Family economic and social well-being in Congolese refugees in Phoenix Study Protocol

Title	Family economic and social well-being in Congolese refugees in Phoenix
Short Title	IPV Prevention Among FDP
Principal Investigator	Multiple PI Leadership: Jhumka Gupta, ScD, MPH Professor and Director of PhD Programs in Public Health Department of Global and Community Health College of Public Health Karin Wachter, PhD Associate Professor School of Social Work Arizona State University
Sponsor(s)	National Institute of Mental Health
Protocol Version/Date	Version 1.0 (8/01/2026)
NCT Number	NCT ID not yet assigned (update after approval/assigned)

External Non-GMU Collaborators

Collaborators	National Institute of Mental Health (NIMH) International Rescue Committee Arizona State University
IRB	George Mason University will serve as the IRB of record (IRB approval ID: STUDY00000294). Both the International Rescue Committee and Arizona State University have reliance agreements with GMU.

Background and Significance

Introduction	**Problem.** Forcibly displaced women and their male partners experience compounding vulnerabilities to IPV and mental health challenges, yet rigorous studies or examples of evidence-based interventions that seek to prevent and reduce IPV and mental health problems among FDPs who seek asylum and rebuild their lives in the US are scarce. **Project Goals.** We aim to address this gap in research and practice by (1) adapting the EA$E curriculum for US-based FD Congolese couples, (2) using a hybrid type 2 pilot study design to explore preliminary effects of EA$E-US on IPV, mental health outcomes and intermediary outcomes, and (3) examining implementation processes and outcomes **Methods and Activities.** Guided by the ADAPT-ITT framework, Cascade Implementation Framework, and the NIMH experimental therapeutics approach, we will develop EA$E-US, examine preliminary effectiveness on intervention and intermediary outcomes, and asses implementation outcomes via a hybrid type 2 pilot study design **Long Term Impact.** Improved mental health and reduced IPV in FD couples within the US.
Background. Existing factors. Preliminary studies. Supporting literature	Exposure to war, persecution, and forced migration put FDPs at disproportionately high risk for IPV and mental health problems. Many FD women arrive from countries where IPV is prevalent, and face increased risk before, during, and after displacement. Foreign-born women who experience IPV are more likely to be severely injured or killed, and report worse mental

	health than US-born women. financial and social stressors, and persistent gender inequities in the US can exacerbate both IPV and poor mental health outcomes among FDPs. Yet, US-based programs primarily focus on connecting survivors to services once IPV occurs, overlooking strategic opportunities to prevent IPV and poor mental health among FDPs. In contrast to the US context, there is a rapidly evolving evidence-base of interventions developed globally that show promise in reducing IPV among FDPs. The EA$E (Economic And Social Empowerment) intervention (developed by IRC and MPI Wachter), has been shown to reduce IPV and PTSD symptoms in a randomized controlled trial (RCT) conducted in West Africa led by MPI Gupta. The International Rescue Committee (IRC), a global humanitarian organization, developed EA$E to address two underlying drivers of IPV in crisis settings--household financial strain and gender inequity in decision-making--innovatively diminishing risk factors associated with IPV. EA$E addresses IPV at the individual and interpersonal levels by leading couples engaged in economic activities through an 8-session discussion series on household financial wellbeing, budgeting, spousal communication, and alternatives to violence. US-based programs for FDPs are in need of evidence-based curricula to address IPV and mental health. Our overall objective is to advance the nascent science of IPV prevention among FDPs in the US.
Innovation. Generalizability. Intended purpose and audience for results.	The proposed study addresses an important gap in prevention research by adapting and piloting an evidence-based intervention for implementation with forcibly displaced populations in the United States and generating preliminary data on its feasibility, acceptability, and potential effectiveness.

Goals/Aims

Aim 1: Adapt the EA$E curriculum for US-based FD couples from the Democratic Republic of Congo (DRC).
We will adapt EA$E by drawing from data-driven recommendations and engaging key stakeholders in an iterative process. We will conduct user-testing to collect session-specific feedback with 3 cultural /linguistic groups (N=7 FD couples) to refine the curriculum and develop fidelity measures. We will develop the facilitator training curriculum based on the updated curriculum and new implementation context. To further refine the curriculum, we will conduct user-testing with the adapted intervention with a group of 3 Kinyarwanda, Kinyamulenge or Kinyabwisha -speaking FD couples from the DRC.
Aim 2: Assess preliminary effects of EA$E-US on intervention targets and IPV and mental health outcomes to inform a future fully powered RCT.
We will randomly assign 46 FD Congolese women and their male partners to experimental and control groups. Surveys will be administered at baseline, post-intervention, and at 3-months follow-up. We will examine preliminary effects of EA$E-US on: (a) IPV outcomes (women's experiences of physical, emotional, economic IPV); (b) mental health outcomes (symptoms of depression, anxiety, PTSD); and, intermediary outcomes (IPV acceptance, equitable decision making, spousal communication, social support, coping).
Aim 3: Examine implementation processes and outcomes of EA$E-US.
We will examine (a) fidelity, quality, and micro-adaptations; (b) participant responsiveness via focus group discussions and recruitment and retention rates; (c) feasibility, acceptability, appropriateness, and safety via survey measures23,24 and interviews with IRC staff.

Study Design

Aim 1: Adapt the EA$E curriculum for US-based FD couples from the Democratic Republic of Congo (DRC).

Organizational structure of the team	● **Principal Investigators:** ○ Jhumka Gupta, ScD, MPH: George Mason University ○ Karin Wachter, PhD: Arizona State University ● **Co-Investigators:** ○ Cady Berkel, PhD: Arizona State University ○ Jessica Dalpe, LCSW: International Rescue Committee ○ Jaffer Zaidi, ScD: George Mason University ● **Consultant:** ○ Nathan Hansen: University of Georgia ● **Graduate Research Assistant:** ○ One Phd level graduate research assistant ● **EA$E-US Adaptation Advisory Board (EAAB):** ○ Ten members including technical and community experts
Setting and location	**Setting.** The study will be conducted at the International Rescue Committee (IRC) in Phoenix, Arizona. **Study site.** The research activities will be conducted at IRC in Phoenix, Arizona. IRC is a global humanitarian organization that has been in operation since 1933. Active in over 40 countries, IRC is 1 of the 9 US resettlement agencies, with 28 offices in 23 states. In FY23, the IRC caseload included 71,190 newly arrived FDPs. IRC Phoenix opened in 1994 and is one of the largest in the US, having served over double the number of new arrivals (5,263) than other IRC offices. Aligned with the federal mandate to foster self-reliance, IRC staff deliver a comprehensive array of social services (e.g., English language classes, cultural orientation, employment services, cash assistance, health) using an integrated, strength-based, and trauma-informed approach. IRC Phoenix offers robust economic empowerment and safety and wellness services. The onsite clinical team offers various therapeutic modalities (e.g. Narrative Exposure Therapy, Mindfulness, Cognitive Behavioral Therapy) to help FDP clients). This team also offers services tailored to address the complex needs of IPV survivors, including case management, counseling, safety planning, and safe referral to specialized services.
Study Population	**IRC Clients:** Congolese Forcibly displaced women and their male partners (couples) who resettled or otherwise sought asylum together in the U.S. The specific inclusion criteria are 1) originally from the Democratic republic of Congo, 2)heterosexual married couple, 3) both wife and husband resettled or otherwise sought asylum together in the United States, 4) arrived in the US in the past 5 years, 5) currently cohabitating, 6) both partners must be ages 18 or older, 7) fluent in Kinyarwanda, Kinyamulenge or Kinyabwisha, 8) resides in the greater Phoenix, Arizona area and does not intend to relocate in the next 3 years; and received IRC general resettlement services in the past 15 months. **IRC Staff eligibility for EA$E US Facilitator Role:** IRC staff must be 1) fluent in Kinyarwanda, Kinyamulenge or Kinyabwisha and 2) English and have prior experience in IPV programing**.**
Recruitment	**EA$E-US IRC facilitator recruitment:** As recommended by the International Rescue Committee, the IRC will identify and select staff that meet the facilitator inclusion criteria and have capacity to take on this additional role. IRC facilitators will be recruited verbally. **User testing recruitment:** IRC staff will compile a list of eligible study participants and will conduct direct outreach (e.g., whatsapp, phone calls) to potential participants based on inclusion and exclusion criteria. Following the World Health Organization's best practices for conducting research on violence against women and girls, participants will be told that they are participating in an economic and social empowerment program; specific references to intimate partner violence (domestic violence, family violence) will not be discussed in any recruitment

	material but will be made clear in the consent forms for women (i.e. the study will involve household and relationship functioning, including experiences with violence between couples). IRC will contact the female partner first and ask if she is comfortable participating in the program with her husband, and if IRC can contact her husband. IRC will track who they contact, note demographics, and reasons for declining to participate.
Field Methods	**Data collection overview:** After obtaining informed consent by linguistically, cultural, and gender matched IRC staff, couples will attend 8 group sessions with other couples and be asked to share their thoughts about the sessions to understand what works and what should be changed. Each of the 8 sessions is about 1.5 hours long and will be held in the IRC Phoenix Office. After each session, we will ask participants for their feedback. This feedback session will take about 15 minutes. We will systematically collect feedback per session from participants (n=14) using a brief structured group interview guide and from EA$E-US facilitators (n=2) using brief on-line surveys via Red-Cap and 30 minute debrief discussions after each session. To further refine the facilitation guides and training, facilitators will be asked about implementation experiences and their overall experience with facilitating the EA$E-US program.
Informed Consent	**IRB approval and oversight.** Our study has been approved by George Mason University's IRB (IRB approval ID: STUDY00000294) and will be further overseen by a Data Safety and Monitoring Board. **IRC clients for user testing:** For couples who have confirmed interest, informed consent will be conducted by linguistically, cultural, and gender matched IRC staff. Following the World Health Organization's best practices for conducting research on violence against women and girls, women and their male partners will be asked separately for their informed consent to participate in the study. Participants will receive a hard copy of the informed consent form for their records.
Potential Risks / Discomforts / Protections	**<u>Risks and protections</u>** <u>Psychological distress:</u> Discussing intimate partner violence, mental health, and intervention topics may cause emotional discomfort or distress. Study staff will be trained in WHO guidelines for violence research, trauma-informed approaches, and participant safety. Participants experiencing distress will receive immediate support and referral to the IRC Phoenix Safety and Wellness Team or other appropriate services. <u>Fear of retaliation:</u> Female participants may fear retaliation if a partner becomes aware of violence disclosure. Safety procedures consistent with WHO guidelines will be used, including interviewing partners separately by language, culture, and gender matched interviewers, administering IPV questions only to female participants, using decoy questions if privacy is interrupted, and conducting gender-specific focus groups. <u>Loss of confidentiality:</u> The risk of loss of confidentiality is low. Identifiable information will be maintained by IRC separately from research data and will not be linked to survey responses available to the research team. While participants in focus groups will be reminded to maintain confidentiality, confidentiality among participants cannot be guaranteed should a participant share information discussed in the focus group with others outside of it. All study personnel will sign confidentiality agreements prior to participating in study activities, and focus group participants will be asked to respect the confidentiality of group discussions. An independent Data and Safety Monitoring Board (DSMB),

<table>
<tr><td></td><td>comprising experts in intimate partner violence, mental health, forcibly displaced populations, clinical trials, and biostatistics, will oversee participant safety, study conduct, and data integrity throughout the trial. The study is covered by a National Institutes of Health Certificate of Confidentiality, which helps protect identifiable participant information from compelled disclosure, except as required or permitted by law.</td></tr>
<tr><td>Benefits</td><td>There are no direct benefits to providing this feedback. Your feedback will help us improve the program for other families. You may benefit from participating in the program activities designed to help couples to manage household finances, manage financial stress, strengthen communication about finances, avoid conflicts about money, and support well-being. We will ask for your feedback on the program.</td></tr>
<tr><td>Compensation</td><td>Aim 1 User testing incentives: Couples will receive step-wise compensation for attending each session, totaling up to $450 in Walmart gift cards per couple. Participants do not need to attend all 8 sessions before being compensated. Participants will be compensated at the end of each session they attend by the IRC EA$E-US facilitators.
<table>
<tr><th>Compensation by sessions for user testing</th><th>Gift card amount ($USD)</th></tr>
<tr><td>session 1</td><td>30</td></tr>
<tr><td>session 2</td><td>30</td></tr>
<tr><td>session 3</td><td>45</td></tr>
<tr><td>session 4</td><td>45</td></tr>
<tr><td>session 5</td><td>60</td></tr>
<tr><td>session 6</td><td>65</td></tr>
<tr><td>session 7</td><td>75</td></tr>
<tr><td>session 8</td><td>100</td></tr>
<tr><td>Total per couple</td><td>450</td></tr>
</table>
<u>Additional Incentives:</u> To reduce participant burden, IRC has budgeted to provide childcare during EA$E-US sessions, transportation costs, and intervention sessions will be held at a the IRC Phoenix office.

<u>EA$E-US adaptation advisory board (EAAB).</u> The EEAB will be comprised of ten members. Each member will receive $500 for their service on the EAAB.</td></tr>
<tr><td>Data Management and Monitoring</td><td>User Testing Qualitative data. Focus group discussions will be audio recorded and will be transcribed verbatim. Pseudonyms will be used in the transcripts. The transcripts will be entered into Dedoose, a computer software program designed for the coding and analysis of qualitative data. Focus group discussion data will not be matched with survey data. All data will be stored electronically in password files on Dr. Gupta’s secure computer at George Mason University. All data from individual interviews and completed questionnaires will be coded and entered into secured computers at George Mason University College of Public Health. The resulting machine-readable data files will not contain any personal identifiers of the individual participants. In the event of any adverse incidence including any indication that collected data are liable to release or misuse, we shall immediately stop the data collection, take reasonable steps to safeguard the safety of the affected subjects and the collected data and report immediately to the relevant data safety and monitoring board, IRB, and NIH personnel. Any paradata resulting from participants’ interaction with the intervention will also be kept on our secured computing system at George Mason University and will not be linked to any individually identifiable</td></tr>
</table>

	information. **User Testing Quantitative Data:** Quantitative data collected during the user testing phase will include implementation monitoring and evaluation data, specifically participant attendance, homework completion, and facilitator monitoring and evaluation surveys administered via Qualtrics. Attendance and homework completion will be recorded throughout the intervention to assess participant engagement and adherence; these data will be stored in IRC's secure file storage system only accessible to the IRC project team. IRC site PI will create a master key for participants and de-identify all data made accessible to the research team. Facilitator survey data will be stored electronically in pass-word protected files on the PI's (Dr. Gupta) secure computers at George Mason University. Study personnel and appropriate oversight organizations (DSMB, IRB, NIH officers) will have access to the study databases. IRC staff will not have access to any identifiable data and results will be shared in aggregate with IRC. A data safety and monitoring board (DSMB) will be convened, which will consist of experts in IPV, mental health, forcibly displaced populations, clinical trials as well as a Biostatistician. DSMB will be apprised of the data collection procedures to safeguard the interest of study participants. The DSMB will be apprised of the data collection procedures to safeguard the interest of study participants. The primary responsibility of the DSMB is to safeguard the interests of study participants. Therefore, the DSMB must approve the safety measures in the protocol to preserve the study's credibility and facilitate the availability of timely and reliable findings to the broader scientific and IPV community.
Plans for Analysis	Data from the user-testing feedback sessions will be analyzed using rapid qualitative analytical techniques to efficiently inform contextually-relevant intervention development in near real time. A member of the research team will lead and take detailed notes during feedback sessions. The research team will meet to review the notes from participant feedback sessions and facilitator survey responses on a weekly basis. The framework method (used in our prior adaptation research) will be used to sort and label the data using deductively-derived categories focused on identifying issues related to fidelity, delivery quality, micro-adaptations, acceptability, appropriateness, feasibility, safety, and satisfaction. Any decisions to further adapt EA$E-US and training manuals based on these rapid team-based analyses will be documented in a detailed audit trail, and vetted by the EA$E-US Adaptation Advisory Group prior to finalizing the EA$E-US intervention and training manuals. Finally, we will develop fidelity measures based on the adapted implementation manual. Regarding the homework that accompanies the EA$E-US curriculum, this is designed to prompt participants to reflect on sessions key learning outcomes, and discussion between couples. The goal is not to find perfect answers, but to share their thoughts, listen to each other's perspectives, and better understand how they can support one another. A hard copy of brief homework activities will be sent home with participants. Participants will not be required to write anything down or turn anything in. At the following session, participants will be invited, on a voluntary basis, to share their thoughts during a brief discussion of the previous homework activity. Completion will be likely indicated by a show of hands.
Confidentiality	**Privacy and confidentiality protection** Multiple measures to protect the privacy and confidential responses of participants will be employed, including: Staff training: All GMU, ASU, and IRC key personnel have already completed the online training modules developed by the Collaborative Institutional Training Initiative (CITI). Any new team GMU and ASU team members, including research assistants, will complete CITI certification, in accordance with their IRB institutional policies. All IRC staff, including IRC caseworkers, EA$E US facilitators, enumerators, and focus group/interview and those otherwise involved in recruitment or survey administration and or supervision will be trained will complete a training led by the

	MPIs that includes training in ethics of human subject research prior to engaging in study activities. EA$E-US facilitators will receive additional indepth training in administering the intervention. Training sessions will include the following topics: IPV referrals, gender dynamics, trauma-informed approaches, and cultural humility. Confidentiality agreement: Upon completion of all research training, we will ask each project staff member and research participants to sign a confidentiality agreement specifying the project's regulations regarding confidentiality and the consequences of any breach of confidentiality. The project staff and research participants will receive a copy of the signed confidentiality agreement. The MPIs will keep the original copy and will periodically review it with the project staff. Data management and data protection: A data safety and monitoring board (DSMB) will be convened, which will consist of experts in IPV, mental health, forcibly displaced populations, clinical trials as well as a Biostatistician. DSMB will be apprised of the data collection procedures to safeguard the interest of study participants. The DSMB will be apprised of the data collection procedures to safeguard the interest of study participants. The primary responsibility of the DSMB is to safeguard the interests of study participants. Therefore, the DSMB must approve the safety measures in the protocol to preserve the study's credibility and facilitate the availability of timely and reliable findings to the broader scientific and IPV community. Due to the sensitive nature of the data being collected and populations involved, this study has been given a Certificate of Confidentiality by the National Institutes of Health to help us protect participant information. This Certificate means that the researchers cannot be forced, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings, to disclose any information that may identify you. The researchers will use the Certificate to resist any demands of information that would identify participants, except as explained below.

<table>
<tr><td colspan="2">Aim 2: Assess preliminary effects of EA$E-US on intervention targets and IPV and mental health outcomes to inform a future fully powered RCT.</td></tr>
<tr><td>Organizational structure of the team</td><td>Please see details listed under Aim 1.</td></tr>
<tr><td>Setting and location</td><td>Please see details listed under Aim 1.</td></tr>
<tr><td>Study Population</td><td>Please see details listed under Aim 1.</td></tr>
<tr><td>Recruitment</td><td>Please see details listed under Aim 1.</td></tr>
<tr><td>Field Methods</td><td>Data collection overview:</td></tr>
<tr><td>Informed Consent</td><td>Please see details listed under Aim 1.</td></tr>
<tr><td>Potential Risks / Discomforts / Protections</td><td>Please see details listed under Aim 1.</td></tr>
<tr><td>Benefits</td><td>Please see details listed under Aim 1.</td></tr>
<tr><td>Compensation</td><td>For Aim 2, all study participants will be compensated for survey completion based on an escalating incentive strategy and may receive up to $225 individually ($450 per coupe) for completing all surveys.
<table>
<tr><th>AIM 2</th><th>individual</th><th>for each couple</th></tr>
<tr><td>T1</td><td>50</td><td>100</td></tr>
<tr><td>T2</td><td>75</td><td>150</td></tr>
<tr><td>T3</td><td>100</td><td>200</td></tr>
<tr><td>total</td><td>225</td><td>450</td></tr>
</table></td></tr>
<tr><td>Data Management and Monitoring</td><td>Quantitative data: Quantitative data will be collected via a HIPPA-compliant survey platform, RedCap. Participants' confidentiality will be maintained through the use of arbitrary identification numbers (ID) on questionnaires and in the database. A master list of the IDs and names of research</td></tr>
</table>

	participants will be kept in secure password-protected files within the IRC site PIs secure IRC storage. A copy of the master list needs to be retained during the study in order to facilitate follow-up assessments that will be destroyed at the completion of the study. Minimal identifiable study data (e.g., name, email, addresses, phone numbers, age, country of origin) will be collected for continued participation but will never be linked to survey or focus group discussion responses. All data will be deidentified by IRC's site PI before making it accessible to the research team. Survey data will not be matched with focus group discussion data. All de-identified data will be stored electronically in pass-word protected files on the PI's (Dr. Gupta) secure computers at George Mason University. Study personnel and appropriate oversight organizations (DSMB, IRB, NIH officers) will have access to the study databases. IRC staff will not have access to any identifiable data and results will be shared in aggregate with IRC.
Plans for Analysis	The focus of the study is on the development of EA$E-US, implementation (feasibility, acceptability) outcomes, and preliminary effectiveness in mental health and IPV outcomes to inform a future fully-powered R01 efficacy trial of EA$E-US. The primary goal of EA$EUS is to decrease IPV and mental health symptoms among US-based FDPs. The analysis of the proposed study will therefore yield indicators to signal change in primary and intermediary outcomes to inform a subsequent, fully powered efficacy trial. **Descriptive statistics** will be generated for all study variables including means, standard deviations, medians and interquartile ranges for continuous variables, frequencies and relative frequencies for categorical variables. Estimates of internal consistency reliability (e.g., Cronbach alphas) will be determined for composite scales and compared to a criterion of .6 which is used here to assess acceptable reliability. Descriptive statistics will be computed on the total pooled sample and by the study arm, and by sex when applicable. **Analysis of Primary and Intermediary Outcomes.** We will use baseline (T1), immediately after the intervention, or post-intervention (T2), and 3-month follow-up post intervention (T3) data to compute preliminary effect size estimates for the aforementioned primary and intermediary outcomes detailed in Table 3. Given the small sample size, the power of this study to identify small but significant effects will be low (70%). To provide preliminary estimates of effect for a subsequent efficacy trial, we will use t-test for independent samples for data at T2 and T3. If the continuous dependent variable(s) is not normally distributed, we will use the Mann-Whitney U test. For binary dependent variables, we will use the chisquare test or, in the event of expected values of zero, Fisher's exact test. **Intent-to-treat analysis** including all participants randomized into each condition regardless of intervention exposure will be conducted. This

	will be a longitudinal analysis using a generalized mixed longitudinal models approach, which allow for continuous, ordinal, and binary variables, to compare participants in the EASE-US to participants in the waitlist comparison condition from baseline across all follow-up assessments on primary and intermediary outcomes. An advantage of mixed models is that participants with missing data need not be excluded as all available data are used in estimating parameters. We will control for covariates, including age, length of time in the US, and educational attainment. Given the small number of groups (2 groups in the intervention arm), group membership will be accounted for through a dummy variable versus group clustering. These analyses will be to explore preliminary differences in outcomes based on intervention condition. GEE is appropriate for continuous, ordinal and binary dependent variables.
Confidentiality	Please see details listed under Aim 1.

Aim 3: Examine implementation processes and outcomes of EA$E-US.	
Organizational structure of the team	Please see details listed under Aim 1.
Setting and location	Please see details listed under Aim 1.
Study Population	Please see details listed under Aim 1.
Recruitment	For the focus groups specific to EA$E-US participants, a member of the research team will attend the final EA$E-US session's "graduation ceremony" and announce the opportunity to participate in focus group discussions. Interested participants will provide contact information and be contacted by the study team for informed consent and focus group participation.
Field Methods	**Data collection overview:** We will examine implementation processes and outcomes. This will involve both quantitative and qualitative methods, as well as detailed record keeping throughout the implementation period. This will involve audio-recording of EA$E-US sessions to assess fidelity, quality of delivery, and micro-adaptations. Participant satisfaction will be measured quantitatively using the short Client Satisfaction Questionnaire (CSQ-4) modified for EA$E-US and qualitatively in post-intervention focus group discussions (FGDs, N=6) with selected intervention arm participants, with the assistance of a trained language interpreter. The FGD guide will include questions about participants' experiences with the program, including the curriculum (session topics, activities, etc.), home practice, facilitation, format (couples in groups), and logistics (location, timing). Facilitators will track participant attendance and home practice completion per session. IRC staff involved in implementation (n=5) will self-administer a survey containing validated scales of acceptability, appropriateness, and feasibility, and participant/facilitator safety, as well as open-ended fields to explore their perceptions of these constructs in greater depth.. Where relevant, we will also calculate Cronbach's alpha for all measures for aim 3.
Informed Consent	Please see details listed under Aim 1.
Potential Risks / Discomforts / Protections	Please see details listed under Aim 1.

Benefits	Please see details listed under Aim 1.
Compensation	**Incentives for focus group discussion participation** Participants will receive $55 for participating in focus group discussions.
Data Management and Monitoring	Please see details listed under Aim 2.
Plans for Analysis	**Quantitative Analyses:** Fidelity scores will be calculated as a percentage based on each activity per session, representing the total number of points received per session out of the total possible. Quality of delivery will be assessed by calculating the mean scores of two subscales: facilitator engagement and facilitator skills. We will visually examine trends in fidelity and quality of delivery over the course of the 8 sessions by graphing summed fidelity scores and mean scores of facilitator engagement and skills by session over time. We will systematically track micro-adaptations per session and following completion of the intervention, we will qualitatively examine these as a whole for the purposes of detecting any trends, emergent innovations, and/or issues, with the purpose of further enhancing the facilitator training or intervention manuals. Micro-adaptations, spontaneous or planned, will be catalogued using a framework for reporting adaptations and modifications to evidence-based interventions.97–100 This analysis of micro-adaptations will seek to further our understanding of the “who, what, how, and why” of spontaneous and planned micro-adaptations over the course of implementation. Attendance will be taken over time and calculated as the proportion of enrolled couples who attended at least 6 sessions out of 8. Client satisfaction will be calculated based on the mean scores of the CSQ-4. Home practice completion will be calculated based on the proportion of couples who complete at least 75% of all assignments. Mean scores of acceptability, appropriateness, and feasibility will be calculated based on IRC staff responses to an on-line survey. IRC staff perceptions of safety will be quantitatively examined. using descriptive analyses and qualitatively assessed using content analytical approaches.101,102 Finally, we will use descriptive statistics to assess female participant perceived safety associated with participating in the EA$E-US (intervention arm only). Analyses: We will further assess participant satisfaction by analyzing qualitative data related to participants experiences with and perceptions of the curriculum, home practice, facilitation, format, logistics, and overall program from the post-intervention FGDs with participants, using thematic analytical procedures. Audio recordings from the FGDs (N=6) will be transcribed verbatim and then systematically analyzed by MPI Wachter and two additional members of the research team in Dedoose, using a deductively and inductively-derived codebook. The reliability of our analysis will be increased by using a team-based approach,103 overseen by MPI Wachter. A coding comparison report will be generated in Dedoose to show the percentage of agreement and disagreement between coders and evaluate intercoder reliability based on two FGD transcripts, which we will use to make any needed

	revisions to the codebook and correct discrepancies in the coded text. Once intercoder reliability has been reached 90% agreement, the remaining transcripts will be double-coded.103 Intercoder reliability will be assessed after every second transcript. If reliability falls below a threshold of 90% agreement, the team will meet to discuss and correct coding discrepancies and determine whether previous transcripts need to be recoded.
Confidentiality	Please see details listed under Aim 1.

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