KENYA

Mental health and problem management support for men to reduce incidences of sexual- and gender-based violence in urban Kenya

Research Team: World Vision Kenya: Phiona Koyiet, Kevina Power, Mary Mugo, Catherine Omenda, William Marwanga, Margaret Njenga. World Vision International: Alison Schafer

BACKGROUND

Kenya has extremely high rates of sexual and intimate partner violence (SIPV). Untreated common mental health problems including heavy alcohol consumption is considered a contributing factor. Research indicates promising outcomes for integrating mental health supports for victims to prevent re-victimisation and for perpetrators to help reduce incidences of violence against women (VAW)[1].

World Vision Kenya (WVK) worked with Kenya's Ministry of Health (MoH), University of New South Wales (UNSW) and World Health Organization (WHO) to pilot and implement a randomised control trial (RCT), studying the effectiveness of WHO's manual, Problem Management Plus (PM+) for women affected by violence in peri-urban Nairobi. 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 gender-based violence (GBV)[2]. The pilot determined PM+ as locally feasible and acceptable[3]. Findings from the RCT[4] confirmed that compared to women receiving treatment as usual through primary health care services, women who received PM+ experienced significantly reduced symptoms of psychological distress and posttraumatic stress, whilst significantly improving their daily functioning. These changes were sustained 3 months after the intervention was received. Despite these positive findings, community consultations noted that communities wished to explore supporting men with common mental health problems (including alcohol abuse), with an idea that this may prevent and/or reduce VAW. This has growing support in GBV literature, particularly around reducing harmful alcohol consumption[5].

This project will build on prior PM+ work and adapt the intervention to a group format (GPM+) for men with common mental health problems; and explore its potential to reduce SIPV. In parallel, the additive benefits of community messaging about GBV will be assessed as well as testing some approaches for PM+/GPM+ to be scaled up through formation and income generation of CBOs and their prospects for ongoing partnership with Kenya's Ministry of Health.

PROJECT AIM AND OBJECTIVE

The project aims to reduce incidences of violence against women in two peri-urban communities in Kenya, via four objectives:

1. The feasibility, acceptability and effects of reducing violence using GPM+ for men with common mental health problems in two districts is assessed.
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.
3. Feasibility of PM+ CBOs to establish income generation initiatives allowing them to provide PM+/GPM+ for Kenya Ministry of Health at scale is assessed.
4. Kenyan Ministry of Health establishes a model for PM+/GPM+ scale-up.

PROJECT METHODS

The feasibility study for GPM+ will work in the Waithaka and Muitini communities, beginning with an ethnographic study for adaptation of PM+ for men (and group format). Purposive, non-representative sampling will screen men with common mental health problems for inclusion to the GPM+ research. A pilot will engage 50 men, while the definitive feasibility study will see 320 men receive GPM+. Community household surveys will assess VAW and pre-post analyses will inform the feasibility study as to whether community messaging had any additive impacts on reducing VAW. The feasibility study for the CBOs to establish alternative income generation initiatives will be less rigorous, but equally critical to ensure recommendations and a model can be developed for PM+/GPM+ to be implemented at scale.

PROJECT OUTCOMES

At the end of the study, the project will have:

1. Established the feasibility of GPM+ for men and whether this contributes to preventing and/or reducing SIPV/GBV;
2. Assessed the potential additive impacts of combining mental health approaches with community-based dialogues about VAW;
3. Enhanced an existing intervention for local use in Kenya (Kiswahili PM+) that can both treat victims of VAW and existing or at risk perpetrators of VAW; and
4. Established a model for scale-up through CBO income generation initiatives and partnership with Kenya's Ministry of Health.

1. UNWomen, ILO, UNDP, UNESCO, UNFPA, UNHRHC, & WHO (2015). A framework to underpin action to prevent violence against women. UNWomen:NY.
2. World Health Organization & Pan-American Health Organization 2012. Understanding and addressing violence against women. WHO/RHR/12.36. WHO:Geneva.
3. Schafer, A. (2014). Pilot process evaluation in preparation for the randomized control trial (RCT) for Grand Challenges Canada research initiative, in partnership with University of NSW, World Health Organization, and Kenya Ministry of Health. Unpublished. World Vision Kenya:Kenya
4. Findings for the research will be officially launch in Nairobi, Kenya on 12th April, 2016 and published in peer review journals throughout 2016/2017. Currently, official data is unpublished.
5. Jewkes, R. (2002). Intimate partner violence: causes and prevention. The Lancet series Violence against women III, 359, 1423-1429.

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