me</strong></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>My partner had a sprain, bruise, or small cut or felt pain the next day because of a fight with me</strong></td>
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<tr>
<td><strong>I showed respect for, or showed that I cared about my partner’s feelings about an issue we disagreed on</strong></td>
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<tr>
<td><strong>My partner showed respect for, or showed that he or she cared about my feelings about an issue we disagreed on</strong></td>
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<tr>
<td><strong>I pushed, shoved, or slapped my partner</strong></td>
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</tr>
<tr>
<td><strong>My partner pushed, shoved, or slapped me</strong></td>
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</tr>
<tr>
<td><strong>I punched or kicked or beat-up my partner</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>My partner punched or kicked or beat-me-up</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I destroyed something belonging to my partner or threatened to hit my partner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>My partner destroyed something belonging to me or threatened to hit me</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>I went to see a doctor (M.D.) or needed to see a doctor because of a fight with my partner</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>My partner went to see a doctor (M.D.) or needed to see a doctor because of a fight with me</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>I used force (like hitting, holding down, or using a weapon) to make my partner have sex</strong></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>My partner used force (like hitting, holding down, or using a weapon) to make me have sex</strong></td>
<td></td>
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<tr>
<td><strong>I insisted on sex when my partner did not want to or insisted on sex without a condom (but did not use physical force)</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>My partner insisted on sex when I did not want to or insisted on sex without a condom</strong></td>
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</tbody>
</table>
WHO Alcohol, Smoking and Substance Involvement Screening Test (WHO-ASSIST version 3.1)


Here are the questions ask about your experience of using alcohol, tobacco products and other drugs across your lifetime and in the past two months. These substances can be smoked, swallowed, snorted, inhaled or injected (show response card).

Substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know.

We are interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Before asking questions, give ASSIST response cards to client.
Your life, which of the following substances have you ever used (non-medical use only)?

<table>
<thead>
<tr>
<th>Substance</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine (coke, crack, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamine-type stimulants (speed, meth, ecstasy, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants (nitrous, glue, petrol, paint thinner, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nons or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If all answers are negative, PROBE: “Not even when you were in school?”

If NO to ALL items, stop interview

If YES to any of these items, ask QUESTION 2 for each substance ever used

In the past two months, how often have you used the substances you mentioned (first drug, second drug, etc.)?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Cocaine (coke, crack, etc.)</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Amphetamine-type stimulants (speed, meth, ecstasy, etc.)</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Inhalants (nitrous, glue, petrol, paint thinner, etc.)</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Nons or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Specify:</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

If all answers are NEVER (0), skip to QUESTION 6

If any substances were used in the previous two months, continue with QUESTIONS 3, 4, & 5 for each substance used.
### Question 3: During the past two months, how often have you had a strong desire or urge to use (first drug, second drug, etc.)?

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Marijuana, pot, grass, hash, etc.</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Cocaine (coke, crack, etc.)</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Amphetamine-type stimulants (speed, meth, ecstasy, etc.)</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Inhalants (nitrous, glue, petrol, paint thinner, etc.)</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Specify:</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

### During the past two months, how often has your use of (first drug, second drug, etc.) led to health, social, legal or financial problems?

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Marijuana, pot, grass, hash, etc.</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Cocaine (coke, crack, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Amphetamine-type stimulants (speed, meth, ecstasy, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Inhalants (nitrous, glue, petrol, paint thinner, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Specify:</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
During the past two months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug etc.)?

<table>
<thead>
<tr>
<th>Substance Type</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Marijuana (marijuana, pot, grass, hash, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Cocaine (coke, crack, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Amphetamine-type stimulants (speed, meth, ecstasy, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Inhalants (nitrous, glue, petrol, paint thinner, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Specify:</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

For ALL substances ever used (i.e., those listed in QUESTION 1)

Has a friend or relative or anyone else ever expressed concern about your use of (first drug, etc.)?

<table>
<thead>
<tr>
<th>Substance Type</th>
<th>No</th>
<th>Never</th>
<th>Yes, in the past two months</th>
<th>Yes, but not in the past two months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Marijuana (marijuana, pot, grass, hash, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Cocaine (coke, crack, etc.)</td>
<td>0</td>
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<td>3</td>
<td></td>
</tr>
<tr>
<td>Amphetamine-type stimulants (speed, meth, ecstasy, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Inhalants (nitrous, glue, petrol, paint thinner, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
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<tr>
<td>Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
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<tr>
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<td>3</td>
<td></td>
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<tr>
<td>Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Specify:</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

For ALL substances ever used (i.e., those listed in QUESTION 1)
Have you ever tried to cut down on using (first drug, second drug, etc.) but failed?

<table>
<thead>
<tr>
<th>Substance</th>
<th>No</th>
<th>Never</th>
<th>Yes, in the past two months</th>
<th>Yes, but not in the past two months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco products (cigarettes, chewing tobacco, cigars, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Alcoholic beverages (beer, wine, spirits, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Cocaine (coke, crack, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Amphetamine-type stimulants (speed, meth, ecstasy, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Inhalants (nitrous, glue, petrol, paint thinner, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Specify</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

*Ask QUESTIONS 6 & 7 for ALL substances ever used (i.e., those listed in QUESTION 1)*

Have you ever used any drug by injection (non-medical use only)?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Never</th>
<th>Yes, in the past two months</th>
<th>Yes, but not in the past two months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Tick the appropriate response box*

**IMPORTANT NOTE** IF CLIENT RESPONDS TO QUESTION 8 - “YES, IN THE PAST TWO MONTHS”

Clients who have injected drugs in the last 2 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of action.

*Ask: On average, over the past two months or less, has your pattern of injecting been 4 or more days per month? Contact Supervisor and support the client to attend a health clinic*
To calculate a specific substance involvement score:

For each substance (labelled ‘a’ to ‘j’) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For cannabis, the score would be calculated as: $Q2c + Q3c + Q4c + Q5c + Q6c + Q7c$.

Tobacco is not coded, and is calculated as: $Q2a + Q3a + Q4a + Q6a + Q7a$.

<table>
<thead>
<tr>
<th>Record specific (actual) substance score</th>
<th>No intervention (Low Risk for health and other problems from current patterns of use)</th>
<th>Receive brief intervention (Moderate Risk for health and other problems from current patterns of use)</th>
<th>More intensive treatment (High Risk of experiencing severe problems (health, legal, financial, relationship) as a result of your current pattern of use and are likely to be dependent)**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-3</td>
<td>4-26</td>
<td>27+</td>
</tr>
<tr>
<td>0-10</td>
<td>11-26</td>
<td>27+</td>
<td></td>
</tr>
<tr>
<td>0-3</td>
<td>4-26</td>
<td>27+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-26</td>
<td>27+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-26</td>
<td>27+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-26</td>
<td>27+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-26</td>
<td>27+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-26</td>
<td>27+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-26</td>
<td>27+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-26</td>
<td>27+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4-26</td>
<td>27+</td>
<td></td>
</tr>
</tbody>
</table>

If the level of risk is high risk, consultation with the Clinical Supervisor is mandatory, as this client may require medical treatment and might not be appropriate for inclusion to the Group PM+ program.
EFFECTIVENESS QUESTIONS

1. CLIENT: I would now like to know about your recent experiences with obtaining health care. I want to know if you needed health care recently, and what type of health care and what type of health care provider you received care from.

<table>
<thead>
<tr>
<th>3 months, have you stayed overnight in hospital?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staying overnight in hospital, in the 3 past months how often have you been to the hospital as an outpatient?</td>
<td>Number: __________</td>
<td></td>
</tr>
<tr>
<td>Details (only if given by the client):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   | 3 months, how often have you bought medication/s from the pharmacy? | Number: __________ |
   | Details (only if given by the client). For example, what medication: |

   | 3 months, how often have you seen a traditional healer? | Number: __________ |
   | Details (only if given by the client): |

2. Ask you a final question about any of the stresses and challenges that you have told me about today.

   | In the past 30 days, how many days were you totally unable to carry out your usual activities or work because of those problems? | Number: __________ |
   | Details (only if given by the client): |
8) SCORING SUMMARY FORM & CHECKLIST

You may use this table as a checklist to ensure that you have completed all the measures.

After ending the assessment with the client you are to complete the first 2 columns of this table and give the pack to the Field Coordinator.

(You do not need to complete the table immediately, while you are with the client).

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>TICK OR SCORE</th>
<th>DATA ENTERED (SIGN/DATE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent Form #2 completed and signed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSYCHLOPS (total score)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEC (tick if it has been completed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCL-5 (total score)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTS2S (tick if it has been completed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHO-ASSIST (tick if it has been completed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Effectiveness (tick if it has been completed)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9) Informed Consent form for participation in trial

This Informed Consent Form is for men in the Dagoretti Sub County of Nairobi, and who we are inviting to participate in research on the feasibility of administering Group Problem Management Plus (GPM+) for use in Nairobi, Kenya. The title of our research project is “Group Problem Management Plus (GPM+) in the treatment of common mental problems amongst men in urban Kenya”.


This Informed Consent Form has two parts:

- Information Sheet (to share information about the research with you)
- Certificate of Consent (for signatures if you agree to take part)

You will be given a copy of the full Informed Consent Form

PART I: Information Sheet

Introduction
We are a group of researchers from World Vision Kenya studying a new support program for distressed individuals. This program is called “Group Problem Management Plus (GPM+)”.
You were interviewed by a research assistant of our research team and your responses indicated that you are probably distressed. Therefore, we invite you to take part in the next part of our study. In this part, we will test the feasibility GPM+ program in reducing these feelings of distress.

I am going to give you information and invite you to be part of this part of the research. You do not have to decide today whether or not you will participate. Before you decide, you can talk to anyone you feel comfortable with about the research.

I may use some words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask me, the interviewer, service provider or other staff members involved in the project.

Purpose of the research
Emotional problems, such as feelings of sadness and anxiety are very common. These may affect the ability of people to carry out day to day tasks. Many people with such problems do not get effective help and they may turn to unhelpful behaviours, such as drinking alcohol in order to cope. In this research, we aim to find out whether a support program called “Group Problem Management Plus (GPM+)” is useful and effective in reducing such problems.
GPM+ consists of 6 group sessions with about 7 other men. Each session will run around 2 hours. During these sessions, a two group facilitators (one man and one woman) will listen to you and the other men in the group. The whole group will discuss issues related to your problems and emotions. You will also be given advice on ways you can address problems that cause distress. Research in other countries suggests that this
program may reduce stress-related problems. We now want to find out whether it is useful and acceptable for men in Kenya.

**Type of Research Intervention**
This type of research study means all participants to can be included GPM+ will be offered treatment, though some may be offered treatment a few weeks before or after others. All the men involved in the groups will be similar to you, in that they too will have shown signs that they may be distressed or not functioning very well.

- **Clarifying questions:** Do you know why we are asking you to take part in this study? Do you know what the study is about?

**Voluntary Participation**
Your participation in this research is entirely voluntary. It is your choice whether to participate or not. Whether you choose to participate or not, all the services you receive in the community will continue and nothing will change. You may change your mind at any time and stop participating, even if you agreed earlier. If you stop, your responses will be destroyed.

- **Clarifying questions:** If you decide not to take part in this research study, do you know what will happen? Do you know that you do not have to take part in this research study, if you do not wish to? Do you have any questions?

**A. Description of the Process**
- You will be interviewed again. The interviewer will ask you some additional questions on adverse events and reactions related to these events, and other difficulties concerning your health. This will take approximately 50 minutes. Finally, another research assistant will tell you to which group you are assigned – when and where they will be meeting. The group are assigned will be run by one male and one female facilitator and one of these two individuals will contact you to confirm your attendance at the first and subsequent group sessions.

- GPM+ will consist of you attending 6 weekly group sessions, each lasting about 2 hours. This will provide you a chance to share your challenges with others, as well as trained facilitators who will help teach you skills and offer advice on ways you can address problems that cause distress.

- At the second assessment, seven weeks after the first, all participants will again be asked questions, which are similar to the first assessment. This assessment will take approximately 60 minutes

- At the final assessment, four months after the first, all participants will again be asked questions similar to the first assessment. This assessment takes approximately 60 minutes. This helps us measure how well you have benefited from the GPM+ program over time.

- **Clarifying questions:** Can you tell me if you remember the number of times that we are asking you to complete questions for our research project? And how many sessions does the PM+ program have? Do you have any other questions? Do you want me to go through the procedures again?

**Risks**
We do not expect that GPM+ will have any negative effects. However, it is possible that talking about your feelings and emotions will make you more stressed, fearful or tense for a little while. Talking about your feelings or emotional topics may be difficult for some people, and cause emotional upset in some. You may always skip any questions which make you feel uncomfortable. If you become upset, you will be able to speak to the person whose contact details we will give to you. Our staff is trained in helping you to cope with such feelings. If you or our staff becomes seriously concerned about your mental wellbeing or symptoms of distress, we will assist you to receive specialized care at the Mbagathi District Hospital.
Benefits
We expect that the programme might be helpful to people experiencing distress. If the study shows that GPM+ is helpful for men, then additional service providers in your area will be trained to deliver GPM+ so that other people who experience stress-related problems may benefit from it too.

Reimbursements
We will not offer compensation for your time to take GPM+ sessions; although we will offer refreshments you (drinks and a small snack at each meeting.)

- Clarifying questions: Can you tell me if you have understood correctly the benefits that you will have if you take part in the study? Do you have any other questions?

Confidentiality
We and any researchers working on this study ensure privacy and confidentiality for all study-related data, documents, and findings. It is possible that if others in the community are aware that you are participating, they may ask you questions. But we will not be sharing the identity of who is participating in the research.

All information collected about you will be kept strictly confidential. The results of all assessments and tests will never be linked to yourself. Any information about you will have a number on it instead of your name. Data will be stored in a document on a computer at the Office of World Vision Kenya, which can only be opened by the researcher. Only group results will be reported that cannot be linked to yourself to protect confidentiality. No one else except the lead research team at World Vision will have access to the information documented during your interviews. The interviews will be destroyed after five years.

- Clarifying questions: Did you understand the procedures that we will be using to make sure that any information that we as researchers collect about you will remain confidential? Do you have any questions about them?

Sharing the Results
The knowledge that we gain during this research will be shared with you through community meetings before it is made widely available to the public. Nothing that identifies you will be shared at these meetings or at any point during this study, and we will not tell anybody that you have contributed to this research. Meetings in the community to share research findings will be announced. After these meetings, we will publish what we have learnt so that other interested people may learn from this research.

Right to Refuse or Withdraw
You do not have to take part in this research if you do not wish to do so. Refusing to participate will not affect your treatment from the community health worker or medical staff the primary health centre in any way. You will still have all the benefits that you would otherwise have at your primary healthcare centre and any other healthcare facility you may wish to visit. You may also stop participating in the research at any time you choose without losing any of your rights as a patient.

Who to Contact
If you have questions now you can ask me. We will also give you the name and phone number of a study team member to contact if you have questions later. This person is:

- Project manager Title: JACINTA SILA
- Physical address: Equity Building, Kawangware, Nairobi
This protocol has been reviewed and approved by the Kenyatta National Hospital Ethics and Research Internal Review Board whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the ethical approval, contact KNH-UoN ERC, P.O BOX 20723 –00202

- **Clarifying questions:** Do you know that you do not have to take part in this study if you do not wish to? You can say No if you wish to? Do you know that you can ask me questions later, if you wish to? Do you know that I have given the contact details of the person who can give you more information about the study?

- **Question:** You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?
PART II: Certificate of Consent

Literate participant:

I have read and understood the above information, or it has been read to me. I have had the opportunity to ask questions, and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this research.

Print Name of Participant__________________________________________

Signature of Participant ___________________________________________

Date ___________________________  
Day/month/year

Illiterate participant:

I have witnessed the accurate reading of the consent form to the participant, and the participant has had the opportunity to ask questions and these have been answered to the participant’s satisfaction. I confirm that the individual has given consent freely.

Thumb print of participant

Print Name of Witness____________________________________________

Signature of Witness _____________________________________________

Date ___________________________  
Day/month/year
Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the purpose and process of the study.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this informed consent form has been provided to the participant.

Print Name of Researcher/person taking the consent_______________________________

Signature of Researcher/person taking the consent________________________________

Date ___________________________  

Day/month/year
Annex F – English version of the during treatment PSYCHLOPS Assessment

GROUP PM+ DURING PROGRAM ASSESSMENT OF INDIVIDUAL CLIENTS

NOTE: This assessment should be completed at the beginning of Group Sessions 1, 2, 3, 4, 5 and 6. Only read to client the text in bold.

| Name of CHW: ______________________________ | Date: ____________ |
| Client code: ____________________________ | Session number: ____________ |

1. Psychological Outcome Profiles Questionnaire (PSYCHLOPS – During version)\(^{41}\)

The following is a questionnaire about you and how you are feeling

**Question 1.1**

a. This is the problem you said troubled you the most when we first asked.

(CHW – this information should be provided to you from the Community Mobiliser. Please write it in the box below before the session.)

b. How much has it affected you over the last week?

(Please tick one box below.)

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all affected</td>
<td></td>
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<tr>
<td>Severely affected</td>
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</table>

**Question 1.2**

a. This is the other problem you said troubled you when we first asked.

\(^{41}\) The questionnaire, reproduced with permission, is an adapted version of During-therapy Version 5 of the PSYCHLOPS. See www.psychlops.org. All rights reserved © 2010, Department of Primary Care and Public Health Sciences, King’s College London. The adapted version is different in that (a) it asks how people have felt this last week rather than how people have felt in themselves this last week (Q1.4) (b) it uses the word program rather than therapy (Q1.5).
b. How much has it affected you over the last week? (CHW - please tick one box below.)

Not at all affected □ □ □ □ □ □ □ Severely affected □ □ □ □ □ □ □

Question 1.3

a. This is the thing you said was hard to do when we first asked.

(CHW – this information should be provided to you from the Community Mobiliser. Please write it in the box below before the session.)

b. How hard has it been to do this thing over the last week? (CHW - please tick one box below.)

Not at all hard □ □ □ □ □ □ □ Very hard □ □ □ □ □ □ □

Question 1.4

a. How have you felt this last week? (CHW - please tick one box below.)

Very good □ □ □ □ □ □ □ Very bad □ □ □ □ □ □ □
b. Suicide risk assessment

NOTE: If client said 4 or 5 on the question above (1.4a), or they have a history of suicidal thoughts or plans while in PM+, complete suicide risk assessment. For all other clients, go to Question 1.5

Now I need to ask you some questions about your safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. In the last week have you had serious thoughts or a plan to end your life?</td>
<td>If yes, ask the participant to describe their thoughts or plans. Write details here:</td>
<td></td>
</tr>
</tbody>
</table>

If the participant responded 'no' to question 1 you can end the assessment.

If the participant responded 'yes' to question 1 please continue with question 2.

<table>
<thead>
<tr>
<th>Question</th>
<th>Please write details here:</th>
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<tbody>
<tr>
<td>5. What actions have you taken to end your life?</td>
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</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>UNSURE</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>6. Do you plan to end your life in the next two weeks</td>
<td>-----</td>
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</tr>
</tbody>
</table>

If the participant says 'yes' to question 3 they are at imminent suicide risk and you must contact your supervisor immediately

If you are unsure whether the participant is at imminent risk of harm tell the participant you would like to contact your supervisor to ask them follow-up questions.
Question 1.5

a. Now that you are in this program, you may have found that other problems have become important.

(CHW- If client says a problem, please write the one that troubles them the most in the box below, or write 'No problem', if the client says no other problems have become important.)

b. How much have these other problems affected you over the last week?

(CHW- Please tick one box below, or leave blank if no other problems have become important.)

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<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
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<tbody>
<tr>
<td>Not at all affected</td>
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<tr>
<td>Severely affected</td>
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</table>

Comments (To be completed by the CHV)

Please provide any comments you may want to record about the client and how they presented/acted in this session.

Total PSYCHLOPS During score\(^{42}\): _____

\(^{42}\) PSYCHLOPS has been designed as a mental health outcome measure. As such, the pre-intervention score is compared with later scores (during- and post-intervention). The difference is the 'change score'.

- All of the responses in PSYCHLOPS are scored on a six point scale ranging from zero to five. The higher the value, the more severely the person is affected. Not every question in PSYCHLOPS is used for scoring. Only the questions relating to Problems (Questions 1.1b and 1.2b), Functioning (Question 3b) and Wellbeing (Question 4) are scored. Other questions provide useful information but do not contribute to the change score. PSYCHLOPS therefore consists of three domains (Problems, Functioning and Wellbeing) and four questions which are scored.
- The maximum PSYCHLOPS score is 20; the maximum score for each question is 5. If both Q1.1 (Problem 1) and Q1.2 (Problem 2) have been completed, the total score is: Q1.1b + Q1.2b + Q1.3b + Q1.4. If Q1.1 (Problem 1) has been completed and Q1.2 (Problem 2) has been omitted, the total score is: (Q1.1b x 2) + Q1.3b
Annex G – Qualitative Process Evaluation Interview Schedules for Key Informant Interviews and Focus Group Discussions

World Vision Kenya: SVRI-WB Group PM+ project with men
Pilot evaluation of GPM+ - Schedules for Key Informant Interviews (KII)

<table>
<thead>
<tr>
<th>Informed consent:</th>
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</thead>
<tbody>
<tr>
<td>Hello, my name is _______________ and I work for World Vision.</td>
</tr>
<tr>
<td>We have been working in Mutuini and Waithaka to try and address common mental health problems affecting men and women, with a particular focus on sexual and gender based violence.</td>
</tr>
<tr>
<td>We have worked a lot with women in the past, but our new project has begun working with men. We know you have had involvement with this work recently and we’d like to speak with you about your experience. This will help us learn about things that worked, or any changes we may need to make to the program as it continues in the coming months.</td>
</tr>
<tr>
<td>We are asking you to participate in this key informant interview and cannot to give you any financial reimbursement for your time. Your participation, therefore, is voluntary, so you are free to take part or not. We think this interview will go for about 1 hour, although this will depend on how much information you wish to share with us.</td>
</tr>
<tr>
<td>If you agree to participate in this interview, we can assure you that your information will remain anonymous so no-one will know what you have told us. We will take notes on the things you say, but we will not record your name – only your gender, age and role in the program. When information is reported, nobody will know it was you who made certain statement.</td>
</tr>
<tr>
<td>Do you have any questions?</td>
</tr>
<tr>
<td><strong>Do you agree to participate in this key informant interview? YES / NO</strong></td>
</tr>
</tbody>
</table>

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+ Q1.4. In other words, the score of Q1.1b (Problem 1) is doubled. This ensures that the maximum PSYCHLOPS score remains 20.
- Note that the suicide risk assessment questions and the score on Q1.5b is not used to calculate the total score.
**Demographic Data:**

<table>
<thead>
<tr>
<th>Location: (Please Circle)</th>
<th>MUTUINI</th>
<th>Location: (Please Circle)</th>
<th>WAITHAKA</th>
</tr>
</thead>
<tbody>
<tr>
<td>KII Gender: (Please Circle)</td>
<td>MALE</td>
<td>KII Gender: (Please Circle)</td>
<td>FEMALE</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Role: (Please circle)</td>
<td>• CHV</td>
<td>Project Role: (Please circle)</td>
<td>• ENUMERATOR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• COMPLIANT MALE CLIENT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• NON-COMPLIANT MALE CLIENT</td>
</tr>
</tbody>
</table>

**INTERVIEWER NAMES:**

<table>
<thead>
<tr>
<th>Interviewer Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Note-taker Name:</td>
<td></td>
</tr>
</tbody>
</table>

**Interview Schedule for CHV:**

- Can you describe your experience of the GPM+ intervention with men?
- We understand some groups managed to work with groups for all six sessions, and yet other groups saw very few continue to attend after session 1. What do you think are the reasons some clients completed the GPM+ program and others did not?
- What did you find difficult about working with men?
- What do you think worked well in this men’s program?
- What GPM+ strategies seemed particularly beneficial for this male group?
- How did the logistics of the GPM+ process work for you and your CHV partner? Are there any changes you would suggest to improve this?
- Describe your experience working with another CHV as a co-facilitator?
- What other information about this pilot men’s GPM+ program do you think is important for us to know?

**Interview Schedule for Enumerator:**

- Describe to us your experience of screening male clients for GPM+?
- Were there any challenges related specifically to screen MEN?
- Of those you completed a pre-assessment with:
  - What questions or tools did you find difficult to ask?
    - *(If they do not mention the CTS2S or the WHO ASSIST tools, ask specifically: “What was your experience using the CTS2S tool?” and, what was your experience using the WHO ASSIST tool?”)*
  - What questions or tools seemed most difficult for men to answer?
  - Were there challenges in administering the pre-assessment?
  - When explaining the GPM+ program to included clients, what aspects of the information seemed to interest them most?
- How did the logistics of the screening, pre and post assessment work for you and your Enumerator partner? Are there any changes you would suggest to improve this?
- What other information about this pilot program with men do you think is important for us to know?
Interview Schedule for COMPLIANT Male Client (who attended all 6 GPM+ Sessions):

- Can you describe your experience of being part of the GPM+ program?
- When you first participated in the assessments for GPM+, were there any questions you found especially difficult to answer?
- When you participated in the assessments for GPM+, were you 100% honest in your responses, or did you make your responses seem better or worse than they actually were? (if yes, why)
- Between the assessment and the GPM+ sessions, many men did not attend their first GPM+ session. What motivated you to attend that first GPM+ session?
- What was it about the first GPM+ session that made you want to commit to coming again the following week for the 2nd GPM+ session?
- Throughout the GPM+ program, which strategies have had the most impact on your life? (Probe if necessary: in what ways has this strategy had an impact on your life?)
- What is different for you today than when you first began GPM+?
- Describe for us your experience of building a relationship with other men in the GPM+ sessions and the facilitators?
- GPM+ is about receiving help for psychological and emotional issues – it is not about receiving material aid or support. We think this might be why some men are not committing to the program. How might World Vision convince these men that even though there is no material aid to GPM+, it is still worth their time and effort?
- What other information about this men’s program do you think is important for us to know?

Interview Schedule for NON-COMPLIANT Male Client (who did NOT attend one or more GPM+ Sessions):

- When you first participated in the assessments for GPM+, were there any questions you found especially difficult to answer?
- When you participated in the assessments for GPM+, were you 100% honest in your responses, or did you make your responses seem better or worse than they actually were? (if yes, why)
- What was it about the GPM+ program that interested you and made you want to attend the program?
- Between the assessment and the GPM+ sessions, many men did not attend their first GPM+ session. Can you tell us why you think this might have happened?
- Did you attend any GPM+ Sessions? If yes, which sessions?
- We understand that you did not attend all the GPM+ sessions. Can you describe for us some of the reasons you felt it was not being helpful to you?
- What would be needed for World Vision to encourage you to attend GPM+ sessions?
- Was there anything about the World Vision staff involved in GPM+ that gave you reason for not wishing to continue with GPM+?
- GPM+ is about receiving help for psychological and emotional issues – it is not about receiving material aid or support. We think this might be why some men are not committing to the program. How might World Vision convince more men that even though there is no material aid to GPM+, it is still worth their time and effort?
- What other information about this men’s program do you think is important for us to know?
Annex H – Qualitative Data Organised to Themes, Sub-themes and Categories

**Thematic coding analyses organised to themes, subthemes and underlying codes for each excerpt. Also, specific recommendations.**

<table>
<thead>
<tr>
<th>Themes and codes</th>
<th>Descriptions and examples of coded items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1: ENUMERATORS / CHVs COMPETENCY</strong></td>
<td>Identified gaps in competency of enumerators and CHVs</td>
</tr>
</tbody>
</table>
| CHV self-disclosure | • The facilitator shared his personal struggles and stories. He opened up to us, which really made some of us open up and share.  
• He appreciates [Derrick] for sharing his personal story which made him open up and share.  
• Male clients used to talk about their wives whereby we would help them understand why their wives would avoid arguments and violence. |
| Sampling at household level | • We move a lot, we can go over 10 plots without getting men. Therefore it takes a long time to get men rather than at home because of the wife. They will not open up about problems in front of their wives.  
• Finding these men was very difficult since a huge number was at work and their availability was scarce.  
• Some men were very aggressive and therefore unapproachable and wouldn’t let us interview them.  
• In some homes or streets there were stray dogs which scared us. |
| Referrals process for drug and alcohol dependence needs strengthening | • They should try and come up with a strategy which supports those under substance abuse and still need PM+  
• A referral pathway for drug and alcohol is needed  
• If you tell some of them to attend to a rehab they found avenues of denying by telling you how expensive it was. |
| Refresher training for increased understanding about research, staff roles and refining skills | • As we interacted with them they could share a lot. We needed to contain them.  
• The men who are addicted to drugs  
• Screening men who are addicted was easy but pre-assessment was difficult  
• Training of enumerators I suggest should be extended so as for them to understand the project better and  
• He [the enumerator] didn’t understand how domestic violence was related with GHQ and WHODAS.  
• They should train us more so that the enumerators can understand the core and aim of the project fully.  
• Training of enumerators should be extended  
• After treatment, some clients keep calling me because they have my number. They are looking for continued support and follow up. |
| Pre-Assessments taking too long – are the enumerators competent and following the survey instructions correctly? | • Most do not understand the language. Language barriers is the most critical issue  
• When we go back there they find it very difficult you’re asking so many questions. When you open “the booklet”  
• By the time you reach the PCL they switch off  
• The questions are repetitive  
• Others really had many stories when been interviewed those that were out of topic and you had to contain...
<table>
<thead>
<tr>
<th>Themes and codes</th>
<th>Descriptions and examples of coded items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 2: CLIENT RECRUITMENT</strong></td>
<td><strong>Factors that contributed to or hindered the recruitment of clients to GPM+</strong></td>
</tr>
<tr>
<td><strong>Subtheme 2a: Screening and pre-assessment questions</strong></td>
<td><strong>Identified challenges during screening and pre-assessments</strong></td>
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</table>

**Screening, or pre-assessment being bulky and long**
- It was a challenge, since getting men in the community who accept to be asked questions. It is a very difficult task because most of them tend to be busy attending to their day to day duties.
- The pack is very bulky and some questions are very personal and intimate
- The papers are heavy in weight and hard to carry
- During pre-assessment… others backed out during pre-assessment because the questions were too many for them.
- Others did not finish their pre-assessment packs since they would receive incoming calls and they had to rush to job
- The pre-assessment is very long and some of the clients are expecting some goodies.
- Most work as casuals and getting them to answer the pre-assessment pack was quite a challenge since you could agree to interview them at a certain day, only to call them and they tell you they are at work and can’t be available until evening. And when you call them at the evening as agreed, they will skip to the day after.
- Some people, they are included, but after asking so many questions [in the pre-assessment] it is not for them.
- The men don’t understand how the questions are related. The clients need to understand why they are being asked all the questions
- I have to explain and explain and they say it’s not relevant. Some are asking about why they need to answer.

**Men found some of the screening and pre-assessment questions difficult and personal to respond to (e.g., CTS2S, WHO ASSIST, SUICIDE, WHODAS, GHQ) and experienced difficulty talking to strangers about intimate issues**
- The question on the GHQ “Do you trust yourself”, is interpreted by the men as us asking about their HIV status [“Kujiamini” / trusting].
- It was basically hard to ask some of the questions contained in the CTS2S, especially those that contained intimacy questions because most men shy off to such questions. They felt uneasy and uncomfortable answering to the point that they would prefer to skip most them; but some were sincere, especially when it came to questions on home-based violence where most admitted to having such issues back at home.
- That CTS2S was most difficult to ask since most questions focused on the marital conflicts and some of the clients were not ready to open up fully to this question. When we asked of what brought about violence at home, many were not ready to answer and some said it was financial problems which led to stress and anger.
- The CTS2S was probably very difficult to ask, especially to the old men. I found it hard asking the man if there was any incidence where the wife had beaten him to make love, this is a rare case. In most of the Kenyan communities and most of the men found the questions to be too personal and some declined answering.
- Others were very insulting and abusive when answering most questions especially in WHO ASSIST and CTS2S, saying their personal life involved only them and their partners and not strangers whom they don’t even know.
- The questions were somehow a bit personal having someone you don’t know asking you whether you have showered in the last 30 days or whether you intend to do suicide or if am able to make my own decision somehow you first wonder where this person is directing you.
- He was honest though some of the questions, especially those that contained domestic violence, he maintained disclosure because he felt bad when he recalled the arguments and fights he had had before with his wife.
- Most of them, despite the challenges they are facing, say they will not take away their lives.
- During the post-assessment the questions were not difficult because they had been asked the same questions during the pre-assessment. The client is familiar with the questions so it takes less time.
- Will I share my experience, my inner things, with a stranger?
- It was difficult telling a stranger personal things.
- Sometimes it is easier because you are talking to a stranger.
- I was shocked to be asked about these issues.
- Suicide questions was really hard. I've never spoken to anyone about that before.
- The thing that were being asked were things I thought of doing and wanted help. I had thought of taking my life and killing my wife.
- Sexual intimacy questions, such as those of harassing a wife to have sex without condom and vice versa also, some of the WHOASSIST questions especially (i.e., have you ever lacked to attend to your chores, that is working or job because of alcohol).
- Men are reluctant to say they have problems because they are supposed to be strong.
- They don’t admit they have stress or problems.

<table>
<thead>
<tr>
<th>Clients withholding information and not answering truthfully</th>
<th>Report challenges accessing men and benefits that enhanced clients attendance</th>
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<tbody>
<tr>
<td>I didn’t give all the information during the first contact with the enumerators.</td>
<td>I shared a little after I was assured of confidentiality.</td>
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<tr>
<td>This first day I didn’t give the full information.</td>
<td>As long as they keep the things confidentially, so I decided to leave my story with them.</td>
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<tr>
<td>At first they would deny, but later they would admit that at times alcohol would make them not work.</td>
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<tr>
<td>So when it came to the questions ‘if they have ever assaulted their spouse to make love without condom they concealed this information’.</td>
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<tr>
<td>Yes; some responses I made were not 100% genuine because I was still suspicious of the enumerators so some I answered correctly and some I didn’t because this are situations that had or have been happening in my life and I don’t like people knowing what am going through especially if am not familiar with those people so I decided to cover my true self….</td>
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**Subtheme 2b: Engaging clients**

- I shared a little after I was assured of confidentiality.
- As long as they keep the things confidentially; so I decided to leave my story with them.

**Suspicion of enumerators**

- At first I thought I would be taken advantage of.
- Some said you’re using us to get what you want. You, you’re working, others are working. You just want information from us.
- Some of the clients feel like they are being asked too many questions and also feel like they are being investigated to be reported to FIDA. “Why do you want to know that about me? Are you investigating me?”
- Some questions I made were not 100% genuine because I was still suspicious of the enumerators so some I answered correctly and some I did not because these are situations that had or have been happening in my life and I don’t like people knowing what I am going through, especially if I am not familiar with those people. So I decided to cover my true self, but afterwards, during the pre-assessment I was confident with the program, having read the consent form and was able to open up directly to them.
<p>| Language | Language barrier was a problem. Communication became a challenge at some time because some of the men we interviewed couldn’t understand the essence of the project and time was a factor we had to consider. Most men do not understand the language. Language barrier is the most critical issue. Meaning gets lost and the screening gets too long. Communication: Kiswahili for many is challenge so people prefer English there should be copies of Swahili and English so one can choose which language he would prefer to be interviewed. |
| Contacting clients (e.g., locations and without phones) | My challenge, being the first time I was doing such an exercise. Getting these clients [for pre-assessment] was hectic, especially those who lacked mobile phones. You would wait for them at their homes, only to find out they had shifted to other areas. Others came up with excuses that they had gone to work and when I would pass by their homes, I would find them. Some indicated they were sick and couldn’t be available at the time of assessment, and others were casual labourers and locating them was a challenge since they worked for late hours. It was tricky and hectic exercise, but we did our best to locate them and pre-assessment. Others who were included as clients were not traceable since they lacked mobile phones so you couldn’t reach them easily. Communicating to some included clients was a problem since their phones were off and locating them became an issue. Apart from locating some of the clients, there were no challenges. Some men who had been screened and could not be traced [for pre-assessment] because they had sold their phones to buy drugs. Some of the clients who qualified had no phones for sessions follow up. |
| World Vision’s reputation | At least World Vision gives us something to talk to people about. The name is reputable. Some know WVK is a big organisation. World Vision as an entity has given us the favour with the community. There was misconception when we introduced ourselves as World Vision because some of the men we met said that there had been other projects brought to them and they ended up disappointing the community since those projects didn’t fully deliver and they were reluctant that World Vision would deliver on this new project we had introduced. |
| Enumerators effective when working in pairs | Working in pairs makes it easy to analyse who gets included. The advantage of two for scoring is one I can give it to my partner to calculate. For me it could have been hard to work alone since this is something I am not familiar with, therefore teamwork is healthier and she covered up for me in areas I wasn’t conversant with. Some of the questions they will not answer especially by a woman. At first I was a bit uneasy introducing myself to total strangers especially men. Most of them were arrogant and hostile but having a co facilitator who was a man I felt safe I gained confidence and was able to walk out there and look for people in need of this program I felt nice and humbled helping the community. |</p>
<table>
<thead>
<tr>
<th>Subtheme 2c: Community awareness of GPM+</th>
<th>Challenges related to the understanding about GPM+</th>
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</table>
| Confusion with previous WV projects    | • Some clients were hostile because they had been promised to be given machines by World Vision so they felt like they were being used.  
• They were confusing us about something for other issues and other projects in the past. It was hard to convince them to do an emotional program. |
| Perceptions that men are strong and do not need support | • For those who get stuck to the society assumption that men are strong, so they don’t talk about their problems. So having someone to share their problem with was important.  
• In our community we assume that men are very strong but when they come to sessions they are able to share their problems without being charged.  
• Men are reluctant to say their problems because they are supposed to be strong |
| Need for community sensitisation before screening and pre-assessment | • I had heard about PM+ but I thought it was only for women  
• Also we need to go to the field to create awareness in the community (Community mobilization)  
• Through these groups we can encourage other people we know where to get these men and we can access them.  
• Encouraging the men in the community that somethings are more important than money for the future.  
• There is need and desire for more engagement people need to be told everything about this program wholesome information is key. They should also create awareness on the importance of this program and how exactly how one can benefit from it.  
• Men need to be brought together and made aware of this program that it entails and the benefits one is to receive if only he agrees to open up |
| More information about what GPM+ is and is not is needed | • There is need in desire for more engagement people need to be told everything about this program. Wholesome information is key. They should also create awareness on the importance of this program and how exactly one can benefit from it before asking all those questions make sure that the man has identified its worth that way people will commit and won’t drop.  
• The enumerators need to emphasise on the money issue, encouraging the clients to attend but informing them that no money will be offered.  
• What we need to do is not to start by mentioning that there will not be material support but that they will be able to solve their problems. Don’t start [the introduction and informed consent] with voluntary and no money – but a project to help men. Replace that statement with a motivation – give them an inner drive. |
| Men like the idea of learning skills | • Most men were excited to learn that they will be attending sessions, which will guide and teach them how to handle stressful events currently and even in the future.  
• Success was from the preparation they received from the enumerators because when they came to us for sessions they were eager to learn and we knew we had to give it our all so that we can make this program a success.  
• One client was not happy when we told him that he wasn’t included because he was eager to join the group sessions  
• The qualified clients felt good that they could get skills to deal with their problems  
• Some said they felt good they’ll receive the skills from the CHVs |
| Men seeking remuneration or recognition for being part of GPM+ (including material support) | • Most men refused to be interviewed because there were no reimbursements provided.  
• Others requested for jobs and material things to boost their lives since they didn’t fully understand how the program would empower them mentally and not physically.  
• Those who agreed to be interviewed would later back out when they heard that no remuneration was being offered. Others say the questions were too much for them and were unwilling to open up, stating that most of their problems, only a money or job would solve. And since we were not offering any of the two they did not find any need to continue with the screening questions. |
- They want money, entrepreneur or training courses. They feel it’s a waste of time; they think these things [physical things] are much better than this one [GPM+]
- Most of the men stress emanate from unemployment. For men distress comes from lack of finance. It’s being a tough experience to convince men due to this kind of thinking.
- Due to lack of finance this causes problems (GBV). Most men said that if they could be given money their other problems will be sorted.

<table>
<thead>
<tr>
<th>Themes and codes</th>
<th>Descriptions and examples of coded items</th>
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<tbody>
<tr>
<td><strong>Theme 3: HINDERANCES TO GPM+ SUCCESS</strong></td>
<td>Factors that hindered GPM+ from being successfully implemented</td>
</tr>
<tr>
<td><strong>Subtheme 3a: Group Composition</strong></td>
<td>Reported issues that hindered effective group therapy</td>
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</table>
| Similar types of problems among groups – separate groups for individuals with higher drug and alcohol needs | - Compatibility of clients. Some clients had some very deep problems, like substance abuse and others have regular lifestyle, so when you mix those two characters, some of these are most likely to feel out of place. It’s like they didn’t belong.  
- For instance, I had this client who had a hearing problem so we had to talk as we shout so as to make him understand what we were discussing. Eventually this client dropped and I’m not sure if he felt out of place or what made him drop.  
- The man who came for one session and said that after listening to another man’s problems he was able to manage his problems better. He said after these men I realise I don’t have a problem. The things that are big to me are small to others. I thought my problem was a mountain, but mine was not.  
- I had this client who had a hearing problem so we had to talk as we shout so as to make him understand what we were discussing eventually this client dropped( am not sure if he felt out of place or what made him drop) |
| Age and cultural appropriateness | - The program should be able to sort out the age barrier so that the groups should be able to use age cohorts  
- In my first group the members were mixed. That’s drug addicts, religious, alcohol, etc. So the bonding was a challenge.  
- There is need to identify that people are different with different cultural variations, needs and also age matters. For example, reasoning of a 20s person is not the same with that person of a 40s and 60s so that gap should be identified and worked out.  
- [Reasons why clients didn’t complete sessions] – Age cohort hindrance  
- Age was a hindrance because being a young man [CHV] I am expected to talk to a man equal to my father’s age, especially on issues such as those of domestic violence. |
| **Subtheme 3b: Severe Drug and Alcohol intake** | Reported cases of inability to be attentive and participate in sessions as a result of high intake of alcohol |
| Men with severe drug and alcohol use were unreliable in attending groups and disrupted them | - Some clients were very high and could not continue with sessions. Communication was a problem and the other clients couldn’t go together with them.  
- Some clients needed more special attention. E.g., the drug addicts, a thief or a peddler. Their cases were a bit dense. Some attended the first session but did not turn up again. They were very high.  
- Some of them were very learned, but because of drugs they don’t complete the sessions  
- GPM+ needs more of a sober mind  
- They should try and come up with a strategy which supports those under substance abuse and still need GPM+ |
<table>
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<tr>
<th>Subtheme 3c: Unmet/Inaccurate expectations</th>
<th>Reported expectations from clients that were not within the GPM+ intervention</th>
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</table>
| Expectations for material (or other tangible) types of support | • Clients wanted money and food.  
• They had expectations. We emphasised they will not get material support, but even at the last session they asked for money or capital.  
• They heard we were not giving money so we needed to look for work  
• The men who left had other expectations. For one of them I followed him up and enquired with the other group members. He had thought the facilitators were medical officers, so he left after realising they were not.  
• Support our groups with livelihoods support for us  
• Some clients dropped because they had hoped there was some reimbursements  
• Most clients had financial problems so we suggest, if possible, clients should be offered a small token to help them attend to their family needs, even if it was a one day token  
• ….. And be offered lunch; that would be a fair deal…  
• They thought they would gain something monetary. We explained and from then on they didn’t turn up  
• Some clients dropped because they came hoping there were some reimbursements  
• Others dropped because they thought there would be some remuneration after attending 1 or 2 sessions even with us convincing them of the advantages of GPM+ they still dropped. |
| Wish for more longer sessions (beyond 2-hours), more sessions (beyond 6 sessions), longer term follow-up (continuous support) | • We need to make follow ups with these men.  
• There was significant changes to those clients who went up to the last session so I would recommend for a follow up of the client as completed the session so as to identify any changes.  
• The pilot was very challenging because clients were not able to practice what was taught on the first lesson due to limited time, so I could encourage for additional session dates.  
• We would prefer 3 hours instead of 2 hours provided for sessions so as to cover the whole topics involved as per the sessions  
• Sessions should be offered more time so as to make sure clients have adequate knowledge of what is required of them to understand fully  
• The time was limited if clients came late, otherwise the time was adequate.  
• Homework could not be achieved because the sessions were conducted twice a week. They needed the full week to practice.  
• Piloting was very challenging because clients were not able to fully practice what was taught on the 1st lesson due to limited time so I would encourage addition of session days  
• After treatment, some clients keep calling me because they have my number. They are looking for continued support and follow-up.  
• It better to also conduct follow up after the project and create a CBO which will include activities such as community work, conducting sessions to other male clients and come up with IGAs that will help them benefit financially in the future. |
Use of material or money problems as a basis for ALL problems with monetary gain viewed as a solution to all problems

- Cracking the man, getting to make him honestly open up is the main problem. They would open up to basic problems but conceal their inner problems which trouble them the most. Thus, most didn’t give definite problems, they would talk of money challenges while there was underlying issues.
- Also, most of their problems consisted of lack of money to cater for their family basic needs and job opportunities.

<table>
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<tr>
<th>Subtheme 3d: Timing of sessions</th>
<th>Reported clients missing out on sessions because of competing priorities</th>
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</table>
| Job opportunities (regular, daily or casual) prevent men from attending GPM+ | - Some clients were casual labourers and they were unable to attend all the six sessions. That was because they had to report to work, which was a full day job.  
- My clients left because they said they had to work since they were casual labourers.  
- Another said he was a casual labourer and this would take priority  
- Casual labourers ... at times, it’s hard for them to attend sessions since they have to sacrifice their work time for sessions  
- There were those who couldn’t attend because they had to go to work  
- Casual labourers with no definite time for reporting to work, thus you could find some would agree to come for sessions, but when the day to report came, they couldn’t be found since they had reported to work  
- Some clients who qualified could not come for the sessions because they work as watchmen so they sleep during the day… and a solution found for those who can’t make to come for sessions due to work related reasons. |

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<tr>
<th>Request for sessions to be held at different times and days</th>
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</table>
| - I would suggest that all the groups would end at the same time, but at different sites at the hospital compound so that when tea arrives it comes at a constant time for all groups.  
- In the morning is tricky because we have to attend to our chores in the farm  
- It was hard when one [client] is available, another is not; so looking for time for the group was hard  
- Rigid times were hard  
- Clients turning up late  
- You will also find those whom reported are those who had accommodative work routines, therefore time was a big challenge  
- There was this issue on lateness, some clients were unable to keep time  
- Clients appreciated the service even there were times when it got late, like one hour late, and clients used to complain a lot.  
- ... a solution provided for those whom can’t make to come for sessions due to work related reasons  
- Timing of the sessions is of essence as far as attending the sessions  
- Some of the clients were very accommodating and available |

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<thead>
<tr>
<th>When clients miss a session they cannot repeat it</th>
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| - My clients were very cooperative and kept time. All my clients attend their sessions except one. If one misses a session you feel for them because you can’t repeat.  
- They were disappointed when they missed the sessions |

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<tr>
<th>Wish for men to ‘bring home’ something from their time away from home</th>
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<tbody>
<tr>
<td>- Most of these clients are breadwinners in their families and having no tokens or reimbursements some prefer to withdraw from the project so they can attend to their casual jobs for them to take home dinner in the evening, because they fear if they don’t, their families will have no food for dinner. So I think that’s the reason why some were unable to finish all the sessions. Not because they don’t want, but they can’t afford to.</td>
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• The challenge is they have no jobs so they have nothing to take home to their families after attending sessions
• Having in mind that most men are breadwinners in their families it was hard for them to attend most of the sessions, since they were preoccupied elsewhere.
• Some of our clients prefer a small token to replace the tea offered that way they would use it for even more beneficial purposes like carrying home dinner or even open up a small business, this will see motivation amongst the clients increase leading to many finishing their sessions.
• Also, if they could be offered some small tokens or stipends that would also encourage them a lot.
• Most clients had financial problems so we suggest, if possible, clients should be offered a small token to help them attend to their family basic needs even if it was one day token.
• Some say they are willing if they could get compensation for their time. If not, then they’re not willing to come.

Clients who find employment cease attending sessions
• There were those who couldn’t attend because they had to go to work.
• Some clients were casual labourers so they were unable to attend all the 6 sessions. That was because they had to report to work and that was a full day job.
• Some clients were casual labourers and they were unable to attend all the six sessions, because they had to report to work, which was a full day job.

Subtheme 3e: Low client engagement

Clients who find employment cease attending sessions
• Others dropped because they thought there would be some remuneration after attending one or two sessions. Even with us convincing them of the advantages of PM+, they still dropped.
• Some have attended 2 to 3 sessions, they say within that week, they got a job far away and could not be able to attend sessions or do post assessment
• We were given a group and only one attended. He heard we were not giving money so he needed to go and look for work
• For me I would say lack of a little token is demotivating because there are those whom can benefit from this program but the will use lack of remuneration as an excuse because men don’t really like opening up and hence are very shy when it comes to discussing such issues.
• My [CHV] disappointment was when one client came for one session and could not come for the next session
• Casual labourers because they would appear saying they found a job
• Some of the clients did not have a reason why they did not turn up
• Other clients expected monetary gains, but all of them praised GPM+ after the 1st session.
• We called them and they said they are coming, but wouldn’t turn up
• Some clients said if only they could be compensated they would come for the next sessions.

Themes and codes

Description and examples of coded items
### Theme 4: KEY ASPECTS THAT ENHANCED GPM+ SESSIONS

**Factors that contributed to the successful implementation of GPM+**

<table>
<thead>
<tr>
<th>Subtheme 4a: Execution</th>
<th>Reported motivation among men to continue with GPM+ based on the nature of execution during session 1</th>
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</table>
| **Emphasising group respect and support** | • We used start with prayers  
• It was a sense of belonging to some since most of them have never had such an experience before and were looking forward to learn what the program entailed.  
• We used a string to emphasize the importance of sticking together (created a bond amongst them). And telling them our “string” needs to stay tight. |
| **Emphasis to attend all 6 sessions** | • The way we introduced ourselves, assuring them of confidentiality and emphasising the need of attending the six sessions |
| **Emphasising confidentiality** | • We were assured of confidentiality and that made us come back  
• Having been invited to the 1st session we were received very well by the facilitators, they told us that all we were to share was to remain confidential  
• …Confidentiality, therefore they respected it |
| **Goal-setting** | • Yes, the first session motivated me to the second session.  
• The goals we set on day one, we started getting casual jobs, reduced alcohol intake. |
| **Men were curious to attend session 1 to better understand GPM+ and what it could offer them** | • It was out of curiosity [to attend the first session]. I wanted to know if it was what I had been told was true.  
• After giving my information to a stranger, I wanted to know if those guys were serious.  
• The things that were being asked were things I thought of doing and I needed help. I had thought of taking my life and killing myself.  
• I had heard about PM+ but I thought it was only for women.  
• To be honest, when I was introduced to this project I saw it as a platform to change my life, it was a beginning of something that would help me in the future to become someone and not to look down upon myself as it has been the case previously  
• I thought to myself, okay, let’s wait and see because at first, I didn’t believe that there would be any phone call, but when I received the call and I was invited to attend the first session I agreed and was eager to avail myself at the hospital [clinic where GPM+ sessions were held] to discover what this sessions we had been waited for entailed.  
• Others were very eager to attend the sessions and finish them as from the beginning because they viewed it as a sign of hope which had come to change their lives for a better cause.  
• I was curious to attend because we don’t get a lot of seminars around here and I felt appreciated and recognised so I was very glad to have been chosen as a client.  
• when I met with the enumerators whom screened and later pre assessed me they told me that I had been included in the program and I was to receive a phone call later so and required to attend the sessions at the hospital, I was curious to know what this program involved since I had so much in my mind and I needed help to know how I could reduce and manage what I was going through. That is what made me interested.  
• Individual responsibility played a very high role in this program |
<table>
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<tr>
<th>Subtheme 4b: Effective Facilitation</th>
<th>Reported enhanced group participation and attendance as a result of good facilitation techniques and skills</th>
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</table>
| Co-facilitation was effective     | • Teamwork plays a major role during implementation of the sessions so it was easier working with a co-facilitator since we could split presentations. It also made us offer guaranteed and specialised sessions where clients were satisfied with our lessons and most gained adequate knowledge and skills needed to deal with their stress. It also makes management of the group easier for it helps one to track the protocol that needs to be followed and whenever one noticed that they were getting out of hand it was easier to bring them back to track and make some small follow ups.  
• Due to teamwork we were able to achieve our common goal of helping the clients understand how to deal with their own problems.  
• I became more confident when working with a co-facilitator. The women felt secure and made group management easier. The other facilitator was able to able follow the protocol when other person was facilitating.  
• It brings assurance that you will not miss a step. But through the session, you’ll have planned so you can specialise on your aspects. You are confident.  
• You find some clients talking too much so when you are two it’s easier  
• When one was teaching you could follow the moment. And share things they may have missed.  
• Not having a co-facilitator; it might have hindered the men opening up about new and different problems  
• Working with a co-facilitator would ensure that nothing is left out during the session.  
• It [co-facilitation] was more of team work helping each other dividing roles amongst ourselves and coming up with a plan on how we would conduct the sessions really made our work easier and well-coordinated. Each one of us had his/her own role to play and this made it easier even for the clients to cooperate and engage with us at ease and openness.  
• We used to help each other a lot when offering sessions for when I got stuck she could engage and take over the session and we ended up having an amazing time with the clients and delivered what was expected of us. Thus, I could add there was good co-ordination because most it was teamwork and demonstrations worked really well.  
• There was a lot of team work between me and my co-facilitator  
• Working with a co facilitator was a good thing, we helped each other in so many ways especially my co facilitator used to interchange questions and interpret them in a language the clients would understand. |
| Presence of women as a co-facilitator | • I came to realise most men see their wives as a problem. So co-facilitation was very good. Seeing a woman in the session who did not judge them was very encouraging.  
• It was very motivational and being paired with a woman really made it easier to tackle with gender violence issues.  
• We [women] felt secure  
• The women felt secure and made group management easier  
• Men were able to open up because there was a woman in the session  
• The presence of a female co-facilitator really made the clients to open up because I believe if it was a man to man thing some couldn’t agree to talk about their innermost issues troubling them physiologically because most men believe that emotional topics women are able to handle them well than men can.  
• it was a wonderful experience working with a female facilitator because she really inspired and motivated clients to open up  
• For me it was a good experience, even better than a previous one we worked on involving females because working in groups made it enjoyable which enabled the clients to feel at ease and easily shared what they were going through. |
The family figure [the woman] was important. Male clients used to talk about their wives whereby we would help them understand why their wives would react in a certain manner and how they could avoid arguments and violence.

Cracking of this men ego required a female figure whom could address a point in a female conscious and make the men understand better.

<table>
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<tr>
<th>Facilitator rapport with clients</th>
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<tr>
<td>Respect between facilitators and clients</td>
</tr>
<tr>
<td>Basic helping skills were well utilised</td>
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<tr>
<td>There was good coordination between the facilitators and clients</td>
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<tr>
<td>Having been invited to the 1st session we were received very well by the facilitators, they told us that all we were to share was to remain confidential</td>
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<tr>
<td>[He, the CHV] maintains eye contact and how ones approach to people is important because it can either make the person to open up or not</td>
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<td>Some interacted very well with the CHVs and so they decided to come for the next sessions</td>
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**Subtheme 4c: Conducive environment for group sessions**

**Reported benefits for men as a result of being in a group that is safe and their wellbeing attended to**

**Group cohesion & teamwork**

- Strengthening social support was really key. On our own we could not get all the information and learning we got
- I realised that my problems were similar with the other group members
- I was able to share and that motivated me
- With fellow strangers, I never thought I'd open up to them. But I did.
- in the first session we didn’t know each other and were a bit uncomfortable with each other but with time when we gathered together and became one class we created friendship whereby we exchanged phone numbers and would call each other whenever we had issues concerning stress the bond was tight in such a way that after the six sessions we still continued to communicate, it was more of a family at the end of it all.
- Men could also support each other during the sessions. Being a group they were helping others. They could listen and help each other.
- I would say pairing them in groups has helped them realize that they are not alone and that the program is of a huge benefit to them
- This group made us feel more of a family where we would come together, share and help each other to deal with stress.
- So they felt acknowledged, accepted and there was a sense of belonging in the session also; it played a huge part in keeping them to continue, so it was all about a joint effort and making the clients feel appreciated.

**Group times being flexible and agreeable to group members**

- We used to agree on the timing of the sessions. We called to establish the best time
- The times varied with different groups

**Groups inclusive of friends**

- My group had seven members and refused to be separated showing the great bond between them. The clients were also from the same locality. They were friends before with a car wash.
- For some they were friends already, but others; their friendship came from the group.
- When they attended, they insisted on including their friends in the group.
- There was a high demand of sessions; some clients were bringing their friends to the sessions
- There is high demand for GPM+ in Mutuini because you would find an incidence where a client would bring along a friend to the sessions and you would find that this clients from Mutuini wouldn’t want to miss out.
### Men learning from each other
- On our own we could not get all the information and learning we got.

### Keeping time (time management of facilitators)
- Lateness of clients and facilitators leading to poor time management
- Time management was efficient
- Clients appreciated the service even though there were times when it got late like one hour late and clients used to complain a lot.

### Confidentiality
- The way the facilitator presented themselves, even recording writing our names in pencil.

### Non-judgemental, safe, caring ambiance
- I was given hope
- I felt cared and loved
- Acceptance was key in this program because if I didn’t accept my current situation I wouldn’t have benefitted the way I have now.
- These people have faced a lot of stigma in the community and when they see people who care, they embrace the project
- If a man is beaten by his wife, he would not share with other people, but they opened up during the sessions.
- When they start talking and talking, his issues – they are strong. But they are even afraid to tell it to anyone, especially the man whose wife is beating him.
- When they came we gladly welcomed them well, made them feel comfortable. So they felt acknowledged, accepted and there was a sense of belonging in the session also; it played a huge part in keeping them to continue, so it was all about a joint effort and making the clients feel appreciated.
- The hospital location was a conducive environment to deal with such issues. Clients felt safe and secure.

### Tea and snacks
- My clients would not leave without the tea and snacks
- My clients could not start the sessions before they saw the tea and snacks
- Sure to be a motivating factor
- They appreciate it
- My client said that he had really appreciated the tea and snacks since he had not eaten for four days.
- There was this client whom even packed the snacks and took them home for his children.
- I would suggest all groups to enter at the same time but in different sites to the hospital compound so that when tea arrives it comes at a constant time for all groups
- Clients appreciated the session, as well as the tea and snacks
- Snacks and tea was a good motivation also
### Themes and codes

<table>
<thead>
<tr>
<th>Theme 5: PSYCHOLOGICAL OUTCOMES OF GPM+ FOR MEN</th>
<th>Descriptions and examples of coded items</th>
</tr>
</thead>
</table>

**Subtheme 5a: Reduced alcohol and drug intake**

<table>
<thead>
<tr>
<th>Reduced intake</th>
<th>Reported successes of GPM+ for men with common mental health issues, alcohol and drug and substance abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Other times I was using Bhang [Cannabis] and I am not using it now</td>
<td>• I was taking alcohol from morning to evening and I could even sleep in the bar. But since I started the session I only take alcohol in the evenings.</td>
</tr>
<tr>
<td>• I was taking alcohol from morning to evening and I could even sleep in the bar. But since I started the session I only take alcohol in the evenings.</td>
<td>• A client reduced his alcohol intake from 5 bottles to one. Another had a goal of stopping drinking and he thought it was impossible, but he was able to reduce his alcohol intake.</td>
</tr>
<tr>
<td>• A client reduced his alcohol intake from 5 bottles to one. Another had a goal of stopping drinking and he thought it was impossible, but he was able to reduce his alcohol intake.</td>
<td>• His goal was to stop drinking. He is trying hard and in one week he has drunk only once. So we give him time and he’s trying hard.</td>
</tr>
<tr>
<td>• Clients are also happy that they can handle matters. One client in my group reduced his alcohol intake.</td>
<td>• He [speaking of colleague] was using heroine but through support of group members we have been following up. He has stopped.</td>
</tr>
<tr>
<td>• He [speaking of colleague] was using heroine but through support of group members we have been following up. He has stopped.</td>
<td>• I had six clients and there was a lot of improvements and also a significant drop in alcohol and drug use.</td>
</tr>
<tr>
<td>• I had six clients and there was a lot of improvements and also a significant drop in alcohol and drug use.</td>
<td>• From session one to the last session there are those who in can say the program was beneficial to them, there was this client whom was a drunkard whom I believe the session really helped him a lot because by the end of the session there were positive identifiable changes.</td>
</tr>
</tbody>
</table>

**Drug/alcohol users were still helped when they attended sessions when high or sleepy**

| • Some of us used to sleep in the sessions but now we are awake because we have reduced our drug intake. | • He used to sleep during the sessions and we would ask him to sit near the door to keep him awake – but no when no longer sleeps during sessions. |

**Alcohol was seen as a stress reliever**

| • Men really go through stressful situations that make some of them bitter and result to alcohol as a stress reliever that is where they go wrong alcohol can make you forget just for a short time about your problem but it cannot help one solve his problems in fact it makes them worse. | • Substance abuse is manageable. |

**Many men identified alcohol and drug use as their goals or approaches for managing problems**

| • He got himself a casual job and he has reduced his alcohol intake from 5 bottles to 1 bottle | • Another client has been employed since he stopped drinking and these were his two goals. |
| • Another client has been employed since he stopped drinking and these were his two goals. | • Another has had goals to stop drinking and he thought it was impossible but he was able to reduce his alcohol intake. |
| • Another has had goals to stop drinking and he thought it was impossible but he was able to reduce his alcohol intake. | • One man was homeless. Stop drinking and a job were his goals. He got a house and in the 6th session he has been employed. |
| • One man was homeless. Stop drinking and a job were his goals. He got a house and in the 6th session he has been employed. | • His goal was to stop drinking. He’s really trying hard and that one week he had only drank once. So we give him time and he’s trying hard. |

**Subtheme 5b: Enhanced social support and family reintegration amongst men**

<table>
<thead>
<tr>
<th>Reduced social isolation of clients</th>
<th>Reported feelings of increased social support and cases of family reunion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• With the get going, keep doing strategy I started talking to people. I used to sleep the whole day and now I am happy.</td>
<td>• I have been sick with my feet and wounds. I’ve been able to get support from other men and I can share with the other men.</td>
</tr>
</tbody>
</table>
We are still in contact with group members and if he [a fellow group member] does not turn up for work, we go and pull him out of bed so he is not isolated and tempted to use drugs again.

We have decided to be in groups now which will help us make our dreams and vision.

I’m talking to people to find a job.

They were very happy they were out of a cocoon. They got a group where they could share.

Through strengthening social support we make sure he doesn’t sleep and miss work.

We have also helped him [one of the other men in the FGD/GPM+ group] to reduce his drug intake by going for him from his house when he does not report to our car washing business. We usually take dinner to him.

We have each other’s contacts and I was supported to go to the hospital by the group, they gave me fare and I was treated.

in the first session we didn’t know each other and were a bit uncomfortable with each other but with time when we gathered together and became one class we created friendship whereby we exchanged phone numbers and would call each other whenever we had issues concerning stress the bond was tight in such a way that after the six sessions we still continued to communicate, it was more of a family at the end of it all.

We solved some problems. Like quarrelling with my wife and making sure it does not get too bad.

I am trying my best to support my family

I am now thinking about my wife and two children. Gradually I am thinking of her coming home now because I am taking less alcohol.

Before the sessions I was separated from my wife because of drugs. But now I’m sober and thinking to bring her home.

Before I attended this session I had the problem and now work and my child would ask “why am I not going to school” – but now he has gone to school.

After joining the PM+ session my stress reduced and now I can cope with my problems

I used to hate myself but when I came to this session I felt loved and cared for

By coming together and sharing we can get some peace of mind.

Managing strength. We are teachers now to others in the community [one of the participants demonstrated the managing stress strategy during the FGD]

One could easily identify the positive impact it had made in their lives because they had changed a lot, they seemed more calm, relaxed and despite what they were going through, their tone changed. They used to talk with a hushed tone, but having gone through the sessions I identified they would speak at a respectable tone and would even choose their words carefully than they used to when they first came in. They learned how to appreciate and work with what they had hence their self-esteem was fortified.

It was very good and successful because by facilitating the GPM+ sessions led to clients changing behaviour and [the CHV] felt contented

From the sessions I could learn that drugs was about peer pressure. Alcohol too.

…all the strategies were connected to help them gain ultimate power to handle their own problems and create solutions to be able to move on with their lives and better their future.

GPM+ really helped them acknowledge that there were people who care for them and that not all hope is lost
Appreciation and acceptance of GPM+ for men in these communities

- It worked so much
- Otieno’s case helped us a lot
- Managing stress session was positively accepted by the clients
- I think you should take people like us out there to state our testimony and tell the community how this program has changed our lives.

Wish to contribute to wellbeing of others (e.g., teachers, recruiters, ‘agents of change’)

- In managing stress, we are teachers no to others in the community
- Even my wife knows about it [Managing Stress]
- We can do this by encouraging more men to attend sessions, by becoming ambassadors (agents of change) and role models in the community.
- If the men can see the change of these men it will attract more men to come.
- I think you should take people like us out there to state our testimony and tell the community how this program has changed our lives.
- There should be certificate of participation once one has completed all the sessions so that we can be able to convince others and make them join the program.
- There should be a certificate of participation at the end of all sessions. I think this would encourage people to attend all sessions, having in mind that this a certificate from World Vision, which to them [the clients] is a well-established organisation, and having a certificate would make them feel honoured and more appreciated.

Changed attitudes and outlook

- I used to think differently but now I’m mentally stable. We learned these problems will be there in life and we can’t change them all, only some. So now I feel very stable.
- These unsolvable problems – they are making us go to drugs and alcohol, but they do not solve – so now we don’t try.
- I learned about solvable and unsolvable. Some of my problems I have been able to solve.
- Money comes and money goes but having a positive mind full of knowledge on how to manage your stress that is something that is there to stay and one will forever benefit from it. It is important for people to understand that this program is worth more than money because it can change one’s life for better even without having money.

<table>
<thead>
<tr>
<th>Subtheme 5d: Employment, functioning and hygiene</th>
<th>Reported cases of men securing jobs and improved grooming</th>
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</thead>
<tbody>
<tr>
<td><strong>Job attainment</strong></td>
<td>Reporteds cases of men securing jobs and improved grooming</td>
</tr>
<tr>
<td>• I have started a business of baking and selling mandazi’s and support my family now</td>
<td></td>
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<tr>
<td>• Before coming to the sessions we had stopped our car washing business in the community but after learning the strategy of get going keep doing we started again.</td>
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<tr>
<td>• My clients were young and some who had decided to steal form people got casual jobs to do</td>
<td></td>
</tr>
<tr>
<td><strong>Improved functioning, self-care/hygiene/cleanliness</strong></td>
<td></td>
</tr>
<tr>
<td>• I am now well cleaned and dressed and now I can get a girl! I have got hope.</td>
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<tr>
<td>• There was a man in my group who changed because he became very clean. This man started taking a shower in [after] the 1st session and by the last session he was very smart.</td>
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<tr>
<td>• For some it was small steps, like bathing. A client was very dirty at the beginning of the session and had no job, and now he is very clean. He shaved.….</td>
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<tr>
<td><strong>Clients became more organised</strong></td>
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<tr>
<td>• Clients were able to write down their problems in order to plan for their solutions</td>
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<tr>
<td>• I used to think differently but now I am mentally stable. We learned these problems will be there in life and we can’t change them all, only some. So now I feel very stable.</td>
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</tbody>
</table>
- It has helped me in stress management because I have changed. I can now relate better with whatever situation comes my way. I feel different and more easily and calmer than I used to before. I am now focused despite my worries. When I include the breathing exercise I can control myself.

<table>
<thead>
<tr>
<th>Subtheme 5e: Effectiveness of GPM+ Strategies</th>
<th>Reported benefits of GPM+ as an effective therapeutic intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of GPM+ Sessions</strong></td>
<td>• I think combining 5th and 6th sessions would be good.</td>
</tr>
<tr>
<td></td>
<td>• Both sessions [5th &amp; 6th sessions] are very important and they should not be combined otherwise the men will have to stay the whole day.</td>
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<tr>
<td><strong>Effectiveness of the strategies</strong></td>
<td>• Clients really acknowledged and appreciated session 2 and 3</td>
</tr>
<tr>
<td></td>
<td>• Mostly session 2, that is managing problems and strengthening social support [session 3]</td>
</tr>
<tr>
<td></td>
<td>• It has helped me in stress management because I have changed. I can now relate better with whatever situation comes my way. I feel different and more calm knowing that I have the capabilities require. I can handle situations now more easily and calmer than I used to before. I am now more focused despite my worries. When I include the breathing exercise I can control myself.</td>
</tr>
<tr>
<td></td>
<td>• I would say all the sessions have been of great benefit to me, they have really changed me. All sessions (stress management, problem management, get going keep doing, strengthening social support, staying well moving forward, closing ceremony) but when it comes to stress management especially the breathing exercise was my favourite and it helped me to be calm and compose myself. When I needed to talk to people social support definitely worked very well for me at some point your able to communicate with them and some will give you hope and from there you’re able to focus and proceed with life.</td>
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<tr>
<td></td>
<td>• Managing problems worked wonders because we were taught how to identify solvable and unsolvable problems and how to relate with them. By identifying these problems he now has a sure way of how he can be able to curb them without this problems bringing him down to a point of him been hopeless with his life. For instance could apply problem management when he found two of his friends were sick and by applying solvable and unsolvable problems tactics he was able to let go of things beyond his control.</td>
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<tr>
<td></td>
<td>• PM+ has a positive impact, since some of the men who did not have someone to talk opened up and shared their issues.</td>
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<td></td>
<td>• There was this remarkable session of managing stress which the clients really enjoyed. They found it to be very flexible and effective when dealing with stress. I can say that after their experience with this session all they could talk of was how fun and helpful this session was they adopted it very well and it was a good experience to see them having the power to solve their own problems.</td>
</tr>
<tr>
<td></td>
<td>• I would say all the strategies were beneficial since all we taught them were new lessons to this men which they have never learnt before and they appreciated them equally because they believed that all the strategies were connected to help them gain ultimate power to handle their own problems and create solutions to be able to move on with their lives and better their future.</td>
</tr>
<tr>
<td></td>
<td>• We would say all [of the PM+ strategies were beneficial] because the first time clients came for the session they were so bitter and angry and most seemed to have lost hope with life but after we introduced to them the breathing exercise we noticed they became livelier.</td>
</tr>
<tr>
<td></td>
<td>• Managing problem was particularly beneficial because most of them were too dull but eventually they became active back home and to the community as well.</td>
</tr>
</tbody>
</table>
## Get Going, Keep Doing – mixed results

- With the get going, keep doing strategy I started talking to people. I used to sleep the whole day and now I am happy.
- In my group, the get going keep doing was a challenge. They did not understand it. Even the words was confusing for them “get going keep doing”. Men only hustle for their families and therefore they could not get it and we therefore need to brainstorm on activities that are common to men. [E.g., the CHVs reflected that unlike women who have many chores throughout the day, men had fewer choices on activities to use for get going keep doing].
- The get going keep doing session was something they understand very well and this will help them face challenges to come in the future.
- Later we taught them about “the keep doing get going exercise” and because of this activity cycle they started doing what they used to ignore like not attending to their chores or jobs due to alcohol.

## Improved problem management

- after attending this sessions he discovered that even though he cannot be able to solve all of his problems he could as well be able to handle them and that’s the secret he learnt, problem management occurs in one’s head and if one is equipped with the right tools (sessions) one can be able to progress well with life despite of the physical problems one is facing
- He learnt managing problems one has to come up with an idea, an action plan to help him focus in dealing with the problem and progressing well in life.
- We were happy to see the men to able to write down their problems to come up with solutions and to follow steps to solve their problems.

## GPM+ and its strategies were acceptable and worked!

- All the strategies were important
- The clients were grateful and thankful
- All in all the program was a success
- All in all it was a good journey which brought a positive change
- There was this session of managing stress which the clients really adapted to very well and liked it so much due to the practical exercises involved.
- One could easily identify the positive impact it had made on their lives because they had changed a lot. They seemed more clam, relaxed, despite what they were going through.
- From session one to the last session there are those who I can say the program was beneficial to them
- Like I mentioned earlier the managing stress strategy my clients liked it a lot because you will find this was mostly a practical than a theoretical session of which they could even practice at home or even introduce it to their friends and that was an fulfilling feeling for they used to talk and joke about it a lot
- Those whom finished the session can tell that the sessions were very good they gained adequate knowledge on how to manage stress

## Appreciation for GPM+ being specific to men

- We felt loved for the boy-child
- Let this not be the last time we work with men!
- They say women have more problems than men but we men, too, have many problems than women since most of these women look up to us to provide and security.
- Us men, we don’t come together to talk about our problems like women. Men commit suicide because they lack forums for men to share their problems
- he is really thankful that he has been changed and urges GPM+ to continue in order to equip more men with the right tools (sessions) they require so they can benefit from it and progress well with life he said that alcohol is not a solution and people need to be made aware of the capabilities they have and how to manage them.
- …and they also, liked been part of something so special something they have never had before.
- Most men don’t have forums when it comes to managing stress due to lack of accepting themselves and agreeing to opening up.
- Men are considered to be left out in such programs whereby most organisations focus on women and bringing this program to men, they felt cared for and wanted to play a role in it as well.
- GPM+ works and it needs to be extended to other men.
- Sometimes we think that men are very strong but I realised that this is not the case.
- The society assumption is that men are strong, so they don’t talk about their problems. So have them to have someone to share with was important.
- When we are through with the definitive study we need to keep working with the men
- The men were happy about the project, because the boy child has been forgotten for a long time.