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The Influence of Organized Diffusion on Social Norms Change:
Addressing Intimate Partner Violence in Nepal

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2017

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An abstract of
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Abstract

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By Simone Francis

Intimate partner violence is a significant global health issue that impacts the health of women worldwide. Organized diffusion has potential to influence changes in attitudes, behaviors, and norms that perpetuate harmful practices by spreading anti-IPV messaging from person to person, throughout social networks. The Change Starts at Home intervention in Nepal leverages radio programming and community mobilization efforts to address the various factors that contribute to the perpetuation of IPV. A qualitative analysis was done using in-depth interviews to understand how the intervention diffused into the community using organized diffusion as a framework, and how this influenced any changes in norms related to the perpetuation of IPV as a result of the intervention. Overall, it appears that the Change at Home Intervention was able to diffuse into the community through various pathways and began to create some changes around norms surrounding IPV. This analysis demonstrates the potential for organized diffusion to facilitate social norms changes around IPV.

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Table of Contents

Chapter 1: Introduction

Statement of the Problem

Gender-based violence is a significant global public health issue that has negative health implications for women worldwide. Intimate partner violence is one of the most common forms of gender-based violence; approximately 30% of ever-partnered women have experienced physical and sexual intimate partner violence during their lifetime, impacting a significant proportion of women globally (Devries et al. 2013; World Health Organization 2013). Intimate partner violence has numerous health implications that include numerous physical, psychological, and reproductive health implications, posing a serious risk to women's health (Breiding et al. 2015; Abramsky et al. 2014; Silverman et al. 2014). Women who experience IPV are more likely to utilize health services, thus spend more money on health related costs than those who haven't (Cadilhac et al. 2015). Additionally, survivors of violence are likely to report lost productivity, subsequent decrease in earnings, and are two times more likely to report a disability (National Center of Domestic Violence, Trauma & Mental Health 2014). Intimate partner violence has many different risk factors that are complex and interconnected; according to the social-ecological model, risk factors exist at the individual, relationship, community, and societal level for the victimization of IPV among women (Heise 1998). Creating sustainable changes in social norms of IPV has the potential to protect women from IPV (Ellsberg et al. 2014; Heise 2011). Given the depth of negative implications that IPV has on women, it is imperative to address this burdensome issue and to work toward preventing the occurrence of IPV worldwide through multi-faceted approaches that address the various risk factors for IPV.

Organized diffusion is the process through which intervention practitioners encourage that participants share new knowledge and understanding with others in their social networks in

order to motivate these others and join with them in a movement of social change (Cislaghi 2019). Organized diffusion has the potential to facilitate the spreading of anti-violence messaging through social networks, and has been found to influence changes in attitudes, behaviors, and norms around harmful practices, such as female/genital cutting (Mackie et al. 2009; Cislaghi 2019). However, research on diffusion and norms change is recent and largely theoretical and there is a shallow depth of evidence on how effective organized diffusion can be to facilitate changes in harmful norms that underpin the perpetuation of intimate partner violence. Thus, this thesis can begin to fill the gap in knowledge about the ways in which organized diffusion contributes to social norms changes and can contribute to the abandonment of intimate partner violence.

Purpose and Research Question

The purpose of this thesis is to analyze the potential for utilizing organized diffusion in IPV prevention. The goal is to examine diffusion as a result of the 'Change Starts at Home' intervention utilizing the organized diffusion framework. This thesis will seek to address the following research question:

> How has the 'Change Starts at Home' intervention diffused into the community to influence changes in norms surrounding intimate partner violence in Nepal?

Significance Statement

This analysis can help garner knowledge and potentially provide novel findings on how organized diffusion can influence changes in social norms surrounding intimate partner violence as a result of an intervention. It can gain insight in how to effectively engage the diffusion model

in intervention strategy and how to achieve changes surrounding harmful social norms that perpetuate intimate partner violence.

Chapter 2: Literature Review

Gender-based Violence and Intimate Partner Violence

Gender-based violence is a global issue that persists in all countries and societies. It is a significant global public health issue and human rights crisis that threatens the health of girls and women worldwide. In 1993, the United Nations was the first to distinguish and define gender-based violence as any act "that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" in the Declaration on the Elimination of Violence Against Women (United Nations 1993). Although it was historically seen as interchangeable with the term violence against women, gender-based violence has been understood as specifically being rooted in the structural subordination and inequalities that exist for women and girls.

There are various forms of gender-based violence, including both interpersonal and structural violence. Interpersonal violence is violence inflicted between individuals. Examples of interpersonal violence include, but are not limited to, dowry-related violence, rape (including marital rape), female genital mutilation/cutting, intimate partner violence, female infanticide, femicide, and sexual trafficking (United Nations 1993). Structural violence occurs when social institutions fail to provide people with basic needs or prevents them from meeting these needs. This can include school-based violence, workplace-related violence, and community-based violence. Examples of these types of violence include bullying, discrimination, stigmatization, or sexual harassment. Structural violence is present in evidence that subjugates women in low-wage jobs. Additionally, women are faced with the lack of opportunities to advance to "decision-

making" positions and do not typically have "bargaining power over the terms and conditions of labor" (USAID 2014).

Intimate partner violence (IPV) is one of the most prevalent forms of gender-based violence globally. According to García-Moreno et al., it is the most common form of violence in women's lives (2005). IPV is the self-reported experience of one or more acts of physical, sexual, or psychology harm, including psychological aggression, sexual coercion, psychological abuse, and other controlling behaviors by a current or former partner (World Health Organization 2013; Breiding et al. 2015). Approximately 30% of ever partnered women have experienced physical and sexual intimate partner violence during their lifetime, impacting a significant proportion of women globally (Devries et al. 2013; World Health Organization 2013). IPV is a serious public health issue that has numerous health effects for women throughout their life course and is associated with leading contributors to the global burden of disease. The health implications that are associated with IPV are staggering; there are numerous physical, psychological, and reproductive health implications that are both acute and chronic in nature, posing a serious risk to women's health globally (Breiding et al. 2015; Abramsky et al. 2014; Silverman et al. 2014).

The Effects of Intimate Partner Violence on Health Outcomes

There are significant health outcomes associated with IPV that have been well documented in the literature. The physical health implications are substantial for women who suffer from IPV, often having long-term health impacts that persist after abuse has ended (Campbell 2002). Most of the women who have suffered from IPV have been abused by their partners many times (Heise et al. 1999). Forty-two percent of women who have experienced

physical or sexual violence perpetrated by a partner have experienced subsequent physical injuries to the body (World Health Organization 2017). Survivors of violence are more likely to have suffered injuries specifically to the head, face, neck, thorax, breasts, and abdomen than women who have been injured in other ways (Campbell 2002). Chronic pain attributed with physical injuries, including headaches, gastrointestinal disorders, back pain, fractures, hemorrhaging, limited mobility, fibromyalgia, and traumatic brain injury, can persist long after violent acts have occurred (World Health Organization 2017). Those who suffer from IPV often are faced with other major health issues. These can include chronic diseases like hypertension, diabetes, cardiovascular disorders, respiratory conditions, musculoskeletal conditions, gastrointestinal disorders, asthma, as well as various infectious diseases (National Center of Domestic Violence, Trauma & Mental Health 2014; Heise et al. 1999). The most extreme physical consequence of IPV is death, either by homicide or suicide. Approximately 64% of all female homicides are perpetrated by an intimate partner; it remains to be the leading cause of homicide death and main risk of homicide for women (United Nations Office of Drugs and Crime 2018; Stöckl et al. 2013). Although men are disproportionally affected by homicide, the proportion of women killed by a partner is six times higher than that of men killed by a partner, reflecting the gender-based disparities that underpin intimate partner violence and homicide (Stöckl et al. 2013).

Intimate partner violence also has many negative mental health outcomes. Women who experience physical and/or sexual IPV are more likely to report higher levels of emotional distress (García-Moreno et al. 2005). It has been found that women often experience extensive emotional distress and emotional abuse compared with more discrete acts of physical and sexual violence, and prevalence of exposure to emotional abuse has been found to range anywhere from

9% to 70% (Jewkes 2010). Emotional abuse is associated with many poor health outcomes. Increased risk for depression, chronic stress, and post-traumatic stress disorder are associated with IPV (Campbell 2002; Devries et al. 2013; National Center of Domestic Violence, Trauma & Mental Health 2014). Women who suffer from IPV are more likely to participate in self-harming behaviors as coping mechanisms that pose additional risks to their health. Survivors of violence are two times as likely to report "problem drinking," and are more likely to smoke (National Center of Domestic Violence, Trauma & Mental Health 2014). Self-inflicted injuries are likely to happen when women are exposed to IPV. Survivors are three times as likely to commit self-harm, are three times as likely to have suicidal ideation, and are four times as likely to attempt suicide (National Center of Domestic Violence, Trauma & Mental Health 2014; World Health Organization 2017). Additionally, IPV is associated with sleep difficulties and disorders, eating disorders, substance use and abuse, and other anxiety and mood disorders (National Center of Domestic Violence, Trauma & Mental Health 2014; World Health Organization 2017). Carbone-Lopez et al. found that IPV and poverty are co-occurring and have parallel poor outcomes on one's mental health (2006). Both poverty and IPV result in stress, powerlessness, and social isolation which can lead to PTSD, depression, and other emotional difficulties. They also constrain coping mechanisms, preventing women from being able to emotionally cope in a healthy manner (Carbone-Lopez et al. 2006).

Furthermore, IPV undermines women's sexual and reproductive health outcomes. There are numerous implications. Women who suffer from IPV have limited sexual and reproductive control, autonomy, and often experience sexual coercion (Silverman et al. 2014). Reproductive control can include various acts of sexual violence, contraceptive sabotage, condom negotiation, the coercion of a women's decision to abort a pregnancy or carry it to full term, and pressure for

women to be pregnant regardless of her wishes (Heise et al. 1999; Hasstedt et al. 2016). According to Campbell, the most consistent and largest physical health differences between battered and non-battered women are gynecological problems (2002). Those who are abused sexually are exposed to various gynecological disorders, including vaginal bleeding, painful menstruation, pelvic inflammatory disease, vaginal discharge, and sexual dysfunction (Heise et al. 2002; Coker 2007). IPV puts survivors at risk of contracting sexually transmitted infections and diseases due to it being associated with sexual risk taking, inconsistent condom use, or partner nonmonogamy (Coker 2007). Additionally, partnered women are 1.5 times more likely to experience HIV and sexual transmitted infections than those who will never experience IPV (Heise et al. 1999; World Health Organization 2013).

Women who have a history of suffering from physical and/or sexual abuse are at an increased risk for unintended pregnancies, high risk pregnancies, induced abortions, and miscarriages (Heise et al. 1999; Coker 2007). Survivors of violence are two times as likely to have abortions and are three times as likely to experience multiple abortions than those who haven't suffered (Silverman et al. 2014). Unintended pregnancies in violent relationships have been associated with worse maternal and child health outcomes, and there is an increased risk for young mothers. Women who experience IPV during pregnancy are less likely to seek proper prenatal and antenatal care (García-Moreno et al. 2005; Salam et al. 2006). IPV is associated with increased risks for low birth weight, fetal growth retardation, fetal death, maternal mortality, postpartum depression, and antenatal hospitalization (Brown et al. 1995; World Health Organization 2017). Women who experience IPV are 16% more likely to miscarry and 41% more likely to experience a preterm birth, which puts a fetus at increased risk for poor health outcomes that affect their entire life course (World Health Organization 2013). The depth of

maternal and child health implications demonstrates the potential for intimate partner violence to have detrimental intergenerational health effects for those who are victimized.

There are other health-related implications to IPV. Survivors of violence are likely to report lost productivity, subsequent decrease in earnings, and are two times more likely to report a disability (National Center of Domestic Violence, Trauma & Mental Health 2014). Furthermore, IPV impacts a woman's health care utilization and health-related costs for those affected. Women who experience IPV have more health needs; in both upper and lower middle-income countries, one in four women who have suffered an injury by an intimate partner required medical care (World Health Organization 2014). Additionally, women suffering from IPV seek health services more frequently than those who have not experienced it. Thus, survivors of violence are likely to have more health associated costs (Cadilhac et al. 2015).

Causes of Intimate Partner Violence

According to the social-ecological model, a framework developed by Heise (1998) to understand the multi-faceted pathways of causality for women for suffering from violence, there are various factors that exist at different social levels that contribute to both the victimization and perpetration of gender-based violence. That model has been expounded upon and risk factors have been identified on individual, relationship, community and societal-levels by various journals and larger global bodies such as the World Health Organization. No factor alone causes the occurrence of violence, but there is a complex interplay of factors that put women at risk for suffering from IPV. Individual level risk factors include histories of abuse. The occurrence of child abuse, witnessing violence in their childhood, and family history of violence can be risk factors for victimization of IPV. Furthermore, demographic factors can put women at risk,

including low educational attainment, low household income, unemployment, and being female. Young women in child marriages are at an increased risk for IPV (Kidman 2017). Individual personality traits and behaviors of both men and women put women at risk for IPV victimization, including low self-esteem, holding attitudes of gender inequality, condoning violence, as well as individual adherence to rigid gender roles (Our Watch et al. 2015). Furthermore, individuals who have disabilities are at an elevated risk for IPV; women with disabilities are four times as likely to report experiencing sexual abuse compared to women without (Martin et al. 2016).

Relationship-level factors add another layer of risk for women. Some of these factors include the internalization of male dominance and female subordination by a spouse or family members, male-dominated decision-making in the household, and male financial control (Heise et al. 1999). Lamicchane et al. found that lack of decision-making autonomy among women is the strongest predictor of IPV (2011). Furthermore, general support of violence against women, alcohol use by a partner, and history of violent behavior by a partner are correlated with IPV (Atteraya et al. 2015). Violence is often used to resolve conflicts in relationships. The occurrence of verbal disagreements and high levels of relationship conflicts have been found to be strongly associated with physical violence (Jewkes et al. 2002; Atteraya et al. 2015). Men who witnessed their mothers experiencing violence are more likely to be perpetrators of IPV in their own relationships, and women who witness their mothers experiencing violence in the home are more likely to beaten as adults (Heise et al. 1999; Jewkes et al. 2002).

At the community level, demographic factors, such as low socioeconomic status, unemployment, and economic related stressors are associated with IPV (Heise et al. 1999; Jewkes 2002; Atteraya et al. 2015). Poverty is also a predictor of IPV victimization and is associated with subsequent poor health outcomes (Atteraya et al. 2015; Carbone-Lopez 2016).

Geographic location (neighborhoods, urban and rural areas, and geographical regions), caste, and ethnicity are strong predictors of IPV in some regions of the world (Atteraya et al. 2015). Furthermore, a woman's lack of social support and experience of isolation in the community predict higher rates of violence, independent of demographic, social, and health related factors (Heise et al. 1999; Dias et al. 2018).

There are numerous factors that exist at the societal level that put women at risk as well. Social norms are informal rules that govern the behavior of groups of people and societies. Social norms, although not the sole cause, drive the perpetuation of IPV. Socially accepted norms around male ownership and male dominance of women at the individual, family, and community level posit women at risk for suffering from IPV (Ghimire et al. 2017; Abramsky et al. 2014). Furthermore, violence against women has been found to be most common in places where gender roles are rigid strictly enforced, as well as in places where there is an established hierarchy, and where norms surrounding masculinity are linked to dominance, toughness, and aggression (Heise et al. 1999; Jewkes et al. 2002; Heise 2011) Other norms that are associated with violence and abuse include the tolerance of violence as a means to settle disputes and to physically punish women and children (Heise et al. 1999).

Situating Intimate Partner Violence in Nepal

South-East Asia has the highest rates of IPV globally, with regional prevalence rates of 37.7% (World Health Organization 2013). In Nepal, 26% of ever-married women of reproductive age report having ever experienced physical, sexual, or emotional violence committed by their spouse (Ministry of Health Nepal 2017). More than half of Nepalese women report having experienced some form of violence in their lifetime (Lamichhane 2011). In the

Terai region particularly, a region where men and women hold more traditional values regarding gender than in other areas, women are at the greatest risk for IPV compared to other regions. In this region, prevalence rates are 32% (United Nations Development Programme 2014; Ministry of Health Nepal 2017). Women who belong to underprivileged caste and ethnic groups, including indigenous, untouchables, Muslim and other Terai caste were found to experience IPV more often than women who lived in other regions and who are from high castes; forty-four percent of Muslims and other Terai caste experience IPV (Atteraya et al. 2015).

Thirty-four percent of ever-married women who had experienced spousal violence have sustained subsequent injuries (Ministry of Health Nepal 2017). Thirty-four percent of Nepalese women who have no education have experienced physical violence, whereas 1 in 10 women with higher education have experienced the same, and women who are illiterate are at an increased risk (Atteraya et al. 2015; Ministry of Health Nepal 2017). In married couples, a husband's level of alcohol consumption directly affects the occurrence of spousal violence (Jewkes et al. 2002); seventy-four percent of women whose husbands often get drunk report having experienced spousal physical, sexual, or emotional violence, whereas 18% of women with husbands who do not drink report the same (Ministry of Health Nepal 2017). The same study conducted by the Ministry of Health Nepal found evidence of intergenerational spousal violence in Nepal. In Nepal, 46% of women who reported that their fathers were violent with their mothers reported that they experience spousal violence, which is more than women who report that their fathers did not beat their mothers (23%) (Ministry of Health Nepal 2017).

In Nepali society, norms strongly dictate practices that put women at risk of suffering from IPV, which is considered to be an "open-secret" in Nepal (Atteraya et al. 2015). Traditional norms and expectations concerning masculinity include male's natural aggression, male

dominance, sexual promiscuity, power, and possession and use of firearms (United Nations Development Programme 2014). Nepali men expect to be respected and obeyed. Thus, they may exert control or force to fulfill the roles prescribed to them (Ghimire et al 2017). Additionally, patriarchal practices, including child marriages, dowry-related practices, and the expectation of women's submissive role in the family are all deeply rooted in Nepali society (Atteraya et al. 2015). These norms and practices have been associated with the perpetration and victimization of IPV and are internalized by both men and women alike. Acceptability and visibility of IPV inside and outside of the home is high among both men and women in Nepal, especially in the Terai region (Atteraya et al. 2015; Clark et al. 2017). In some regions, 85-94% of Nepalese people have witnessed men beating and/or scolding women, and 27% have witnessed this frequently. Fifty-two to fifty-seven percent of people have witnessed sexual violence against someone (United Nations Development Programme 2014).

In Nepal, there have been some important policy-related events over the past decade that the government has initiated to address IPV perpetuation. In 2006, the Gender Equality Act amended or repealed numerous discriminatory provisions between men and women in Nepali laws, and expanded definitions of many crimes against women, including rape and sexual harassment (Act to Amend Some Nepals Acts for Maintaining Gender Equality 2063 2006). In 2009, the Nepali government passed the Domestic Violence (Crime and Punishment) Act 2066; this law made domestic violence criminally punishable and sought to prevent and control violence occurring within the family, defining domestic violence as "any form of physical, mental, sexual, and economic harm perpetrated by person to a person with whom he/she has a family relationship and this word also includes any acts of reprimand or emotional harm" (Domestic Violence Act 2066 2009). Although these laws have been put into place to protect

women from violence, there are still numerous barriers that exist for women who have been victims to obtain the proper justice for incidents of violence. Due to the persistence of patriarchal ideologies held among legal institutions and personnel, discriminatory laws, and a legal process that is slow and does not view women and men as equal, women are often hesitant to report cases of violence (United Nations Development Programme 2014). Most women (66%) who have experienced a form of physical or sexual violence have never sought help nor shared their experiences with anyone (Ministry of Health Nepal 2017). Thus, it does not appear that women in Nepal have the structural support to protect them from IPV.

In addition to the governmental initiatives listed prior, organizations have increasingly implemented interventions in order to protect women from IPV in Nepal. Successful programs addressing IPV in low- and middle-income countries (LMICS) like Nepal have been found to engage multiple stakeholders with multiple components, to incorporate specific strategies for diffusing impacts beyond a core intervention group, engage both men and women, are informed by theory, and target known risk factors for intimate partner violence (Ellsberg et al. 2014; Garcia-Morena et al. 2016; Jewkes et al. 2015; Carlson 2015; Flood 2011). Two intervention strategies that are utilized in interventions in LMICs are media campaigns that incorporate social marketing strategies and participatory discussions (Cislaghi 2019). Additionally, targeting social norms has been found to begin successfully changing norms and attitudes surrounding IPV (Ellsberg et al. 2014). Programs that are able to successfully achieve gender norms and gender relations transformation often intervene at the 'community' level in LMICS and are community-led (Cislaghi 2019). Creating sustainable changes in social norms of IPV has the potential to protect women from IPV (Ellsberg et al. 2014; Heise 2011). Thus, it is important for preventative

interventions to occur in places like Nepal in order to work toward reducing IPV and it is important to continue to create interventions that can do this in the most effective manner.

Diffusion of Innovation and Organized Diffusion

Sign of norms changes and abandonment of harmful social practices in communities can result from the 'organized diffusion' of anti-violence against women messaging content in community interventions. Organized diffusion is the process through which intervention practitioners encourage that participants share new knowledge and understanding with others in their social networks in order to motivate these others and join with them in a movement of social change (Cislaghi 2019). Organized diffusion stems from a history of diffusion research that has been applied to various disciplines, including agrarian sociology, communication studies, health promotion, evidence-based medicine, studies of organizational process, context, and culture, and knowledge utilization (Greenlagh et al. 2005). In 1962, Rogers introduced a theoretical framework of change referred to as 'diffusion of innovations' to evaluate developmental programs in relation to improving agrarian practices (Rogers 1971). Diffusion is defined as the process by which an innovation is communicated through certain channels over time among the members of a social system. It is important and can be considered a type of social change because when new ideas are invented, diffused, and are either adopted or rejected, leading to certain consequences, social change can occur (Rogers 1971).

There are some key elements to diffusion research; diffusion includes the innovation of a novel idea, adopters of the innovation, communication channels that facilitate the sharing of information from one person to another, an element of time allowing for innovations to be adopted over time, and the role of social systems as being a combination of influences on an

adopter. There are five stages of the adoption process that Rogers (1962) outlines. The first stage is knowledge, when the individual is first exposed to what they perceive to be an innovative idea. The adopter then becomes interested in the innovation and learns about the innovation, which is the second stage called persuasion. The next stage is called the decision stage; at this point the individual decides whether or not to adopt the intervention by considering both the advantages and disadvantages. They take on the innovation and continue to learn about it in order to determine the usefulness of the innovation in the implementation stage. Finally, in the confirmation stage, the individual finalizes the decision to adopt the innovation by continuing to collect information that justifies their decision. When a number of individuals in a social system adopt the innovation to a point when it is considered to be self-sustaining, this is when the innovation reaches what is called the critical mass. (Rogers, 1962).

Organized diffusion distinguishes itself from its predecessors in that change is created not because of unilateral imitation of a behavior that is adopted in a process of spontaneous diffusion without thought like in Rogers's original theory, but that it occurs through a process of information sharing, active persuasion, and mutual deliberation about the advantages and disadvantages of abandoning interdepending practices through existing and created social networks (Mackie et al. 2009). Mackie and Lejeune identified six phases that occur in the diffusion of knowledge by examining the abandonment of social norms surrounding female genital mutilation and cutting (FGMC) in West Africa (Mackie et al. 2009). As Cislaghi (2019) summarizes, phase one occurs when interest is sparked about the intervention before the program is implemented. Phase two is when discussion about new knowledge occurs with a select group of participants, often happening in group discussions. Once this group has this new knowledge and has adopted it, this is the point of the intervention that is considered to be the critical mass.

Phase three is when the selected participants share the new knowledge with a selected member in the community outside of the participant group, often being a family member or people within their immediate social networks. In the final phases of organized diffusion, the information continues to spread, further and further into participants' more distant social networks and eventually reaching enough people in the larger social system (i.e. ethnic group, region, or country) (Cislaghi, 2019). The tipping point is when the critical mass recruits enough of the population that is to ready to abandon the harmful practice (Mackie et al. 2009). The final phases of organized diffusion incorporate an element of community mobilization. Participants of the intervention become agents of change by raising awareness of new knowledge and generating community action in order to change attitudes, norms and behaviors.

The potential for organized diffusion to create normative changes in LMICs has largely been theoretical (Cislaghi et al. 2019). Only few health-related interventions have purposefully used organized diffusion to continue the spread of knowledge from participants to their social networks. An example of community-led approaches that have been effective in achieving gender norm equality by facilitating change in gender norms and have some sort of organized diffusion component are the SASA! Program in East Africa, which aimed to reduce violence, gender inequality, and HIV vulnerability among women through community mobilization. Another example is Tostan's Community Empowerment Programme (CEP) in West Africa that sought to create changes in social norms and practices of female genital mutilation/cutting through family and community mobilization and structured curriculum. In Nigeria, Voices for Change, which used various media including radio programming, advertising, social media, and political advocacy, was implemented to change attitudes and practices around violence against girls and women. Change Starts at Home (Change) in Nepal is another intervention; it used radio

programming and social behavior change communication to change norms and ultimately behaviors surrounding IPV in Nepal. There has been some documented evidence of how organized diffusion can contribute to changes in people's attitudes or practices, as evident in the CEP, but there are not many studies that have examined how well organized diffusion can facilitate change in social norms (Cislaghi et al. 2016). Data analysis conducted on SASA! found that radio programming and interpersonal communication contributed to change and in the SASA! intervention specifically in Rwanda, organized diffusion was increased by the visibility of change, which eventually changed the behavior of non-participating community members (Starmann et al. 2018; Stern et al. 2017). Cislaghi et al. is one of the few that has examined how participants can be effectively empowered to share their knowledge with others in their social networks to eventually facilitate social norms change, providing quantitative evidence from a comparative case method on CEP, Change, and Voices for Change (2019). Overall, they found that organized diffusion can increase change in harmful gender norms (Cislaghi et al. 2019). Thus, there is demonstrated potential for organized diffusion to create effective norm changes that can prevent women from suffering from IPV globally.

This paper differs from what has been done by providing qualitative evidence to garner a more robust understanding of how organized diffusion influences changes in social norms surrounding intimate partner violence after programmatic events have ended, specifically examining the Change Starts at Home intervention in Nepal.

Chapter 3: Methods

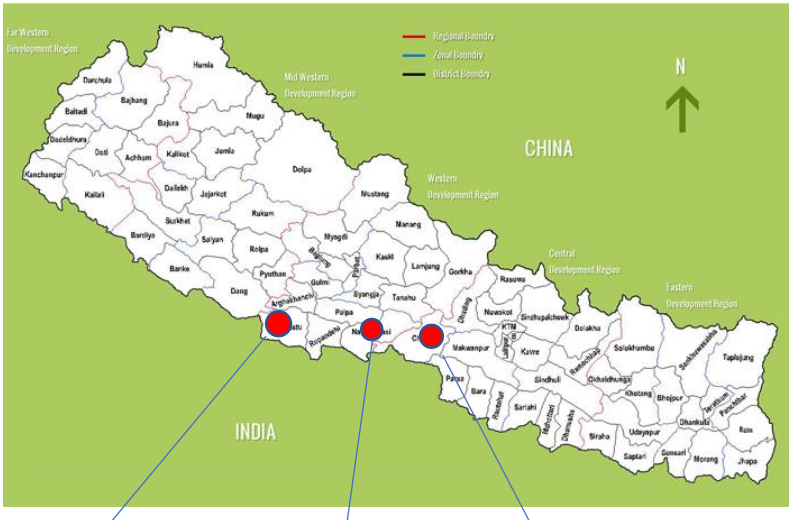
Ethical Considerations

IRB approval was obtained from Emory University (IRB00091115), University of Minnesota (1601S82063), George Mason University (802242-1), and the National Health Research Council in Nepal (178/2015).

Study Context

The study was conducted in the Terai region of Nepal due to it having the highest prevalence of intimate partner violence (IPV) in Nepal (32%) (Ministry of Health Nepal 2017). Within the Terai region, the districts of Chitwan, Nawalparasi, and Kapilvastu were selected for this study due to an existing collaboration with the local NGO Vijaya Development Resource Center (VDRC). Figure 1 graphically demonstrates where the districts are located geographically.

Figure 1. Map of study site districts in Nepal



Source: marketwatch.footprints.com.np

Study Design

The '*Change Starts at Home'* study is a randomized control trial that uses a mixed-methods approach. The aim of the program is to use radio drama, community mobilization, and advocacy to reduce the perpetuation of IPV in Nepal. It uses a multi-component social behavior change communication strategy (SBCC) that is comprised of a 9-month weekly radio program and listening and discussion groups (LDG) (*N*=36 clusters, 1440 individuals). Participants in the intervention arm were exposed to a radio program and participated in LDGs, while participants in the control arm were exposed only to regular radio programming. The goal was to assess the impact of the radio program on IPV at various points in the trial. In the intervention arm, 360 couples were selected to participate in the gender-separated LDGs, in which they participated in a curriculum-based weekly discussion group led by trained facilitators. Additional program activities included engaging the families and community of LDG participants in focus group discussions to understand changes in attitudes related to gender equity and IPV, as well as a street theatre that exposed gender equity messaging to community members. These were part of the programmatic events to expose members of the community to anti-IPV messaging as part of the multi-faceted approach of the intervention. (Clark et al. 2017).

Study Sample

Study participants were selected from village development committees (VDC) by global non-profit organization Equal Access International in consultation with Vijaya Development Resource Centre (VDRC), a local NGO. First, they selected twelve VDCs per district (*N*=36 clusters) based on the district's ability to host program activities. Each district was then pair-matched to a district based on various demographic factors including language, caste, and

literacy rates, which represented the control district. Then two wards were randomly selected in each of the VDCs. In each of those wards, 10 couples were chosen based on the eligibility criteria to participate in sex-separated LDGs that followed a weekly curriculum that featured gender-equitable content. Eligibility criteria included being a woman of reproductive age (18-49) who is married to a man over 18 years, residing near the study, and who is willing to commit 9 months to participate in the program.

Data Collection

Both quantitative and qualitative data were collected. Quantitative data comprised of surveys from female community members and female LDG members. Qualitative data included in-depth interviews and focus group discussions with LDG participants, family members of participants, and community leaders. In-depth interviews were conducted with a sub-sample of couples in the LDG prior to the intervention, at midpoint (6 months past baseline), endline (12 months post baseline), and 18-month follow-up. Focus group discussions were conducted with family members of LDG participants prior to the intervention and at endline. There were 3 additional focus group discussions conducted with community leaders taken at two timepoints: (1) the first quarter of the program and (2) six months after. Other qualitative data approaches included a listener feedback analysis that was collected quarterly from radio listeners through interactive voice response (IVR) and short message service (SMS) and finally, 6 LDG groups were followed over the first month of programming, at intervention midpoint, and at endline. The longitudinal approaches were used in order to assess long term impact of the intervention both within the intervention group and among the community members. Table 2 displays a timeline for all qualitative methods used.

Table 1. Timeline of qualitative data collection points *****

Audience	**Time Point**	**Qualitative Method**
Couples in Listening and Discussion Groups	Prior to the intervention, midpoint, endline, and **18 month follow-up**	18 in-depth interviews per each time point
Family Members of LDG participants	Prior to the intervention and endline	12 focus group discussions per each time point
Community Leaders	1st quarter of the project and 6 months after	3 focus-group discussions per each time point
Radio Listeners	Quarterly	IVR/SMS listener feedback analysis
LDG Members	1st month of programming, midpoint, and endline	6 LDG groups followed per each time point

*Table adapted from Clark et al. 2017
**Data that is being used for this thesis

The interviews used for this analysis (*N*=35) were taken at 18-month follow-up to understand the impact of the program after programmatic events have ended. Interviews were conducted individually with trained interviewers that followed a semi-structured interview guide. The questions used in the guide were related to changes in attitudes, perceptions, and behaviors about gender equity in oneself, their spouse, family members, and community as well as if they invited any of the community members to the intervention programs such as the street drama or the family member LDG sessions. Sample questions include "How has your involvement in the Change program impacted your relationship with your spouse?" and "Did you invite others to listen to the program or share what you were learning in the Change with others in your

community?" The interviews lasted 45-90 minutes, were conducted in Nepali by professionally trained interviewers, and were transcribed directly from Nepali to English. All interviews were recorded with participant's consent.

Data Analysis

Analysis was conducted on the couple interviews taken at 18-month follow-up in order to understand the effect of the program events after they have ended (*N*=35 individuals). All interviews were transcribed from Nepali to English. De-identified transcripts were uploaded to MAXQDA 2018 software for analysis. The interviews were coded thematically using the existing codebook from the broader study, comprised of both inductive and deductive codes that were developed by the principal investigator and members of the EA staff. Coding was conducted independently by the researcher and a fellow graduate-student with mutually agreed upon code definitions from the codebook. Inter-coder agreement was conducted within MAXQDA 2018 in order to assess consistency of coding between the two coders. Thematic analysis was conducted. The organized diffusion model was used to guide data analysis. Each phase of the sequential model was used to inform how to categorize relevant codes, themes and topics together. A thick description of the relevant codes for each phase were made, followed by the comparison that allowed for identification of patterns and associations across each phase.. Major themes and patterns among each phase were summarized with relevant quotes to support these. In order to understand how the intervention diffused into the community, it was important to consistently refer back to the literature on diffusion and refer to the data to see where the data fit into the model and where it differed. Then, any changes that were discussed among participants were grouped together based on relevant themes and summarized in the results. In

order to verify the results, it was necessary to return to the data to make sure the results fit into an existing framework, the organized diffusion model. This was also done to check consistency of the results across the data.

Chapter 4: Results

The following chapter will summarize the results in the following section according to the phases of organized diffusion. Phase I is when discussion about the intervention occurs before any program events begin. Phase II is when selected participants gain new knowledge. The third phase is when participants begin to share the new knowledge with members of the community that are outside of the participant group, often occurring within the participants' immediate social networks. In the final phases, the new information spreads out further into the participants broader social networks. Each phase of organized diffusion will separated under different headers and briefly described. The data that supports each phase will be summarized. Finally, there will be a description of results that indicate any resulting changes that were found among participants and members of the community that were revealed in the data.

Phase I: Interest About the Intervention Before the Program Begins

In the first phase of organized diffusion interest about the intervention is sparked before the programmatic events begin. In this phase, some participants expressed curiosity and excitement when they found out that they were selected to be in the intervention group. A woman from Nawalparasi recalled "in the beginning I was curious about the program..." The interest that participants express is mostly related to the general prospect of learning something new, gaining knowledge in a topic, and being a part of a larger group. A woman from Chitwan said when she found out she was selected, "I felt happy as I am able to participate in it. I was able to learn new things that I didn't know about. So, I was happy."

When participants learned that they would be learning content specifically related to the topic of violence against women, they expressed many positive feelings. Participants felt that

their knowledge on this topic was limited, thus many were happy to be learning more about topics related to relationships and violence. A man from Chitwan recalled “first of all, I was very happy about such program coming in our community. Our knowledge about issues raised by the radio program were limited. Issues such as husband-wife relationship.” Most of the participants who mentioned that they were specifically interested in topics related to violence against women were women. A woman from Nawalparasi described “in the beginning I was curious about the program... later when I knew about the program I was happy. It was for us and related with violence against women.” Participants were also happy to be able to learn new information and gain knowledge in general, not necessarily specific to the topic. One woman from Chitwan recalled “I was very happy to know that I was selected because I would learn many things, new things.” There was discussion among the participants about how they were going to make time to participate due to them having other obligations, which indicates a willingness to learn. One man from Chitwan expressed that his expectations for the program were to “learn more, get more information, [and] learn how to talk better…”

On the other hand, there were also negative reactions to the program among participants. Some participants felt confused about the program. A man from Chitwan recalled that in the beginning “I was confused what the program was about. Whether it is news or something else.” Furthermore, a man from Nawalparasi shared that “in the beginning I was reluctant. When I heard the word "class" I was not interested.” Participants discussed the reactions of their community peers when they found out who had been selected to participate in the LDG groups. A man from Nawalparasi remembered “when we were told that we were selected... others were also interested and blamed us that we manipulated the selection process. We made them clear. So

many people were interested to learn." This indicates interest in participating in the intervention not only among selected participants, but also from members in their community.

Phase II: Acquiring and Accepting the New Knowledge

The second phase of organized diffusion is characterized by the acquiring of new knowledge among selected participants, often happening in group discussions like the LDGs. Participants mostly discussed that they had attended most, if not all, of the LDG sessions. They shared the various topics and skills that they remember discussing within their groups, including content and skills related to relationships with their spouses and family members, sharing of household chores, and discussions related to intervening in cases of violence. There are also participants who were unable to recall some, most, or almost all of the content of the program.

Many participants recalled having discussions that were related to the marital relationship between husband and wife. Many of the skills that they had discussed within the LDGs were related to conflict resolution, including content on anger management, communicating through problems, and finding solutions to these problems. As described by a man from Nawalparasi, "there was one program 'get to the roots' which means knowing the reason of the conflict... so we apply that. First knowing the reason then find the solution." Participants also talked about learning about the effects of alcohol consumption; men more often shared how they have learned about the role that alcohol consumption plays in contributing to disputes within the house and how that takes away from potential financial earnings and savings. A man from Nawalparasi shared, "if I see anyone else drink like that, I try to advise him not to drink too much as it will lead to fights in the house and I tell to save the money rather than spending like that on alcohol only…Those were the things I learned from the program." Furthermore, a lot of participants

recalled discussing how to distribute the workload both inside and outside of the house. “The topics of discussions used to be about role division among the couples, working together in household works and agriculture works” (woman from Chitwan).

Another thing that participants mentioned is content that is related to decision-making. A man from Chitwan recalled that he “learnt that we need to have conversations with each other before taking any decision.” They had discussions about shared decision-making that also included sexual relationships and consent. “…We discussed about what do when husband forces sex on wife, or if husband forces to do anything without wife's consent. We discussed that these are wrong. We also discussed about dividing role among ourselves and helping each other in home” (woman from Chitwan). Another woman from the Chitwan recalled that she “learnt about consent, and learnt that [nobody should] force each other in any activity that [a] partner doesn't want to engage in. Our sexual intercourse should be mutual, and [we] shouldn't force each other.” Content included any family-related decisions. “We should…practice mutual decisions in all family matters” (man from Chitwan).

Furthermore, many participants discussed learning about how to handle their relationships with their parents and/or in-laws, brothers, sisters, and children. Specifically, participants talked about learning about the relationship between mother-in-law and daughter-in-law. “The issues discussed were mostly about the relationship between husband and wife, and relationship between family members. Like we talked about the mother-in-law and daughter-in-law relationship, and how we can improve such relationship by proper communication” (woman from Chitwan). They also talked about the importance of maintaining a good relationship with their children, as well as the effects that conflict among parents can have on children. As a woman from Chitwan states, “we learnt from the conflicts among the couples, and its impacts on

the children and their education. We understood that if the couple [is] happy, the family will be happy…we learnt about treating children on [an] equal basis."

Another topic of discussion that participants remember is having to go out in to the community and share what they have learned. This is the community mobilization aspect of the program. They mentioned remembering conflict resolution tactics (i.e. talking about what the issue is and finding a solution to the problem) as well as what specific actions that they need to take if they intervene in cases of domestic violence in their village. A man from Nawalparasi recalled "we were taught to go and solve if there is any fight in the community…we also learnt to bring justice to the victims." Furthermore, a woman from Nawalparasi remembered learning that she should "[report] to [a] police station if there is domestic violence." Many of the skills that participants discussed participating in during LDGs sessions were related to increasing their capacity to speak in front of others; this was done so that participants were better able to go into the community to diffuse the information and to help them better able to handle cases of conflict.

Few participants failed to remember many of things that they had discussed during the LDG sessions. Male participants, more so than female participants, often discussed how they couldn't recall most or all of the program content. "…But it has already been a year and I might have forgotten most of the things" and another said he "can't remember all skills" he learned while in the class (man from Nawalparasi and Kapilvastu). One male participant stated that he doesn't recall what he learned while in the LDG groups, however he does remember learning about family related content from the radio program. This data was collected 18-months post programming, thus there could be issues with recall.

Phase III: Sharing New Knowledge with Immediate Social Network

The third phase of organized diffusion is when members of the participant group begin to share knowledge they found interesting with a selected person outside of the core participant group, often somebody in their immediate social network. Participants mentioned that the people who they had typically shared information with immediately with include their spouse, various family members, and then neighbors or other members of their community. This also includes inviting others to participate in any programmatic events like listening to the radio program, watching the street drama, or participating in family-member LDG groups.

Participants most often talked about sharing what they have learned immediately with their spouses. One woman from Nawalparasi shared that the "[radio drama] used to broadcast every week and [my husband and I] used to discuss about it." Another woman from Chitwan discussed how her husband would share what he liked about meetings with her. She said "he used to share what he liked about the meetings. Like he said what he learnt in those meetings, and convinced me that we should work together for the family, and help each other."

Others shared with their family members. A woman from Nawalparasi discussed how she would share with her mother-in-law. She says "after listening to the program, I used to get home and tell mother about the programs I had attended. And mother also asked what things were told in the program and I used to explain to her about it." A man from Nawalparasi recalled "we talked about [the program] with our family members and if we meet someone while we go out then we used to inform them about the things we learned. We used to tell them about the things that we have learned in the program."

Some participants talked about how they would share with their friends and neighbors about the program. More often, it was immediately shared with their spouses and family

members. A man from Kapilvastu remembered that he used "to tell my [neighbors the program] is good and has benefit. I used to bring the recording for them to listen. It also used to broad cast in the radio. I make them listen." A woman from Chitwan recalled "whenever we [had] gatherings, I used to talk to my neighbors and friends about the program. I used to talk about the importance of mutual decision making and how to improve marital relationship."

Most of what they would share was interesting, would improve their relationships or community, educational. Participants would share information that was related to improving marital relationships and conflict resolution, programming that was about saving money and making financial plans, decreasing the consumption of alcohol. Participants didn't explicitly discuss any information that they would not share with others. However, some participants indicated that they didn't share any of the program content with others.

Final phases: Spreading Information Beyond Immediate Social Networks

In the final phases of organized diffusion is when the information continues to spread from the intervention group to others, further and further into their distant social networks and eventually reaching enough people in their larger social networks to abandon a harmful practice. This is also when participants raise awareness and promote community mobilization and action in their community and potentially in other communities. They also shared their experiences with participating in community mobilization.

Men discussed how they would eventually reach out to their friends who were perpetrators of violence or who had unhealthy relationships with their wives to invite them to program events. A man from Chitwan recalled "I think those who listened to the radio program, they might have learnt at least something related to anti violence, marital relationships and

communication. But not everyone might have listened." A man from Kapilvastu recalled "one of my friends use to be unfaithful to his wife. Didn't care much of his house. I used to advise not to do that. He had kids too. I can guarantee that after I talk to him his habits are improved. I used to call him in the radio programs and street dramas as well." Men also discussed more often how they would invite others to come to program events and those people failed to show up, expressed that they didn't care, or were not engaged. One man from Chitwan said "we used to share with them what we learnt in the programs…[the community members] were not consistently engaged." Another from Chitwan described that "…men are busy and do not show interest in such activities. I did share about the programs. But they didn't come."

Sometimes, participants would only share information from the program because a situation would occur. An example of this is when a woman from Nawalparasi went to go intervene in a case in which a husband and wife in the village fought over the fact that the husband had married another woman. She says that they told the wife,

> "not to [scold him] and informed about the program Also told [her] to take her husband with her and he himself will bring positive changes after participating in the program. She asked when the program will take place, so we informed her that it was tomorrow at this time and that her mother-in-law also comes to attend that program. They went to the program, told about their problems, and the people from the program explained them everything and now they don't fight."

As described by a woman from Nawalparasi, "the program had provided books and posters. Elders used to sit in our yard and ask us about it. I told them about the program… [and] requested them to go to the program and gain the knowledge from it since it is here now. And they went to the program."

Furthermore, some participants had only shared what they have learned in casual encounters, while other participants have made more of an effort. For example, a man from Chitwan village shares that he shares when specifically asked, “I shared it with people who ask us about it. Like some people ask us ‘you guys do go to the radio program, so what did you learn?’ We tell about them about what we learn from the radio program.” Others have made more intentional attempts to spread the content. One man from Kapilvastu discussed how he “wanted to gather monthly to meet and discuss so that we don't forget the lessons of the program, we fixed a date too but it didn't happen... to spread awareness, we did programs like drama, stage program, video shows...” A man from Kapilvastu described that “if we were told to bring 2 people by our trainer I would bring” indicating that sometimes participants would only diffuse information at the instruction of intervention leaders.

The spreading of content from the program was not only done by members of the participant group. Those who weren’t in the participant group have participated in diffusing program information. A woman from Kapilvastu discussed how members of the community would share program events with others. She recalls that “whenever there were activities like movies, those who went to those activities used to explain things to those who didn’t go.” A woman from Kapilvastu says that “two times I took my [neighbor’s] sister who is also my [cousin’s] sister as my guardian for [the] radio program.” And when asked if she shares the information with those around her, the woman said “yes, she does.”

It is unclear how far into the social networks the information diffused. A woman from Nawalparasi said, “I didn’t go to other villages but I did inform about the event in my own village and neighborhood.” However, a man from Nawalparasi recalled that people “from different wards like 3 and 7” were present at the program. Furthermore, a woman shared that

some her friends had went to a community event, and that "they liked it…they were interested in [this program]…they were expecting it in their villages too," which indicates that diffusion went past village boundaries.

Another component of these phases of organized diffusion is community mobilization. Participants talked about intervening in cases of violence in their own homes, in their neighbor's homes, and in their community. Their discussion included perceptions of intervening, the actual act of intervening by the participant, and instances of a spouse, family member, or community member intervening in disputes. Participants mentioned that as the intervention begun, it was common to ignore cases of domestic violence that weren't within their own home. A woman from Nawalparasi recalled that before she hadn't intervened in others disputes because "at the time it was like, it is other's family problem and we should not get involved in it. But now I think that after staying in the same society we should all share our things and knowledge." As the program began, community members were not as open to having participants intervene in their disputes. They gave reasons that included the perception that cases of domestic violence were private matters. A woman from Kapilvastu shares that "in the beginning days we went to talk to one family. They said, 'it's their personal matter, why do you interfere?'" Participants discussed making sure to understand what the root of a conflict was in order to address the situation appropriately. They also mentioned instances when they handled a situation with the authorities in order to resolve disputes. A man from Chitwan recalled,

> "even in our community, there were few cases of violence. In one of the cases, we went and convinced the couple, and also the security agency (police) handled the case and made the husband sign a paper not to commit violence again. We also convinced him by

giving him examples of what his children might think of him. He seems to have realized his mistake and committed not to repeat such again."

Factors Influencing Organized Diffusion

Participants discussed many different factors that influenced their ability to diffuse program information as well as the barriers that held them back. One main factor that participants mentioned was confidence: the confidence they had gained from the program allowed them to be able to share the information they had learned and to intervene in cases of violence within their community more often. A man from Nawalparasi said that he didn't share the things that he learned from the program with others because he felt that he is "not so good at speaking." More often, participants discussed how they had gained more confidence and were now able to speak up. A woman from Chitwan claimed that the program events have "also helped me develop confidence to speak up."

Social proximity is another factor that influenced diffusion. Often, those who participants shared the information with were those in their immediate social networks, often a spouse first, then family members within household, family members who may live around them, and then to community members. A man from Nawalparasi discussed how he used to visit a shop after the program and would talk to the shop owner about what he learned; he recalled "I had to go to the shop to work and sometimes used to get late due to the program. [The shop owner] used to ask me and I told him that this kind of program has been running near our house and [teaches them] about the family."

Another element that participants mentioned was time. While the program was occurring, diffusion was happening the most. Participants mentioned that cases of violence decreased as

therefore there wasn't much of a need to discuss messaging. A woman from Chitwan said "I used to [go talk to the community a lot]. But now, it has decreased because now it's not much of necessity. Many people are now aware about it. The cases of fights and quarrels have also decreased a lot." A woman from Kapilvastu said that "before a lot of people didn't know. Later they started to ask us where did we go...then when we told them... We had some pictures of the program, we showed it them then they come to know."

There was a lot of discussion among participants about the responses they received when they tried to diffuse programmatic events. Some reactions were positive: there was a willingness to receive information from participants because they thought positive and visible changes in participants. Many thought the information was beneficial and would improve the community. A man from Nawalparasi recalled "then when we told them that we are learning something then they used to ask what benefit do you get from it? When we talked about the radio program based on the true events of the society.... problems and solutions... They used to appreciate the program and were interested to include their family members too." Some of the reactions participants received were negative. A man from Kapilvastu talked about how others said to him that the "radio programs are useless. There is no benefit." Furthermore, participants discuss that there are thinking that matters involving domestic violence are private and thus shouldn't be discussed.

In relation to intervening, participants discussed the reaction of community members to them stepping in. Responses to those who intervened were varied among participants. In some instances, participants said that people would respond positively. A woman from Kapilvastu shared, "some used to say I was right… Some disliked some liked [when I went to solve community problems]." These weren't the only negative reactions. A woman from Nawalparasi mentioned,

> "Like when there were fights, they told us, why you care to interfere in our matter. There will be fights between couples, and family members and asked us why we interfere. Then we tell them, we learned all this kind of things from the program and it is also our right to tell you all of these things. Ladies didn't speak but the gents told us to leave because we will also fight after listening to them (smiling)."

Although the participants were able to diffuse much of the program information, they mentioned various barriers that prohibited them from being able to diffuse any information into the community or to invite others to programming. One main factor was distance: participants weren't completely able to teach learnings to those who were further away. When asked if she taught others what she had learned, a woman from Nawalparasi stated "yes, to those who are near. Not from far" and that "all of [the] village knew. During the video program everyone was invited." Some thought that there weren't enough ignorant people or people who participate in the behaviors associated with domestic violence, thus they didn't feel the need to spread content messaging. One man from Kapilvastu shared that "this program would have been more effective if it was taken to a lower class or Dalit." Another man from Kapilvastu said "if the program was given who need it desperately, change would have happened faster... it would have been more effective."

Changes Made Among Participants and their Social Networks

The goal of organized diffusion is to create broad level changes in knowledge, behavior, or attitudes in a population. Participants discussed at length the noticed changes that they have seen among themselves and among members of their social network since the program has

begun. This summary of changes include behavioral changes, changes in attitudes or beliefs, or no changes in either of those mentioned previously.

Overall, participants shared how they saw changes in themselves that were mostly related to how they manage their relationships. Some of the things that they noticed having changes in is their ability to understand their spouse better, improved communication in their relationship (consulting about financial matters/land with wife). A man from Chitwan said,

> "[My wife and I] have realized the importance of clear communication among couples. [It's] not just about oneself but you should also think from your partner's perspective. This learning has definitely been into practice…In the past, we used to have quarrels because none of us compromised. But now, after the program, we talk clearly about any misunderstanding and now deal with the situation together."

One of the most notable changes that many participants noticed in themselves is that they have better anger management skills, thus have less quarrels with their spouses. "Like sometimes I get angry and then I remember all the things I learned then I control my anger" (woman from Nawalparasi village). A man from Kapilvastu said, "I control my anger... I learnt it from that program..."

Women, for the most part, mentioned that they are better able to express their feelings and are able to speak up to their husband and/or family members. A woman from Nawalparasi shared, "I speak up for myself. I don't get [scared] now." Another woman from Nawalparasi said, "I felt that we should not argue with our elders and listen to whatever they say in the past. I used to tolerate some of my husband's behavior before. I couldn't express the way I felt because I felt inferior to him. But after going to the program, I learned that we should not tolerate wrong things even if it is from elders or younger." Women have been able to have an increased ability

to not only express themselves, but specifically to express wishes of buying something or participate in decision-making. As one woman from Kapilvastu recalled, "after that program I can express my feeling with husband…if I don't want or wish to do I can say that now. If I have a desire to buy something I can say that to my husband."

Participants discussed that since participating in the intervention, they have an improved sexual relationship with their spouses. Women felt that they were better able to assert their opinions related to sex with their husbands. A woman from Kapilvastu said that before the program "we could not talk about sexual relation openly as it was a secret topic. Now we can discuss openly more about it. We gain confidence that we should not hide it." A woman from Nawalparasi discussed how her husband no longer forces sex on her. She shared, "he did not know about it before but now he doesn't force me into it if I don't want to. There are changes in these all things."

One major change among men was decreased alcohol consumption. Decreased consumption in alcohol also allowed them to save money and spend more time with their families. A man from Chitwan shared numerous changes he had noticed in himself.

> "Firstly, I have completed quit alcohol. I used to drink in the past. I had heard about it in the radio program where the husband who used to drink alcohol and always quarreled with his wife. After listening to the radio program, I also decided to quit alcohol… When I used to drink alcohol, I wasted a lot of money. So, I can save a lot of money. The money that I used to waste in alcohol can now be used for [something?] for my child."

Closely related to alcohol, male participants talked about not spending as much free time outside of the house and/or wandering with friends. They also discussed being more communicative with their wives about their activities outside of the home. For example, a man

from Kapilvastu said, “before I used to wander around with my friends without caring about my home. Even if [my wife] called me I wouldn’t care and answer her carelessly… but after the program I realized that what I was doing was wrong. So I am changed and reduced those habits.” Furthermore, because they have decreased their consumption, there are less instances of quarreling with their wives as a result.

Participants talked about sharing responsibilities with their spouses more since the programming. They said that now they are more likely to divide work. Women discussed becoming more active in certain activities, like going to help their husband with work, doing things on their own without needing the assistance of their husband, and being better able to express themselves. Men discussed how they are less likely to have a dominating place in their household. A man from Nawalparasi recalled, “in the beginning I didn't listen to anyone. I was senior in the house so I handled it. I never suppress my family but still I had the dominance over my wife and sister in law. Later when I realized that we should not be dogmatic and let them learn what they want. All was right. if they want to go to participate we should let them go.” Men also discussed taking on more chores, such as washing dishes and cooking. A man from Kapilvastu said that now “[me and my wife] divide work too... If I work outside of the house she handles the kitchen. In the evening we both work together in the house.” Another man from Kapilvastu shared, “I wash all the dishes when I’m at home.”

Many of the participants expressed that they felt that they had increased confidence in relation to speaking in front of others and feel that they are more likely to intervene in cases of conflict as a result. A woman from Chitwan shared, “I do speak confidently. In the past, I lacked confident and also lacked the understanding of the issues. Now, I have learnt about a lot of issues, and since I have knowledge on the issues, I feel more confident to speak about it.” They

discussed how they felt more confidence to speak about what they think is right and wrong and to speak up for what they believe. “We used to ignore domestic violence in our neighborhood thinking that it's their personal matter... but now we go and try to settle it by finding out the reason and advise them not to do that” (Woman from Chitwan). A man from Chitwan says that after participating in the program, “I am able to speak in the community. I can speak up when there is injustice in the community to anyone.” Although he used to do that before the program began, he “can do so more frequently and confidently now.” They also felt that were more confident to report to the police in cases of domestic violence that occur within in their community.

Participants noticed changes in the manner in which they parent their children. Many participants mentioned that they do not beat their children as often or at all. One woman from Nawalparasi shared, “I used to beat my children but it has been one year since I have beaten them. [My husband] even tells me not to yell at children.” They also don’t fight among each other in front of children anymore because they understand that it is negative. .” A man from Nawalparasi said that he doesn’t fight with his wife much because he learned that “It will have a bad impact on the children’s as well and they might get scared.” A man from Chitwan said, “in the past, we used to talk harshly with children at times. After being in the project, we realized the importance of proper communication and talking politely with the children, and convincing them. Even the children realized the importance of polite conversation, and we felt we have developed respect among each other.”

Furthermore, participants discussed changes that they have noticed in their spouses since the programmatic events have begun. “We have a unity now and we understand each other more... when husband and wife are good same flows to their children to their family...” (man

from Kapilvastu). Women mainly talk about how their husbands don't drink as much. A woman from Kapilvastu talks about the many changes she has noticed in her husband and notes,

> "He used to drink and fight. He used to feel embarrassed that I was social worker... so it was very difficult to solve this... how I used to deal with this was... I used to run away when he got violent... it was embarrassing to anyone if I had bruises... and also men are physically stronger than us... he also wanted to have sex when he was drunk but I didn't wish to... His ejaculation time was longer than usual which I didn't enjoy either so we used to have fights on this matter too... But now after this program he is changed... now I tell him not to drink if he wants to have sex with me... he agrees on that... this is changed."

Additionally, participants discussed seeing changes in their family members. This could be as little as seeing specific behavioral changes or broader changes in the mentality of family member, including elders, siblings, and children. Among the parents, in-laws and older family members in general, participants noticed overall positive changes in them. A man from Kapilvastu said, "we have unity now and we understand each other more…when husband and wife are good same flows to their children to their family…it affects their neighbors…and the village and the society…we have felt that."

Participants discussed improved relationships with the elders in their household, which can include decreased quarreling and increased efforts to maintain an understanding among each other. A man from Nawalparasi shared that his mother "used to nag a lot and complain a lot to me, my wife and even my kids. Now after she learnt she convinces us to do something in a nice way. She gives good advices to my sons..." A woman from Nawalparasi described improved relationships among her entire family, specifically between her mother and father-in-law. She

said, “before they used to scold the sister-in-law if [she made] any mistake but now they care to say it in a better way.” A woman from Chitwan said about her aunt “quit smoking after participating in these programs. In the past, she smoked as much as 1 packet of [cigarette].” There was also a change in the response that a mother had in reaction to her son doing chores. A man from Kapilvastu said, “yes, my mother used to feel bad when we had to wash dishes when my wife is not around... But I convinced her that the chores are for the family members... we have to help each other... And now it's good.” There was also discussion among participants that they had not seen any changes or had seen few changes in their parents, in-laws, and aunts and uncles. This was expressed by few of the participants, as most had discussed their being changes. Many had positive relationships with their family members before the program, and thus there were no changes.

Participants discussed changes that they had noticed in their siblings as well. They shared that their female siblings and in-laws have been more helpful with sharing chore loads and noticed that the relationships between their siblings and spouses have improved. One man from Nawalparasi said that his brother and sister-in-law “have a helping attitude. She is a teacher and he does chores when she is not home. [He] looks after the cattle.” A woman from Kapilvastu noticed that the relationship of her brother-in-law and his wife had improved because now they have a “helping attitude towards each other…” and better “understanding.” A woman from Kapilvastu said that her husband and his brother’s relationship “[had] improved [more] than before. Before he did not use to have a good understanding with his brother but now it’s nice and helpful.”

Changes were noticed among the children of participants. Some of the changes that they saw in children include that children don’t get as angry with their family members, they are

generally more aware of events concerning their family, are more aware of the need to participate in financial savings, and listen to their parents more often. A woman from Chitwan said her children "used to get angry sometimes, but now they are more aware. They realize that they should understand parents' feelings as well." Another participant discussed that children are more aware of how to limit expenses, to be more helpful with home activities, and to better communicate with their parents when they plan to leave the house or to ask for money. A woman from Chitwan says "our sons have also grown older. We also discuss with them about our family and household activities. They didn't use to help much in the household activities in the past. But now they do help. We also discuss frequently about our family."

Children have also stepped up to resolve conflicts within their homes. A woman from Chitwan shared, "my daughter used to say to my husband, 'Father you have gone to the program, and have also listened to the radio programs. So, you both shouldn't quarrel.' If she notices us quarreling, she would remind us about the program." A woman from Kapilvastu said, "before [my children] used to be scared and couldn't talk as they had seen my husband beating me. Now they express. If they need money they only used to ask money with me. If they had to ask with their father, they would message him as they could not talk in front of him but now they ask him face to face which is also a positive change in my view."

According to participants, there were positive changes in the lives of members of their community. Overall, participants have felt that there have been less cases of violence and less public disputes in their communities. A woman from Chitwan said, "even among neighbors, we see that the cases of violence has decreased than the past." Another woman from Chitwan shared, "there is a family nearby our [neighborhood], and the couple used to quarrel. We used to go, and discuss with them and convinced them not to fight, and think about their children and

their future. Now they have changed for good." Another woman from Nawalparasi talked about how couples in the community have started to share chores more equitably. She said, "most of the couples attended the program. Before the program, almost all the works were done by women from washing clothes, bring water, cleaning toilets and even putting the toothpaste in the brush and handing it to the husbands, but all of those things have changed after listening to the program." Furthermore, a woman from Kapilvastu noticed that among community members there is a "change in mentality... small things like one husband shared that before used to hesitate to remove his wife's undergarments from the place you keep them for dry in her absence but now he is not hesitant." Furthermore, a man from Chitwan discussed how "there is an example in [the] community where a husband has started to work together with his wife now to discuss on finance related transactions and savings."

There were changes seen in community members who specifically participated in programming. A man from Kapilvastu recalls that "the couples who were involved were benefitted. From the community those who were interested and active got benefitted but some were hard on us. Not all are equal. In our Tharu community some went for the program for some weeks and left saying it "useless"..." A woman from Nawalparasi specifically noted, "there are 2 couples who did not listen [to the program] at all. They didn't change."

Men talked about changes they have seen specifically in their friends, even friends who they brought to program events. In some instances, they said that their friends have improved. A man from Nawalparasi said that one of his friends "used to drink and beat his wife and children... fighting was almost daily. we gather friends who also take classes like us. We talked to him and now he stopped beating his wife. He did not stop drinking though. After that we never heart him

beating his wife." In some instances, the friend had stopped beating their wife but hadn't improved their alcohol-related behaviors.

There is also evidence of there not being any changes noticed in the participants, families, and community members. Participants also indicated that they are not sure if there are as many changes due to domestic violence being a private issue that occurs within the home, but there has been a decrease in public disputes. One of the participants mentioned that some community members didn't understand the program events and some did, thus indicating that change could be related to whether or not the material is easily understandable. A woman from Kapilvastu said that she saw changes in the behaviors of her neighbors, but not in their mentality. A man also discussed how he invited his friends to the programs but didn't see any changes in them, either due to them not showing up or because they didn't seem to care about the program.

Some additional barriers to changes described by participants include levels of community engagement. One man from Chitwan said that he doesn't know if there have been changes in community members because all "were not consistently engaged. So, [I'm] not sure if any significant change occurred. For those who are willing to change, they would change for good. But for those who are not willing, we cannot really do anything for them, nor would they bring any change in their behaviors." Some participants shared that their family members or neighbors were unable to be engaged for various reasons and didn't learn any new knowledge or demonstrate any change in behaviors.

This concludes a summarization of the results in this chapter. Chapter 5 will discuss the implications of these results.

Chapter 5. Discussion and Conclusion

This chapter consists of a discussion of the results that were presented in the previous chapter. The aim of this study was to examine diffusion as a result of the 'Change Starts at Home' intervention using the organized diffusion framework. The study addressed the following research question:

How has the 'Change Starts at Home' intervention diffused into the community to influence changes in norms surrounding intimate partner violence in Nepal?

Overall, the intervention did seem to create some normative shifts surrounding IPV among the population which is evidence of diffusion. While nascent in the field of IPV, the broad findings of this study corroborate earlier studies examining organized diffusion of social norms around IPV and women's empowerment, including Tostan's CEP intervention (Cislaghi 2016; Starmann 2018; Cislaghi 2019). The present study contributes novel findings on how the process of organized diffusion can contribute to norms changes among a population in relation to IPV.

Phase I: Interest About the Intervention Before the Program Begins

In the first phase of organized diffusion, participants express interest about the intervention before any programming has even begun. According to Mackie et al., this group of participants, known as the critical mass, is often self-selected, should consist of both men and women, and should include early adopters and notable leaders in the community. For the most part, this reflects the make-up of the core participant group in this intervention. The early interest and support of the intervention that was displayed by most of this core group is necessary at the beginning of the intervention to facilitate successful abandonment of IPV (2009).

The results indicate that there were both positive and negative reactions to the program among participants and community members. Many participants felt positively about the intervention because of they were interested in the prospect of learning something new; the desire to learn was also a motivating factor for participants to engage in the SASA! intervention (Starmann 2018). Negative attitudes were also expressed by participants, however not as commonly. These sentiments may have arisen out of confusion, which according to other studies, could be due to the novelty of new knowledge (Rogers 2003).

Phase II: Acquiring New Knowledge and Discussion Among Participants

In the second phase of organized diffusion the participant group learns the new knowledge. This is a critical stage of organized diffusion, because members of the selected participant group need to actively take on the new knowledge and make the commitment to push for the abandonment of IPV. If the group doesn't take on the collective commitment to abandon norms associated with IPV, it cannot and will not spread continue to spread any further into the community. Furthermore, the commitment to continue to attend the LDGs and learn more of this new knowledge also creates a new social network among members of the core participant group. This second stage of organized diffusion hasn't been thoroughly explored in previous research. Overall, results show that many participants embraced most of the programmatic messaging and were committed to challenging the norms and behaviors associated with IPV. When participants have positive attitudes about the intervention innovation, this has been associated with the stronger intention to adopt the innovation, maintain the innovation, and talk about it with others around them (Smith 2018). Furthermore, it has been found that having a core group of motivated activists is necessary and effective at increasing the awareness of wide-spread discontent with

current harmful practices (Cislaghi 2019). Relevance of the content to the participant is an essential component for diffusion (Starmann 2018). Some participants were receptive to the content because it related to their experiences; Starmann et al. found that participants in the SASA! intervention had expressed similar sentiments in relation to them adopting the intervention content (2018).

The variation of acceptance of new knowledge is similar to results in other interventions. Even though many embraced the new knowledge, few participants felt that the content of the program was not useful to them and did not continue to participate, similar to what occurred in the intervention group in the SASA! intervention (Starmann 2018). Participants are more inclined to embrace and adopt knowledge they feel is useful and relates to their situations, which was mentioned by a few of those who didn't adopt the intervention messaging (Rong et al. 2013; Starmann 2018). The lack of relevance of content to some members of the core group presents a barrier to the diffusion of the intervention into the greater community. However, the extent of the disinterest was considerably lower among study participants than that expressed by participants who found the content relevant for themselves and others in their social networks and communities.

Phase III: Sharing New Knowledge with Immediate Social Network

This phase of organized diffusion involves participants sharing the new knowledge with selected people outside of the immediate core group, often those in their immediate social network. This phase is important because it begins the process of diffusing anti-IPV messaging into the broader social networks of core group members. Also, this time spent sharing this new knowledge can promote discussion between participants and their peers which has been found to

potentially change communication norms making it more socially acceptable to talk about certain health related topics (Latkin 2016) and can strengthen existing social networks. IPV is a private matter, but the results demonstrate participants have become more comfortable discussing the issue within their household and in public settings.

Most often, participants mentioned that they shared the information with their spouses and family members, and less often they mentioned neighbors and other community members. This was a similar finding among the CEP participant group (Cislaghi 2019). Processes of diffusion can be better facilitated when the listener and speaker know each other well, which can explain these results (Lau et al. 2001).

When participants remember much of the relevant programming and are talking about this information with others, diffusion occurs faster (Rogers 2003). Much of what the participants shared was often information that they thought would improve their relationship or community and what they thought was interesting from each class. This is very similar to what some participants expressed in the CEP intervention that also utilized the organized diffusion model to prevent FGM/C (Cislaghi et al. 2016). Other motivating factors, including sharing what they thought was useful, echoes additional findings from studies that examined innovation adoption and sharing (Cislaghi et al. 2016; Smith 2018). Existing literature has found that participants may be motivated talk to others about an innovation in order to make a good impression or to appear as though they know more than others (Smith 2018). Although this issue was not supported by the results of this study, it may be an additional factor.

Final Phases: Spreading Information Beyond Immediate Social Networks

In the final phases of organized diffusion, the new knowledge continues to spread further and further into the participants' social networks, eventually reaching enough people who are committed to the abandonment of IPV. Based on study results, it is difficult to assess how far into the social networks the intervention had diffused. Participants indicated that there were people outside of the intervention core group who would intervene in violent cases or who would tell others about the intervention information and the events that they had, so this indicates that diffusion continued beyond the core group and those with whom they initially shared the results. These findings are similar to a study on CEP, which found that information recipients had also become active diffusers and this had contributed to further norms changes among the population (Cislaghi 2019). However, the extent of this latter stage of diffusion was less frequently and less precisely discussed compared to the previous stages, potentially suggesting less diffusion beyond immediate social networks. The short duration of the intervention (9 months) compared to other interventions that were years (e.g. CEP, SASA) in duration might account for this finding. The indication of any diffusion beyond immediate social networks with only 9 months of programming is promising and worthy of further investigation.

A number of factors that have been shown to impact diffusion were mentioned in this study. First, participants most often talked about how they remembered most of the programming from the radio program. This was referenced more often than any other intervention component (i.e. LDGs, street drama). This could indicate how the radio program could be an effective pathway to facilitate spreading information into the community. In the analysis conducted by Cislaghi et al. on the same intervention, they found that TV was the most common media of IPV

messages followed by radio, while messages via a community leader was the least common (2019).

Another pathway is interpersonal communication and dialogue. This is relevant to LDG discussions and the sharing of knowledge between participants and members of their social networks. The results indicate that discussion among community members as well as visibility of intervention activities within the communities motivated community attendance to intervention activities, which echoes findings from the SASA! intervention (Starmann 2018). This also creates an opportunity for participants and members of the community to strengthen their social ties by encouraging discussion among social networks. Findings from Papa et al. indicate that interpersonal communication and dialogue facilitate the discussion of sensitive topics in a way that supports social stability and social change in community and family dynamics (2011). One participant mentioned that she shared the information with a women's group, which was similar to a finding by Mackie et al. in that women from the core group then diffused some of the discussion in their local women's groups (2004) and other relevant parties.

Successful mass abandonment of harmful practices (like female-genital mutilation/cutting as described by Mackie et al. 2009) have noted that is important not only for the core group to re-evaluate the practice and to recruit others to do the same, but also for those who they recruit continue recruiting and re-evaluating IPV, which is implicated by that finding. Many participants made statements similar to "everyone in the village knew," but it is difficult to confirm how accurate those statements are. Mobilizing one community eventually stimulates the interest and eventually extends to overlapping communities that weren't directly targeted by the intervention (Mackie et al. 2009). Other participants shared that the diffusion went past village boundaries and noted that people from other wards had participated in the events. This is important because

it demonstrates potential for the intervention's anti-IPV messaging to continue to diffuse into overlapping communities.

The end of the organized diffusion process reaches a point at which there is the complete abandonment of a practice among the entire community, also referred to as the tipping point (Mackie 2009). What remains unclear from the study results is how far the diffusion of information went and to what extent there was the abandonment of IPV in the community. Many participants reported noticing that the incidence of public disputes has decreased since the beginning of the program, which could indicate the beginnings of a new social narrative to abandon IPV. Previous studies have mentioned that once new norms emerge in the larger community, there are often public events (i.e. declarations of abandonment) that solidify the abandonment of harmful practices (Mackie 2009; Cislaghi 2019). There weren't community-wide declarations that indicate sustained abandonment in these results. However there was an instance in which a man who had perpetrated IPV had publicly signed a declaration not to do so anymore. Since IPV is viewed as a private matter, it is possible that the practice continues within households and participants don't have the knowledge of its occurrence. The findings from the quantitative portion of the study suggest some decrease in IPV among LDG members. However, widespread changes relative to the control condition were not evident, suggesting the need for greater time to realize the tipping point for behavior (Clark, under review).

Factors Influencing Organized Diffusion

There were many different factors that influenced the diffusion of information from the 'Change Starts at Home' program. The confidence that participants had was something that many had mentioned that they acquired during the program as a result of the LDG events;

previous studies have found that participants of organized diffusion interventions often speak differently, especially in public (Cislaghi 2019). This can be important because, like Cislaghi states, public speaking skills can help these participants participate in discussions about healthy behavioral actions with their social network and they will likely discuss improvement strategies for the broader community (2019).

As mentioned previously, social and geographical proximity to participants and direct programming affected diffusion; this was a major factor that influenced diffusion in this study. This finding is similar to the results of other studies in that those who were closest to core participants were more likely to be exposed to the intervention messaging/events than those who were socially or geographically further (Lau et al. 2015; Abramksy 2016; Cislaghi 2019). It has been found that closeness to participants who directly engaged with the intervention was found to be the strongest predictor of intervention exposure (Pickerin et al. 2017).

Changes Among Population

Results show how organized diffusion can influence changes among the population, although at varying levels. There were many changes noticed mostly within the participant group, but also somewhat among family members, and community members. Another study examining organized diffusion and norms found that organized diffusion increased positive changes in behaviors that were sustained by harmful social norms changed, more often among participants and less so among community members (Cislaghi 2019). This suggests that anti-IPV messaging and knowledge have become part of a newer social narrative. Specifically, there were changes that included a decrease in physical and sexual violence among couples, at various

degrees, within families, and among community members, which is similar to the results of other interventions (Cislaghi 2019; Diop et al. 2008; Abramsky 2016).

Many of the changes that participants noticed in their relationships challenged prevailing norms surrounding IPV. The intervention challenged rigid gender roles; many of the changes described of men included that they would complete more household chores and would be more open to consider the opinions of others in addition to their own. Overall, women's decision-making autonomy increased because they felt that they are better able to express themselves and do so more often. These findings are similar to what has been found in other interventions (Abramsky 2016; Tostan 2018; Cislaghi 2016).

According to existing literature, addressing major risk factors for IPV, like alcohol, is critical for influencing norms changes in populations (Ellsberg et al. 2014). There were many changes in alcohol consumption among male participants and their male peers, which is a finding that isn't greatly explored in existing literature on diffusion and norms change.

Cislaghi found that the way participants take care of their children changes (2019). In this intervention, either children's behaviors changed or the relationships participants had with their children improved. This has many positive implications. When there is reduced violence within households, this begins to break the intergenerational cycle of IPV perpetuation because it decreases visibility of IPV to children in the household (which is a risk factor for perpetration and victimization of IPV). As a result of the program fathers discussed becoming more involved in childrearing activities, which also indicates the increasing the distribution of gender-based responsibilities more equitably. The children of those participants are also more likely to grow up with anti-IPV sentiments. They themselves have the potential to be more likely to advocate against IPV, as they have been discussed intervening or reminding their parents not to quarrel.

Some participants reported little or no changes in themselves, their family members, and their community members as a result of non-acceptance of messaging and lack of participation in events. Similarly, participants were found less likely to adopt if they felt that they didn't need to change. Similar findings have been documented in the literature (Starmann 2018; Cislaghi 2019). Participants indicated that this could have also been due to others not being consistently engaged in the program and people not understanding the content. The lack of understanding may stem from a few factors, such as language barriers, differences in educational levels among program participants, and other differences that may be a result of the vast diversity of Nepal (Ministry of Health Nepal 2017). Thus it is important for interventions like Change Starts at Home to work toward effectively engaging populations and making content understandable for diverse populations.

The results indicate that organized diffusion has had the ability influence some normative changes surrounding intimate partner violence in Nepal through the Change Starts at Home Intervention. However, there were barriers and challenges to complete diffusion of the intervention and the complete abandonment of IPV related norms. It is imperative that the diffusion persists and changes continue to occur after time passes.

There are some limitations to this study. It is difficult to accurately assess just how far the intervention diffused into the community and how far actual changes have occurred in participant's social network due to the data focusing on the intervention group's perspective. Given that these interviews were conducted at the 18-month follow-up, there could be issues with recall and recall bias. Furthermore, participants perceptions of their own actions regarding the spread of program content and community mobilization efforts could be influenced by social desirability bias, they may have responded what they thought was expected of them. Finally, any

changes that were noticed could have resulted from other influences and interventions unknown to the research team conducted in the same population.

Implications and Recommendations for Future Research

The findings from this analysis have implications for public health research. The findings suggest that there is potential for organized diffusion to influence social norms changes surrounding the harmful practice of IPV. The study of organized diffusion in public health is not extensive; this research adds to the recent and mostly theoretical findings of organized diffusion on social norms change and harmful practice abandonment from the perspective of participants that have, for the most part, agreed and engaged in ending IPV in their communities. This analysis gives a qualitative understanding to the way that intervention activities diffuse into the communities in which it was implemented to address a practice that has deeply rooted social norms. Furthermore, this thesis gives insight into the various barriers and challenges to creating and sustaining social norms changes through diffusion.

Future research should examine the most effective mechanisms for organized diffusion to create changes in other demographic areas and address any barriers to diffusion and change that were presented in this analysis. It should also be examined in other geographical contexts, and with other types of harmful practices. Researchers should examine how community mobilization within social networks can effectively and efficiently create social norms change and decreased perpetuation of IPV. The initial group's adoption of program material and commitment to abandoning IPV is critical to diffuse into their social networks, thus it can beneficial for researchers to consider how to fully engage the initial core group or to assess how much engagement is need among the initial group is needed for successful diffusion (Mackie et al.

2009). Finally, researchers should explore other mechanisms used to facilitate the diffusion process (other than LDGs, radio programs, and street dramas).

Conclusion

In conclusion, this thesis gives a qualitative understanding of how organized diffusion influenced social norm changes surrounding IPV as a result of the Change Starts at Home intervention in Nepal. This work adds to the shallow depth of evidence on organized diffusion and social norms change related to IPV prevention. Although it is unclear how far the anti-IPV messaging and IPV abandonment diffused into the community, this analysis gives insight into the facilitators and barriers of the diffusion process and resulting changes. Future research should seek the most effective mechanisms to sustain diffusion and expand further into the social networks in order to work toward the abandonment of IPV.

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