

Jenga Dada:

A scalable model to empower women by
reducing gender-based violence and
supporting reproductive and economic agency

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Purpose

This slide deck was created as a stand-alone product to provide an overview of the *Jenga Dada* (“Lift Up a Sister” in Kiswahili) intervention. It highlights the co-design, content and findings from a recent RCT (randomized controlled trial) of the Jenga Dada model.

The goal of Jenga Dada is to improve women’s reproductive health and economic participation while reducing multiple forms of gender-based violence (GBV) including intimate partner violence (IPV), reproductive coercion (RC) and economic abuse (EA).



VSLA member receiving her certificate for successfully completing the Jenga Dada program (Uasin Gishu, Kenya)

Background | Gender-based Violence (GBV)

Jenga Dada is unique in that it focuses on multiple forms of GBV that co-occur in many women's lives, impacting their safety as well as their financial security and reproductive health.

Intimate Partner Violence + Reproductive Coercion

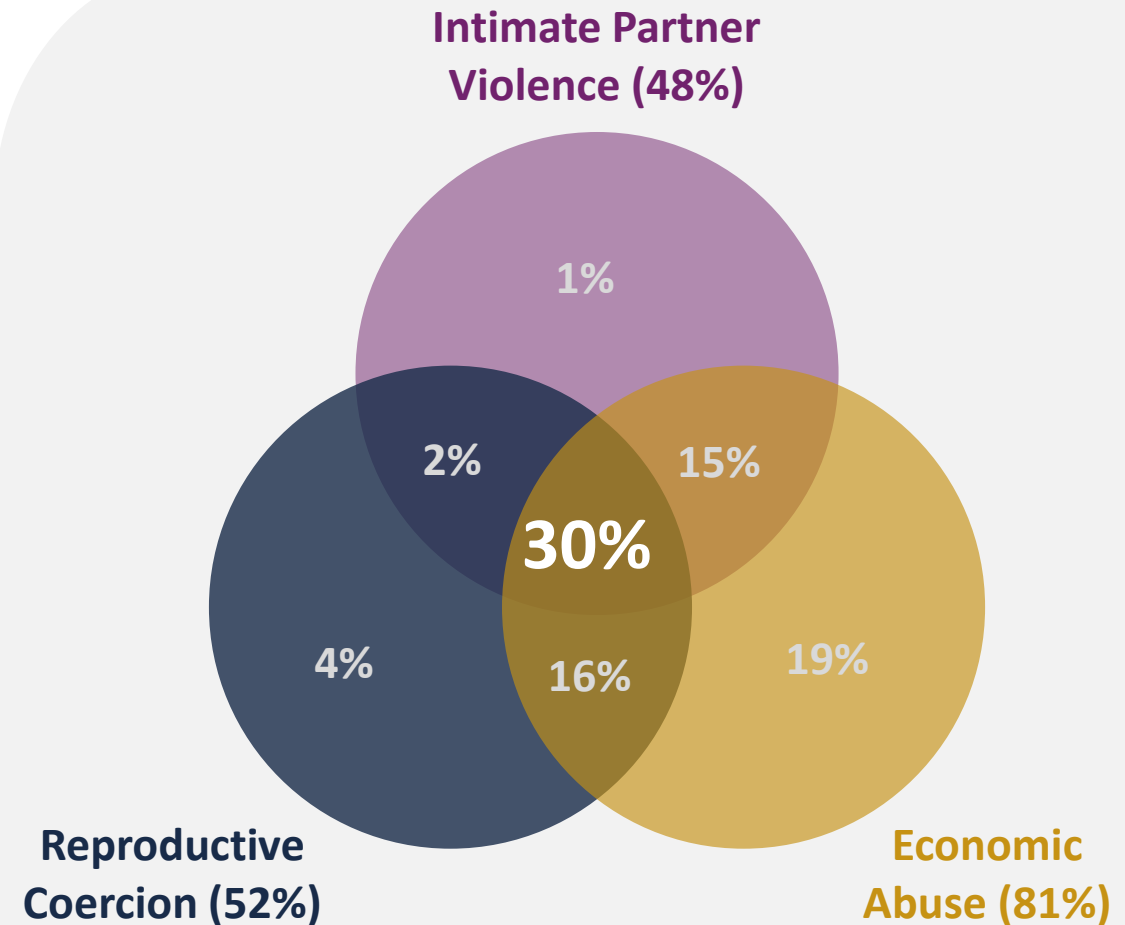
Worldwide, between $\frac{1}{4}$ and $\frac{1}{2}$ of all women report experiencing IPV from male partners.¹ Reproductive coercion (RC) describes behaviors by male partners or family members designed to interfere with women's family planning (FP) use or pregnancy decisions.^{2,3} **Women experiencing RC are 4.7 times more likely to report experiencing unintended pregnancy and 8.0 times more likely to report experiencing IPV.**^{4,5}

Economic Abuse

Economic abuse (EA) involves male partner behaviors that control a woman's ability to acquire, use, or maintain economic resources and often includes restricting funds for basic needs (e.g., food, healthcare).⁶⁻⁹ **Multiple studies across Sub-Saharan Africa and elsewhere have documented that EA is associated with reduced control over reproductive decision-making and increased risk for IPV.**^{7,9-12}

GBV Prevalence among VSLA Members

In Kenya, a recent study among Village Savings and Loan Association (VSLA) members found that **48% had ever experienced IPV, 52% had ever experienced RC, and 81% had ever experienced EA.**¹³



Venn diagram showing the co-occurrence of forms of GBV ever experienced by VSLA members in Uasin Gishu, Kenya (n=279).¹³ Only 12% reported never experiencing IPV, RC, or EA.

Background | ARCHES + Girls Invest

Jenga Dada combines two evidence-based interventions that address GBV, sexual and reproductive health and rights (SRHR), and financial literacy and control, taking a **wholistic approach to increasing women's agency.**



ARCHES

ARCHES ([Addressing Reproductive Coercion in Health Settings](#)) is a brief single-session, clinic-based model designed to address IPV and RC among women seeking contraceptive care and has been demonstrated to increase women's control over reproductive decisions and reduce IPV in multiple trials, including two in Kenya.¹⁴⁻¹⁷

The most consistent feedback from ARCHES participants has been the need to offer the program at the community level.¹⁸



Girls Invest

Girls Invest is an economic empowerment intervention that has been adapted for use and evaluated via an RCT among young women in Nigeria. Results indicate that Girls Invest reduces risk factors for IPV, including reducing economic vulnerability and increasing self-efficacy to cope with economic abuse from male partners.¹⁹

Background | VSLAs

Jenga Dada is integrated into village savings and loan association (VSLA) programming which provides a pre-existing, scalable platform to jointly address GBV, SRHR, and economic empowerment.

What are VSLAs and why embed Jenga Dada in this platform?

VSLAs focus on group savings and access to small loans. VSLAs predominantly serve women, are self-managed, operate in at least 77 countries, and include more than 20 million participants, with the greatest concentration in East Africa.²⁰ Importantly, VSLAs serve women who do not have access to formal financial structures, i.e., the poorest and most vulnerable to all forms of GBV.²¹

Previous research has demonstrated that embedding health programming in VSLAs can improve multiple health-related outcomes.^{22,23} Unlike previous VSLA models addressing GBV and health, Jenga Dada is implemented completely within existing, scheduled VSLA meetings without requiring additional modalities and resources, significantly enhancing acceptability and scalability.

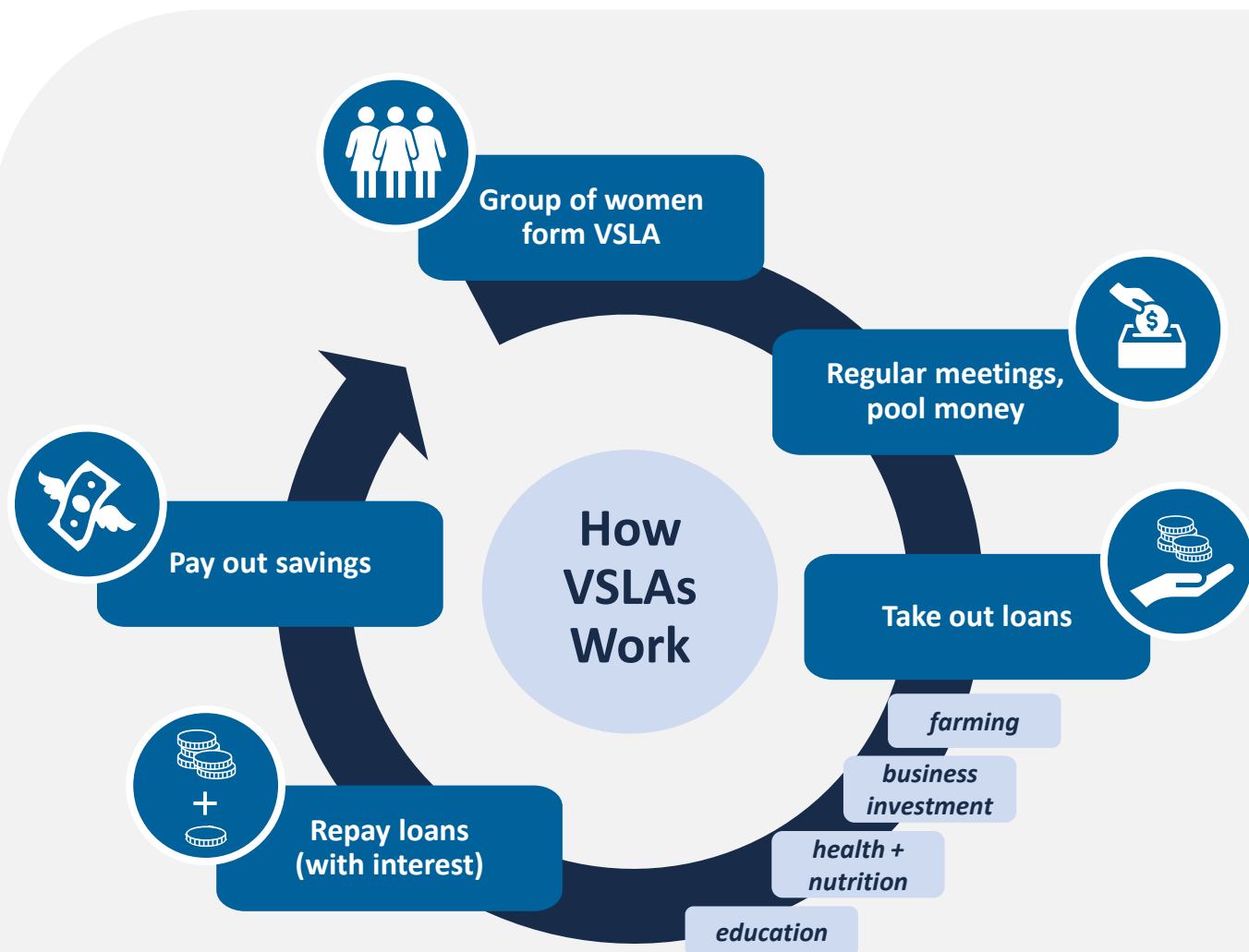


Figure adapted from [CARE VSLA Annual Report 2022](#)

Jenga Dada | Co-design

Jenga Dada was developed via a co-design process (see steps below) resulting in an 8-session curriculum integrated within regularly-scheduled VSLA meetings and facilitated by local NGO staff. Each Jenga Dada session is 60-90 minutes in length and includes structured education, critical reflection and development of group-based problem-solving and support. **Notably, no financial resources are provided to incentivize participation, significantly increasing the scalability of the model.**



Co-design workshop with CAB members to develop the Jenga Dada intervention (Eldoret, Kenya).

1

Formative Research with women participating in VSLAs was conducted to understand common EA, RC, and IPV experiences/coping strategies and suggestions for content and implementation strategies.

2

Community Advisory Board (CAB) was developed and included 8 VSLA group members who would validate the formative research findings and participate in co-design of the Jenga Dada intervention.

3

Co-design Workshop (2 days) was held with CAB and project staff to design the Jenga Dada intervention. This included making key implementation and intervention decisions.

4

Curricula and Materials were developed by project staff informed by decisions made during the Co-design Workshop.

5

Jenga Dada Pilot Implementation was conducted among three VSLAs with data collected to capture participant and facilitator feedback on the intervention followed by refinements to the model.

Jenga Dada | Content

Session Topic	Description
1. Introduction	Introduction to the <i>Jenga Dada</i> intervention, setting ground rules, and beginning to build trust among members.
2. Gender Roles	How traditional relationship roles affect women's economic self-sufficiency and reproductive autonomy.
3. Economic Abuse	How to identify and cope with EA, how to support peers or family members experiencing EA, and effects of EA on health.
4. Intimate Partner Violence	How to identify and cope with IPV, how to support peers or family members experiencing IPV, and effects of IPV on health.
5. Reproductive Coercion	Information on RC including how to safely access and use FP methods in the face of RC and how to support peers.
6. Family Planning	Clinic-based family planning providers join this session to provide information and answer questions.
7. Financial Literacy	Information on money management, savings, accounting, interest, budgeting, loans, and investing.
8. Goal Setting	How to develop achievable goals and guides individuals and the group to create goals including feasible, actionable steps to achieve these goals.



Pilot RCT Study | Overview

Purpose: To jointly improve reproductive and economic empowerment outcomes and reduce GBV among women attending existing VSLAs in Uasin Gishu County, Kenya.

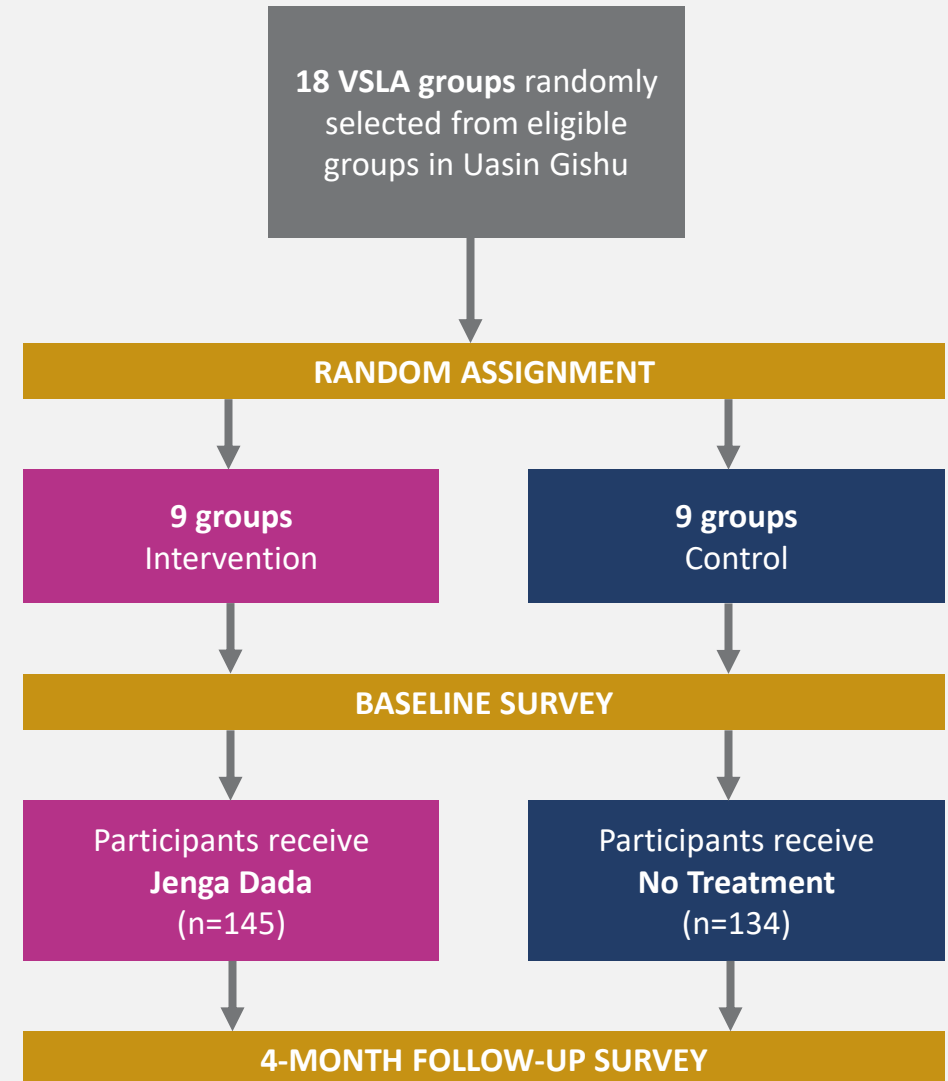
Timeline: 2023 – 2024

Primary objectives: To adapt ARCHES and Girls Invest strategies and educational content for inclusion in VSLAs via a model that:

- 1) Demonstrates high feasibility, acceptability and scalability.
- 2) Results in improvements in women's self-efficacy to:
 - a) use family planning including in the face of opposition (i.e., RC)
 - b) control economic activities and resources in the face of EA
 - c) seek support for IPV from formal services and VSLA members

Evaluation design: Cluster-randomized controlled trial among 18 VSLAs (n=279 women). Data were collected just prior to the start of the program and four months later; post-program qualitative interviews (n=14) were conducted with participants and facilitators.

Pilot Study Design



Pilot RCT Results |

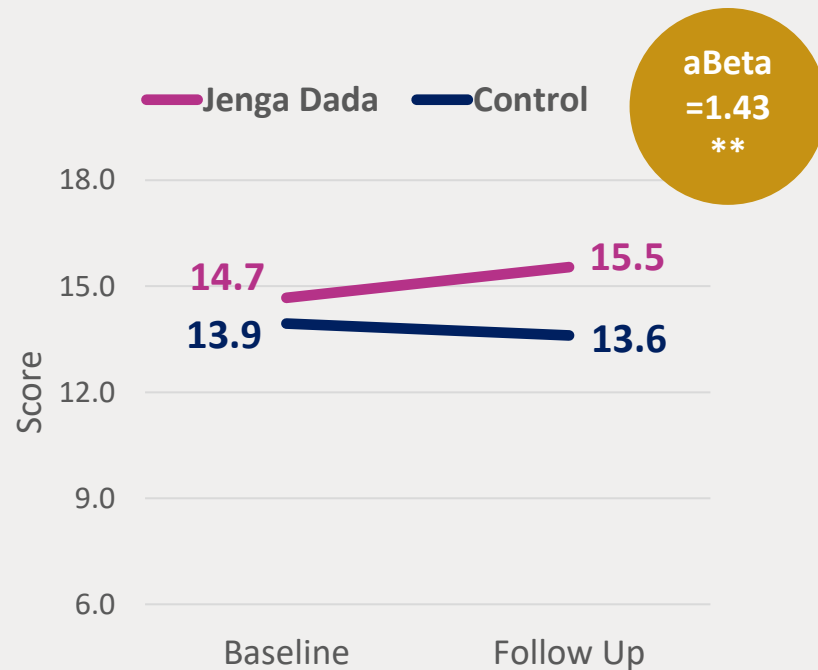
Increased Self-efficacy to Cope with GBV

Self-efficacy to cope with economic abuse

(among those with current male partners)

Score Range: 6-18

Women receiving Jenga Dada reported increased self-efficacy to cope with economic abuse, while controls reported reduced self-efficacy over time.



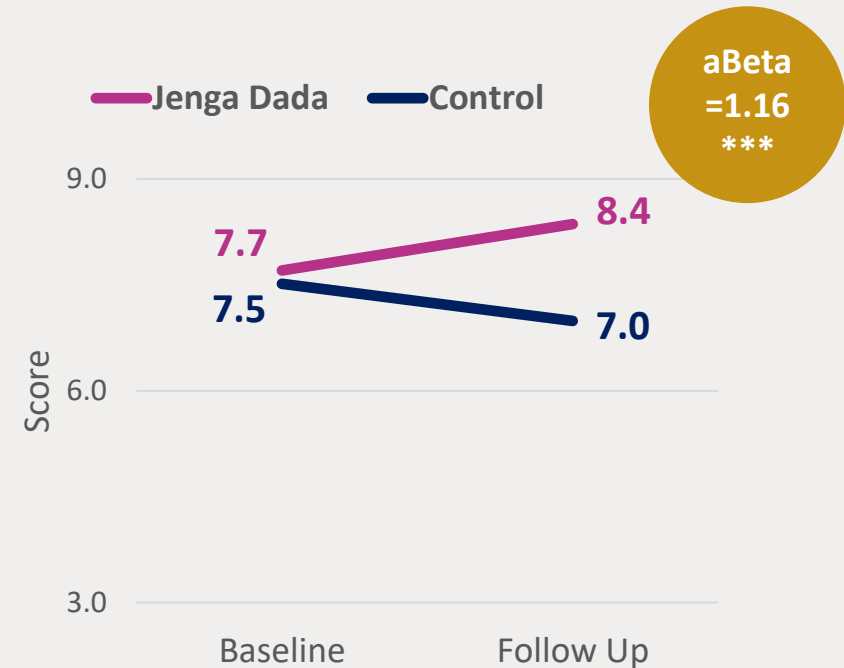
** $p < 0.01$

Self-efficacy to use FP in the face of RC

(among women 15-49 years)

Score Range: 3-9

Women receiving Jenga Dada reported increased self-efficacy to cope with reproductive coercion, while controls reported reduced self-efficacy over time.



*** $p < 0.001$

“It has really helped me in terms of saving. I have used my savings to take my child to school. I [couldn’t] have done that if I did not know how to prioritize my expenditure – I learnt about this from Jenga Dada.” *-Jenga Dada participant*

“It has made a great impact in my life. It wasn’t just a training, I have a goal...by 2026 I should be somewhere, yes.” *-Jenga Dada participant*

Pilot RCT Results |

Increased Self-efficacy to Seek GBV Support

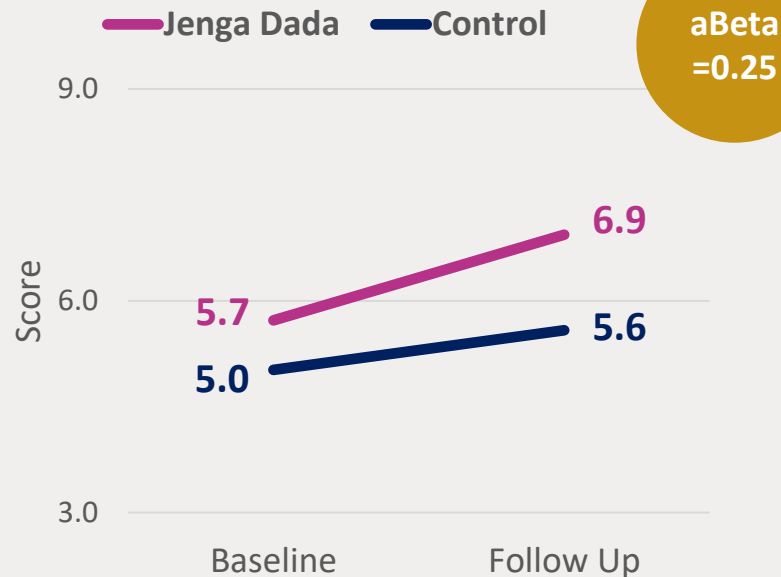
Self-efficacy to seek support from VSLA members for experiences of EA, RC, or IPV

(among women 15-49 years)

Score Range: 3-9

Both Jenga Dada and controls reported increased self-efficacy to seek group support for GBV over time.

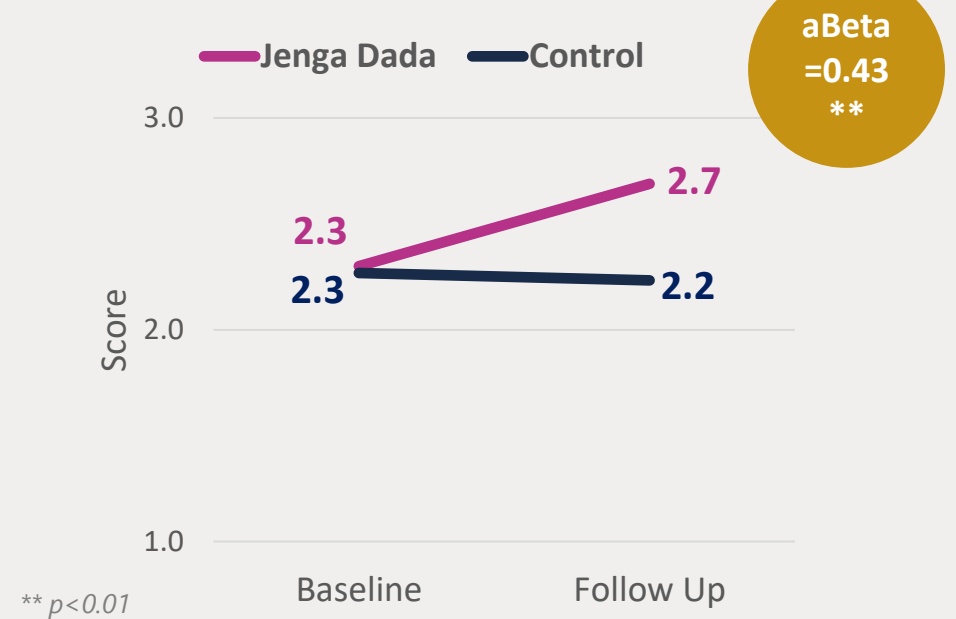
Women receiving Jenga Dada reported a larger increase but this difference was not statistically significant due to the small sample size.



Self-efficacy to seek formal IPV support services

Score Range 1-3

Women receiving Jenga Dada reported increased self-efficacy to seek formal IPV services, while controls reported decreased self-efficacy over time.



“I happen to be having a sister who is going through a lot of GBV. The husband has controlled everything about her, but when the Jenga Dada group came in then they introduced us to the counsellors in our near hospital. My sister visited and she was very much assisted.” *-Jenga Dada participant*

“Earlier on, you would take care of yourself, but right now we are trying to bring up women so that they ...also elevate themselves.” *-Jenga Dada participant*

“ Right now, I am not that person that I used to be earlier on. I am myself times two. I am a Mwanamke Bomba (a powerful woman).”

-VSLA member explaining the impact of Jenga Dada on her life

Local Co-design, Implementation and Research Partners



Women's Empowerment Link

Women's Empowerment Link (WEL) is a non-governmental Kenyan organization that seeks to advance women's and girls' social, economic, and civic rights. They served as technical advisors for the Jenga Dada project.



Rural Women Peace Link

Rural Women Peace Link (RWPL) is a grassroots, women-led organization that mobilizes, influences, and promotes the participation of local women in peace building, governance, and development through collaboration and networking with diverse actors. They are based in Eldoret, Kenya and co-facilitated the co-design process and served as the implementation partner for the Jenga Dada project.



Population Council Kenya

Population Council Kenya's mission is to co-create ideas, produce high-quality evidence, and implement proven solutions to improve the lives of the underserved with a focus on expanding sexual and reproductive health and rights for all. They served as the research partner for the Jenga Dada project.



Summary and Next Steps

***Jenga Dada* is a promising, low-cost and scalable model to promote women's economic and reproductive agency and reduce GBV at the community level.**

We're seeking opportunities to partner with implementers and funders to:

- Conduct a larger-scale trial to assess longer-term effects on women's economic status, reproductive health and safety and to develop scaling guidance.
- Consider integration of Jenga Dada into broader, comprehensive efforts at scale to improve women's status and health (e.g., community-level demand generation for FP).



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Learn more: <https://arches.net/projects-kenya/>

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