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A Public Health Approach to Intimate Partner Violence Prevention in Uganda: The SHARE Project

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Abstract

Research from Rakai, Uganda, suggests intimate partner violence (IPV) is common and attitudes condoning it are widespread. We used a public health approach to develop and implement an evidence-based IPV prevention intervention named the Safe Homes and Respect for Everyone (SHARE) Project. SHARE was designed on the Transtheoretical Model of behavior change and adapted IPV prevention strategies from Raising Voices and Stepping Stones. SHARE was implemented in four regions of Rakai. This article describes the design and implementation of SHARE, provides details on strategies and activities used, discusses challenges and lessons learned, and provides recommendations for other violence prevention programmers.

Keywords

community-based intervention, intimate partner violence, Rakai, Uganda

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Introduction

Intimate partner violence (IPV), the most common form of violence against women (VAW; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002), is associated with numerous adverse consequences for abused women, including physical injury and death, emotional and social problems, substance abuse, reproductive, and sexual morbidity (Campbell, 2002; Campbell & Soeken, 1999; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Garcia-Moreno et al., 2006; Krug et al., 2002). IPV has also been linked with increased risk for acquisition of HIV and other sexually transmitted infections (STIs; Campbell et al., 2008; Decker et al., 2009; Dude, 2011; Maman, Campbell, Sweat, Gielen, 2000). IPV against women not only affects the primary victims, it has negative health and social consequences for those indirectly exposed (e.g., children, family members, friends) through witnessing violent events and/or providing support and care to the victim (Krug et al., 2002; Stiles, 2002). In addition, IPV has adverse economic consequences at the societal level, including increased absenteeism at school and in the workplace, decreased productivity, lower earnings, and increased cost of health care and other services (Duvvury, Grown, & Redner, 2004).

IPV occurs throughout the world but sub-Saharan Africa has some of the highest self-reported rates. The World Health Organization (WHO) estimated between 41% and 71% of ever-partnered sub-Saharan African women have experienced some type of physical or sexual violence (or both) in their lifetime. Uganda, the setting for the project described in this article, was not part of the WHO's study but data were collected in both metropolitan and provincial areas of Tanzania which are relatively comparable to urban and rural settings of neighboring Uganda. Findings from the WHO study estimated that rates of physical and sexual IPV were extremely high in Tanzania, especially in provincial areas, when compared to other African countries surveyed. Almost two thirds of women interviewed in rural Tanzania indicated they had ever experienced physical or sexual IPV, 30% in the past year. These rates were only exceeded by one country in Africa (Ethiopia) and two countries in other parts of the world (Bangladesh and Peru; Garcia-Moreno et al., 2006). Similar trends have been seen in Uganda where Demographic Health Survey data estimate that 48% of adult women have experienced physical IPV at some point in their life (35% in the past year), and 36% had ever experienced sexual IPV (25% in the past year). Most Ugandan adults (70% of women and 60% of men) believed wife beating is justifiable under certain circumstances (Uganda Bureau of Statistics [UBOS] & Macro International, Inc., 2006), which not only normalizes the practice but also poses challenges to prevention efforts.

The magnitude of global IPV and mounting evidence on its role in increasing women's risk for injury and ill health has contributed to a growing consensus that a strong health sector response should focus on researching and preventing violence before it begins (Krug et al., 2002). A great deal has been written about research on IPV and other forms of VAW in Uganda (Karamagi, Tumwine, Tylleskar, & Heggenhougen, 2007; Kaye, Mirembe, Bantebya, Johansson, & Ekstrom, 2006; Koenig et al., 2003; Koenig et al., 2004a; Koenig et al., 2004b; Osinde, Kaye, & Kakaire, 2011; Wagman et al., 2009), yet a gap exists in the literature on evidence-based interventions developed to prevent these forms of abuse in the country.

This article aims to lessen that gap by describing how researchers in the rural southwest district of Rakai, Uganda, used a public health approach to measure the magnitude of IPV, identify risk and protective factors, and develop and implement a rights-based, primary IPV prevention intervention. Details are provided on the ecological framework used to conduct formative research; the Transtheoretical Model (TTM) of behavior change used to design the intervention; how IPV prevention strategies that were empirically tested and proven successful were adapted for use in Rakai; and specific strategies and activities used to raise awareness, build capacity, and partner with the community to prevent IPV. The article ends with a discussion of challenges encountered and lessons learned. Recommendations are provided for future prevention program efforts.

The Public Health Approach to Prevention

A four-step public health approach was designed to prevent violence and other public health problems that affect populations. Step 1 was to define the problem. Step 2 was to identify risk and protective factors. Step 3 was to develop and test prevention strategies, and Step 4 was to assure widespread adoption (Centers for Disease Control [CDC], 2002, 2009). These four steps are used throughout the article to describe how researchers and health professionals from Rakai Health Sciences Program (RHSP) developed and implemented a violence prevention intervention, named the Safe Homes and Respect for Everyone (SHARE) Project in four regions of the district.

Step 1: Define the Problem

The public health model posits that design of a prevention program first requires understanding the magnitude of that problem in the target population (CDC, 2009). Systematic data were collected on IPV between 2001 and 2004 through qualitative inquiry and the Rakai Community Cohort Study (RCCS), a longitudinal cohort study that conducts survey interviews every 12 to 18 months with all consenting people aged 15 to 49 in approximately 5,000 households in 47 to 50 communities throughout Rakai (Wawer et al., 1999). These 47 to 50 communities represent 7% of the 720 communities in the district.

RCCS findings suggested Rakai women's experiences of IPV were relatively common but lower than those estimated via DHS from other rural regions of Uganda. Among adult Ugandan women, 30% and 50% reported physical IPV (Koenig et al., 2003; UBOS & Macro, 2006), and 24% and 37% reported sexual IPV (Koenig et al., 2003, 2004a; UBOS & Macro 2006) at some point in their lives in Rakai and other rural Ugandan areas, respectively. Recent IPV was also investigated in Rakai. In the year before the survey, 20% of women experienced physical abuse (Koenig et al., 2003), while 15% experienced sexual violence (Wagman & Charvat, 2008). Among 15- to 19-year-old female adolescents, 14% reported that their first sexual experience involved physical force (Koenig et al., 2004b). Qualitative investigation revealed that sexual violence occurs in Rakai along a continuum and involves forced sex and other forms of coerced intercourse (resulting from threats or other pressures), unwanted touching, verbal harassment, and transactional sex (Wagman

et al., 2009). Overlap was found between women's experiences of physical and sexual IPV. Almost all (96%) women who reported lifetime experience of sexual violence also reported enduring physical violence at some point in their lives (Zablotska et al., 2009).

Step 2: Identify Protective and Risk Factors

The second step of the public health approach to prevention is to understand the determinants that protect and/or put people at risk for experiencing or increasing others' risk of experiencing an outcome (CDC, 2009). As recommended by violence research experts (Heise, Ellsberg, & Gottemoeller, 1999), we used an ecological framework to investigate how an individual's risk for experience of IPV was influenced by factors at 3 main levels: individual behaviors and beliefs, relationship characteristics, and societal level attitudes about the acceptability of IPV. We investigated individual and relationship level determinants of IPV RCCS and qualitative research. Society-level factors were examined in part through primary data collection, but mostly by reviewing existent literature on social-level factors known to influence risk of gender inequality and VAW. Main findings on risk and protective factors are highlighted in Table 1 and discussed below by level of influence.

Individual-Level Factors

Protective factors. Individual level factors that protected women from IPV in Rakai included older age, higher education, having multiple living children, and personal intolerance of IPV as an accepted behavior. Older age (≥ 35 years) was associated with decreased odds of self-reporting sexual IPV, as compared to women less than 25 years (Koenig et al., 2004a) as well as physical IPV (when compared to women 34 years and younger), but this second finding was not statistically significant (Koenig et al., 2003). Women with 8 years or more of schooling experience had significantly lower risks of physical violence than those with no education ($OR = 0.66$; 95% CI [0.47, 0.92]) but these findings varied slightly for sexual abuse. Women in the more educated group (8+ years of school) were also less likely to experience sexual abuse when compared to those who only completed primary school. However, no significant differences in risk were found when compared to uneducated women. This could be due to the fact that our population was relatively homogeneous with respect to low levels of education (Koenig et al., 2004a).

Women with many (≥ 6) children were significantly less likely to experience physical IPV (compared to women with 2-5 children) and sexual IPV (compared to women with 1 or no children) (Koenig et al., 2003; Koenig et al., 2004a). Women who reported personal beliefs that male-perpetrated VAW was not acceptable under any circumstances were less likely to report having experienced physical violence in their own lives compared to women who believed partner abuse was justifiable (Koenig et al., 2003).

Risk factors. Younger age, early sexual debut, and multiple past-year partners were individual level risk factors for IPV. Women's age was a significant predictor of sexual, but not physical, IPV. Women 34 years and younger were significantly more likely to report sexual coercion relative to women aged 35 years or more (Koenig et al., 2004a). Younger age of

Table 1. Protective and risk factors for IPV among women in Rakai, Uganda.

Level of influence	Protective factors	Risk factors
Individual	• Older age (PV & SV) • Higher education (PV & SV) • Having many (≥6) children (PV) • Personal beliefs that IPV was unacceptable (PV)	• Younger age (SV) • Age at 1st sex ≤15 years of age (PV&SV) • Having >1 sex partner in the past year (PV&SV)
Relationship	• Being in longer duration (10+ years) intimate relationships (PV) • Being in relationship where safe sex behaviors were practiced (PV&SV)	• Male partner's use of alcohol before sex (PV&SV) • Woman's use of alcohol before sex (PV) • Perception that male partner is at high risk for HIV infection (PV&SV)
Society		• Permissive attitudes about the acceptability of IPV in marriage (PV) • Patriarchal cultural and social systems (PV&SV)

Note. PV = physical violence. SV = sexual violence.

women at first intercourse was strongly and positively related to the risk of both physical and sexual IPV. Compared to women whose first sex occurred between the ages of 15 to 17 years, women whose sexual debut was early (defined as less than 15 years) were 1.5 and 1.25 times more likely to experience physical and sexual IPV, respectively. Compared to women whose first sex occurred at or older than 18 years, women who reported early sexual debut were 1.9 and 1.5 times more likely to experience physical and sexual IPV, respectively (Koenig et al., 2003; Koenig et al., 2004a). Both physical and sexual violence were significantly more common among women reporting two or more (compared to those with only one) sex partners in the previous year (*OR* = 1.52; 95% CI [1.28, 1.82]; Zablotska et al., 2009).

Relationship-Level Factors

Protective factors. At the partner level, survey data indicated that length of partnership and safe sex practices were associated with risk of IPV. Women in longer relationships (10+ years) had significantly lower risks of physical violence than women in relationships of intermediate (5-9 years) and shorter (< 5 years) durations (Koenig et al., 2003), but this was not found to be true for sexual coercion (Koenig et al., 2004a).

Women who reported recent safe sex behaviors with intimate partners (e.g., consistent condom use) were also significantly less likely to report recent experiences of physical or sexual abuse (*OR* = 0.61; 95% CI [0.43, 0.86]; Zablotska et al., 2009). This suggests women

in relationships characterized by more equal decision-making with male partners (as demonstrated by their ability to negotiate/discuss safe sex practices) might also be more empowered to promote other healthy choices in their lives such as positive conflict resolution.

Risk factors. Alcohol consumption and perception of a male partner's risk for HIV infection were relationship level risk factors associated with risk of IPV in Rakai.

A man's use of alcohol before sex was found to increase the risk of male perpetrated physical (Koenig et al., 2003) and sexual (Koenig et al., 2004a) partner violence against women. Alcohol consumption by the woman prior to sex was significantly associated with physical abuse (against her; Koenig et al., 2003), but not sexual coercion (Koenig et al., 2004a). A separate analysis examined the relationship between alcohol use, IPV, and HIV risk and found a woman's adjusted odds of being HIV-infected was significantly increased (*OR* = 1.79; 95% CI [1.25, 2.56]) if she reported sexual IPV and alcohol consumption (Zablotska et al., 2009). It is plausible that behavioral disinhibition and/or impaired judgment due to alcohol use can increase a woman's vulnerability to IPV (as well as acquisition of HIV and other STIs). Alcohol use with sex is common in Rakai. Most men (75.5%) and 37% of women reported they drank alcohol before sex (Wawer et al., 2009).

A woman's perception of her intimate partner's HIV risk was also associated with physical and sexual IPV risk. Women who reported it was "very likely" that their partner was at risk of acquiring HIV were almost four times as likely to report IPV when compared to women who believed it was "somewhat likely" or "not at all or unlikely" that they had been exposed to HIV via their partner. It is hypothesized that women will be reluctant to have sex with a partner at significant risk of HIV and a woman's self-protective refusal to engage in sex is plausibly met with increased risk of physical violence or forced sex (Koenig et al., 2003; Koenig et al., 2004a).

Mixed results on type of relationship as a determinant of IPV. Inconsistent findings emerged from Rakai data on whether marital, cohabitating, or casual relationships were more or less violent. Results varied by type of violence (physical v. sexual) reported. With respect to physical IPV, women in consensual unions reported significantly more experiences of abuse when compared to those who were officially married or in casual relationships (where the male partner was described as a boyfriend, casual friend, fellow student, workmate; Koenig et al., 2003; Koenig et al., 2004a). A consensual union, in this setting, refers to a man and a woman living together as if they are married but whose relationship is not formalized by the dominant systems of law, religion, or culture. Similar findings from other studies have suggested higher rates of IPV among cohabiting couples (Stets, 1991; Stets & Straus, 1989; Yllo & Straus, 1981). A possible explanation is that men and women in the most healthy, happy relationships get married, while those in less healthy partnerships (with increased risk of violence) break up or linger in cohabiting/consensual living patterns. This might lead cross-sectional samples, such as those generated by Rakai data, to overrepresent people in long-term consensual unions who have more troubled/abusive relationships (Kenney & Mclanahan, 2001).

When it came to sexual abuse, however, women in both marital and consensual unions had significantly higher risk of IPV than women in casual relationships (Koenig et al., 2004a). This result might be partially explained by the fact that casual relationships are

often marked by shorter duration and less commitment (as well as increased ability to leave the partnership if problems occur). In addition, a woman's report of being in a casual relationship might be a surrogate measure for her being more empowered, with more decision-making ability because in Ugandan society entrance into marriage or informal union is not always a result of self-choice (Orubuloye, Caldwell, & Caldwell, 1993). Qualitative research among adolescents highlighted the extent to which young girls felt sex was obligatory in marriage. Many young women narrated how they frequently acquiesced to unwanted intercourse to avoid punitive forced sex or "correctional" physical violence (Wagman et al., 2009). These findings might suggest that married (or cohabitating) women withstand sexual violence (including unwanted sex) as a way to prevent more severe, subsequent physical or sexual abuse.

Our mixed results on how type of relationship influenced a woman's risk for IPV highlighted the importance of SHARE targeting women and men in all types of intimate partnerships. Couples-level prevention efforts were needed for married, consensual, and casual relationships alike.

Society-Level Factors

Uganda's cultural and social systems are historically patriarchal, upholding values that privilege men in decision-making, as well as the allocation of roles and resources. For instance, customary laws subordinate women, community-based dispute resolution forums are dominated by men, and women's representation is limited in community-based groups, professional organizations, the justice system, and economic and political decision-making bodies. Land ownership and inheritance are mainly patrilineal. It is estimated that only 7% of women versus 93% of men own registered land. Most Ugandan women are economically dependent on men (Ellis, Manuel, & Blackden, 2006). These patriarchal values and systems place women at a disadvantage in many ways, including increased risk for IPV and other forms of gender-based violence.

With respect to marriage, Ugandan women often lose social and economic support from their natal families upon marriage. This increases risk for IPV because once this support is lost, women are less able to exit violent relationships, leaving them with fewer resources to draw on and protect themselves in their marital households (Orubuloye et al., 1993). In addition, payment of bride price is common in marriages. One Ugandan study found bride price was paid in 68% of all marriages (Bishai, Falb, Pariyo, & Hindin, 2009) and qualitative research suggests bride price limits women's independence and perpetuates unequal gender power relations in marriage (Kaye, Mirembe, Ekstrom, Kyomuhendo, & Johansson, 2005).

An association was found in Rakai between permissive attitudes about the acceptability of IPV in marital relationships and increased perpetration of physical IPV in relationships in the population. This result was of concern because attitudes condoning IPV were widespread. Most adult men (70%) and women (90%) believed wife/partner violence was justifiable under certain circumstances (Koenig et al., 2003). These findings suggested cultural norms encouraged men and women to view violence as an acceptable dynamic of intimate relationships—something women should tolerate and men should perpetrate. Research

from other settings indicates permissive attitudes toward violence are associated with higher reports of perpetration and experience of IPV (Uthman, Moradi, & Lawoko, 2009). It was clear that prevention programming in Rakai would need to dispel beliefs that VAW is acceptable and raise awareness about women's right to live without violence.

Step 3: Develop and Test Prevention Programs: The SHARE Project

The third step of the public health prevention model is the development and testing of prevention programs (CDC, 2009). This section describes the Safe Homes and Respect for Everyone (SHARE) Project.

SHARE Project Goals

Following the data collection between 2001 and 2004, the SHARE Project was conducted between 2005 and 2009. The mission of SHARE was to reduce IPV by transforming community attitudes about gender norms and the acceptability of partner abuse by raising awareness about women's rights and the negative consequences of IPV on women, children, relationships, and communities. SHARE had five specific violence prevention goals: (a) reduce levels of physical IPV; (b) reduce levels of sexual IPV; (c) increase the proportion of community members who agree IPV is not justifiable under any circumstances; (d) raise awareness about human/women's rights; and (e) integrate high quality, culturally appropriate violence-related services into the health and social support structure that already existed in the intervention areas of the Rakai.

Project Setting

SHARE was implemented by RHSP, which operates in approximately 50 communities, aggregated into 11 regions, of the Rakai District. SHARE was conducted in 4 of those 11 regions in approximately 15 of the 50 RCCS study communities (Figure 1).

Adapting Promising Practices

SHARE adapted methodologies from two community-based IPV prevention programs successfully implemented in sub-Saharan Africa: *The Resource Guide for Mobilizing Communities to Prevent Domestic Violence* (Michau & Naker, 2003) and Stepping Stones (Welbourn, 1995). *The Resource Guide for Mobilizing Communities to Prevent Domestic Violence* (hereafter the *Resource Guide*) was developed by Raising Voices, and provides a rights-based approach to reducing violence by changing attitudes about its acceptability at the community level (Michau & Naker, 2003). The *Resource Guide* reduced community attitudes about the acceptability of IPV and levels of IPV in the urban setting of Kampala, Uganda.

Stepping Stones is a participatory training program designed to prevent HIV and improve sexual health by challenging gender norms that violate women's rights and condone

Figure 1. Map of the Rakai district, Uganda with SHARE regions highlighted.
Note: Figure is available in full color in the online version at vaw.sagepub.com

subordination of and violence against girls and women. Stepping Stones has been implemented in more than 40 countries, including Uganda (Welbourn, 1995) and was found to reduce IPV perpetration in the rural Eastern Cape of South Africa (Jewkes et al., 2008).

SHARE built on these two interventions because both: (a) were developed for use in rural Africa; (b) were effectively conducted in Uganda; (c) reduced self-reported IPV; (d) were community based and developed for sustainability; and (e) focused on change at multiple levels.

SHARE's Theoretical Approach: Stages of Change

SHARE's violence prevention approach was based on the Transtheoretical Model (TTM) of behavior change, which promotes the adoption of healthy practices by influencing an individual's attitudes and decisions. The premise of the TTM is that behavior change occurs over

the course of time as opposed to all at once. The TTM is traditionally aimed at individuals and its central construct is the Stages of Change Model (SCM), which posits that behavior transformation involves progressing through five specific stages (precontemplation, contemplation, preparation for action, action, and maintenance; Prochaska & DiClemente, 1983; Prochaska & Velicer, 1997). Following the *Resource Guide*'s framework, SHARE applied the TTM/SCM at the population level and involved five community-focused phases that complemented each of the five TTM/SCM stages: (a) community assessment; (b) raising awareness; (c) building networks; (d) integrating action; and (e) consolidating efforts (Michau & Naker, 2003). Table 2 shows each TTM individual-level stage and its characteristics and each complementary SHARE community-level stage and its characteristics.

Violence Prevention Strategies

SHARE used five violence prevention strategies to target individuals, their friends and family, local institutions, opinion leaders, and government officials. They were advocacy, capacity building, community activism, learning materials, and special events. These five strategies were concurrently used to engage individuals and groups and guide them through a systematic and structured process of behavior change. A brief description of SHARE's strategies is shown in Table 3.

Violence Prevention Activities

SHARE used multiple IPV prevention activities, all of which were developed to focus on the factors empirically found to be associated with increased risk of IPV at the individual, relationship, and society levels in Rakai (see Figure 2).

Strategy-specific activities were tailored to match the communities' readiness for behavior and attitude change at each stage of the process, as measured through systematic monitoring and evaluation done by SHARE staff, volunteers, and partners. Each SHARE stage had key topics for discussion, but a principle of the *Resource Guide* was that successful community mobilization should emphasize ideas, not messages (Michau & Naker, 2003). Thus, SHARE promoted key ideas to provoke personal reflection and critical thinking as opposed to telling people what to think. The main IPV prevention activities and key topics are described below by phase and strategy. First, a timeline is shown to illustrate the length of each phase and the sequence and order of the multiple components of RHSP's public health approach to violence prevention.

Timeline: Incorporating the Phases of Share into the Public Health Model

The entire process of designing and implementing SHARE took place between 2001 and 2009. The first phase (community assessment, described above) was the longest, taking approximately four years, and each of the subsequent four phases (2-4) took approximately one year. An impact evaluation of SHARE is currently underway (Figure 3).

Table 2. Complementary TTM stages of individual change and SHARE phases of community change.

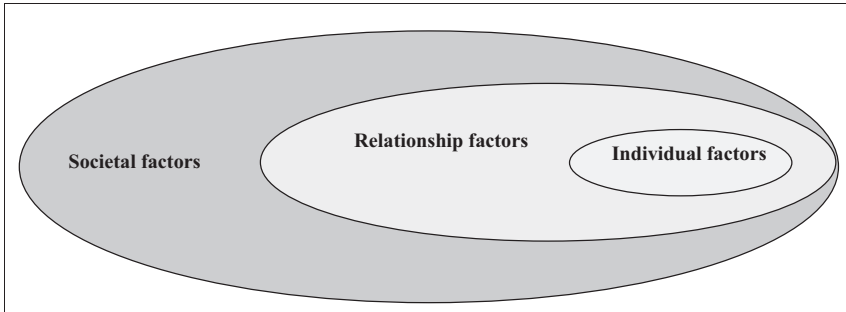
Stage/phase	TTM stages of individual-level change		SHARE phases of community-level change	
Number	Name	Characteristics	Name	Characteristics
1	Precontemplation	*Individual does not intend to change behaviors in the next 6 months.*	Community assessment	*Community does not recognize IPV as a problem, know its consequences or feel need for behavior change.*
2	Contemplation	*Individual is strongly inclined to change behavior in the next 6 months.*	Raising awareness	*Community recognizes IPV as a problem and contemplates behavior change to prevent it.*
3	Preparation	*Individual intends to act in the near future (generally in the next month).*	Building networks	*Community members intend to change their own behavior in the near future.*
4	Action	*Behavior has already been incorporated for at least 6 months.*	Integrating action	*Violence prevention becomes an integral part of life, institutions change policies to prevent IPV and promote women's health.*
5	Maintenance	*Action has been happening for more than 6 months. Chances of relapse are few.*	Consolidating efforts	*Violence prevention has been happening for more than 6 months. Community works to ensure sustainability of efforts.*

Phase 1: Community Assessment and Intervention Planning (2001-2004)

Aims. The aims of Phase 1 were to learn about common perceptions and practices regarding IPV in Rakai, develop relationships with community members, establish SHARE's infrastructure, and build capacity of staff to implement SHARE. After the community assessment was completed, five SHARE staff members (2 male, 3 female) were appointed (from within and beyond RHSP) to conduct the intervention. All SHARE staff members were Ugandan and spoke the dominant local language of Luganda. The entire SHARE team underwent training by violence prevention experts from Raising Voices and their partner organization, the Centre for Domestic Violence Prevention (CEDOVIP), focused on conducting community-based IPV prevention work. SHARE staff members also received training on provision of basic psychosocial support. Training was done through workshops conducted by professional counselors from the Kampala-based organization, Empower Children and Communities against Abuse (ECCA). Finally, the entire SHARE team underwent training, conducted by RHSP investigators, on research skills and ethics.

Table 3. SHARE violence prevention strategies.

STRATEGY	DESCRIPTION
Advocacy	Focused attention on women's needs with specific groups, including collaborations with local organizations, professional sector partnerships, and community leadership forums.
Capacity building	Conducted with SHARE staff, SHARE volunteers and counselors and within various professional sectors. Capacity building done through a Community Activism Course, training of community volunteers and professionals, and structured, on-going dialogue with various decision-makers in the region and at RHSP.
Community activism	Engaged community members to participate in preventing IPV in their community through activities such as a community volunteer network, IPV watch groups, open discussion with couples, community action groups, and community dialogues.
Learning materials	Booklets, posters, stickers, story cards, and information sheets were used widely throughout the intervention communities
Special events	Public forums were created for exploring ideas and values, such as community theatre, music and dance, newsletters, exhibitions, and campaigns.



Societal factors	Relationship factors	Individual factors
• Cultural norms that condone the acceptability of IPV • Less value placed on girls' education	• Alcohol use with sex • Being in a relationship with limited power to make decisions and negotiate protective behaviors	• Less education • Younger age • Belief that IPV is acceptable • Having more than one sex partner in past year • Alcohol use

Figure 2. Factors that put women at risk for IPV in Rakai, Uganda.
Note: Figure is available in full color in the online version at vaw.sagepub.com

SHARE partners. Key SHARE partners were identified and they included Rakai District Police and the District Government Office of Community Services, which employs social welfare officers and community development assistants. "Resource Persons" were

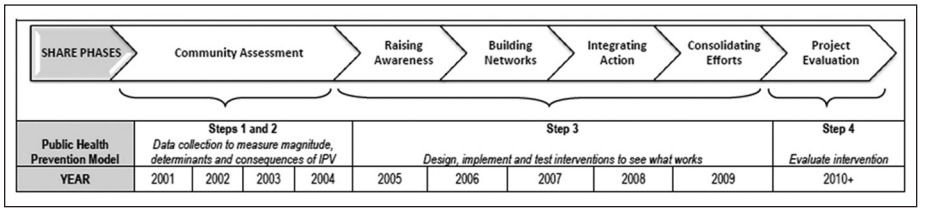


Figure 3. Timeline: Planning, developing, implementing SHARE (2001-2010).

identified from the regional Ministries of Health, Education and Gender, Labour and Social Development. In addition, 40 community volunteers (CVs) were appointed (10 per region) to work as local ambassadors of the project throughout the intervention regions. SHARE CVs were residents in each of the regions and volunteered their time to facilitate project activities and events, get involved with outreach activities, and liaise with SHARE staff from RHSP. CVs were provided materials needed for field activities (e.g., educational tools, pens, paper) and were compensated for their time with a monthly stipend of 10,000 Ugandan shillings (~US$6). SHARE received ongoing technical support from Raising Voices and CEDOVIP throughout the course of the intervention's implementation.

Phase 2: Raising Awareness (2005)

Aims. The aims of Phase 2 were to stimulate dialogue on IPV, help people define it and understand why it happens, and raise awareness about IPV's negative consequences.

Key discussion topics. Key discussion topics were adapted from the *Resource Guide* (Michau & Naker, 2003) and tailored to meet the needs of our setting. They included: (a) IPV is a public, not private, issue that needs attention. (b) IPV hurts everyone, not just women. (c) Women experience IPV more than men do. (d) Women experience different types of IPV (i.e., physical, emotional, sexual, economic). (e) Everyone has a right to live free of violence. (f) Education protects girls and women from IPV. (g) Excessive alcohol use increases risk for IPV and other negative outcomes. (h) Marriages without violence are more satisfying for the whole family.

Activities by Strategy

Capacity building

Community activism course. The primary foundation for the intervention's capacity building program came from the *Resource Guide*'s Community Activism Course (CAC), which included three separate workshops to be conducted sequentially at equal intervals spaced out over the course of the intervention. Themes of the three workshops were: (a) understanding domestic violence; (b) human rights awareness; and (c) advocating for women's rights (Michau & Naker, 2003). Before facilitating any of the capacity building activities, SHARE staff members were trained (by CEDOVIP) on each of the three modules. During the Raising Awareness Phase, the SHARE CVs, SHARE partners, Resources Persons, and RHSP departmental heads underwent CAC workshop number 1: understanding domestic violence.

Other training. SHARE invited professional violence counselors from ECCA to train RHSP's resident voluntary counseling and HIV testing (VCT) counselors and RHSP antiretroviral therapy (ARV) counselors to understand IPV, recognize signs and symptoms of abuse in clients, help women develop safe HIV disclosure plans, offer facilitated disclosure of HIV results, and practice risk reduction strategies for avoiding violence in intimate relationships. SHARE also appointed and trained 12 community counseling aides (CCAs), three per region (one adult female, one adult male, and one youth representative). CCAs were trained to offer basic support to community members experiencing violence. They received clients directly or upon referral from a CV. Cases beyond the scope of a CCA's ability were referred to the RHSP counselor or a local social welfare officer. CCAs received a monthly stipend of 10,000 Ugandan shillings (~US$6).

Community activism. This strategy aimed to reach people within their own environment. Whenever possible, community activism activities were conducted by the CV's who were known and trusted by those in the intervention areas. The goals of activism were to engage community members, get them involved in project activities, and build support and enthusiasm for SHARE's mission and objectives. Three main activism activities were: community action groups; youth outreach efforts; and programs to involve men and boys.

Community action groups. Community action groups (CAGs) were established in each of the 4 SHARE regions to catalyze community involvement in and personal commitment to preventing IPV. CAGs were formed by bringing specific groups of individuals together (e.g., men's groups, women's groups, religious leaders, teachers) and helping them come up with focused plans for preventing and mitigating IPV in their communities. CAGs ultimately served to suggest progressive and original ways to help people in need and educate the community about how to prevent violence. For instance, one of the women's CAGs formed a support group for women victimized by IPV and invited them to come to regular gatherings to share their stories and receive nonjudgmental friendship and encouragement. Youth groups created role plays on IPV conducted at schools and youth-focused locations (e.g., the football field). CAGs were also trained to recognize the signs and symptoms of excessive alcohol use and steps for how to intervene when a community member was in trouble with alcohol or other drugs.

Youth activism. Rakai data indicated young women were disproportionately affected by IPV (Koenig et al., 2003), that a concerning proportion experienced forced first sex (Koenig et al., 2004b), and many felt IPV was implicit in marriage (Wagman et al., 2009). Further, both young women and men (15-19 years) were more likely than adults in the same population to believe wife beating was justifiable (Koenig et al., 2003). These findings on adolescents' beliefs about gender roles and violence, as well as their increased risk for abuse, clearly warranted targeted activities for violence prevention among young people in Rakai. SHARE designed special programs for adolescents that used participatory learning approaches from the Stepping Stones training package to help adolescents improve their communication skills and build more gender-equitable relationships with sexual partners (Welbourn, 1995). This program included approximately 10 sessions that were conducted in schools (with the permission of the school heads) and central community locations (to reach out-of-school youth). Session topics included: (a) listening and

communication; (b) sex and love; (c) HIV and other STIs, safer sex, and condoms; (d) the importance of staying in school; (e) gender equality; (f) nonviolent conflict resolution; and (g) the importance of mutually consensual sex. Activities were facilitated by same-sex SHARE staff members. Recognizing that many young people were out of school and/or married and/or pregnant, activities were tailored to meet the needs of each population. Twelve peer groups (one per region) were formed for adolescents who were married (n = 4), in school (n = 4), and out of school (n = 4).

Working with boys and men to prevent IPV. Recognizing men's authority in our setting, their role in IPV perpetration, and that they were potential resistors of change, we knew that activities for engaging men and boys in the community's effort to prevent violence were critical. We adapted and used many materials from the Family Violence Prevention Fund's online "Toolkit for Working with Men and Boys to Prevent Gender-Based Violence," including a 10-lesson work plan with section topics including, but not limited to masculinities and violence, working with young men, working with schools, cross-cultural solidarity, and building partnerships (Family Violence Prevention Fund, 2004). One of the largest components of SHARE's work with men was the *Kojja Program. Kojja* is the Luganda term for the maternal uncle responsible for offering premarital guidance to young men, based on traditional lessons about how to be a good husband and provider to the family. This program was facilitated by 48 adult men (12 per each SHARE region), who were selected by the community and referred to as SHARE *Kojjas*. All 48 *Kojjas* were trained using the CAC curriculum to encourage boys/men to consider how cultural mores surrounding the concepts of masculinity and female subordination impact attitudes and behaviors toward girls and women. The *Kojjas* were trained to raise awareness about nonviolent approaches to problem-solving and conflict resolution. They conducted small discussion groups as well as larger village meetings. Throughout all *Kojja* sessions the link between alcohol use and IPV risk was emphasized and tips were shared for reducing alcohol consumption.

Advocacy. The advocacy strategy was used to establish dialogue with decision-makers in the community and influence change toward violence prevention in their own attitudes, practices, or policies. Activities included establishment of a local network collaboration and facilitation of 1- to 2-day seminars for managers of community-based organizations, heads of religious institutions, local council leaders, and heads of local government offices. Seminars aimed to discuss the SHARE approach, listen to feedback, and seek endorsement of the intervention from local leaders. Also conducted through the advocacy strategy were workshops with SHARE partners and Resource Persons, including the Rakai District Police, and the Rakai District Government Offices of Community Services, Health, Education and Gender.

Special Events. A local theater troupe was hired to conduct performances related to violence prevention throughout the four intervention regions. Before our collaboration with the drama group began, a 1-day seminar on violence, health, and rights was facilitated by SHARE staff and available CVs to increase the actors' knowledge about main, relevant issues. A short play on IPV was developed, with several narratives that portrayed issues from a woman's perspective. Film shows were also held during the evenings (using the

RHSP film van) depicting dramas about IPV and the benefits of its prevention. Travelling poster and media exhibitions were held at central locations (clinics, hospitals, police stations, schools).

Phase 3: Building Networks (2006)

Aim. The aim of Phase 3 was to prepare the community for attitudinal and behavior change. This phase focused on helping individuals and groups build networks and social support systems to highlight the fact that community change requires everyone's involvement.

Key discussion topics. Key discussion topics included: (a) Everyone is responsible for her/his own behavior. (b) Violence is never an acceptable response to anger, frustration, or conflict. (c) All community members contribute to shaping community norms and beliefs. (d) Everyone is a member of a community and is influenced by the attitudes and behaviors of their peers. (e) All community members have a responsibility to create safety for the entire community. (f) Everyone has a right to safety and a responsibility to respect that right of others (Michau & Naker, 2003). (g) It is the community's responsibility to make sure both girls and boys have the same chance for attaining an education. (h) Alcohol and drugs will not solve your problems; they often make them worse. (i) Couples need to work on making their relationships healthy; both partners are responsible for doing their part and respecting each other.

Networks established. SHARE became part of a regional Gender-based Violence Prevention Network and participated in the 16 Days of Activism Against Gender Violence, an international campaign linking violence against women and human rights. During the 16 Days Campaign, SHARE worked closely with community partners, volunteers, and residents in Rakai to organize rallies and marches, distribute posters and "Prevent VAW" purple ribbons, and stage performances of community dramas focused on IPV prevention. A prevention and referral network was also established among local agencies and professionals. Referral ranged from helping women and their children find a safe place to directing women to legal assistance and counseling where possible. To protect privacy and safeguard women from discovery by an abusive partner, all referrals were made verbally.

Continued education and capacity building. During Phase 3 the SHARE CVs, SHARE partners, Resources Persons, and RHSP departmental heads underwent CAC workshop number 2 on human rights awareness.

Phases 4 and 5: Integrating Action (2007) and Consolidating Efforts (2008)

Aims. The aims of the last two phases were to make actions against IPV part of everyday life and institutional policies and practices (Phase 4) and ensure their sustainability, growth, and progress (Phase 5).

Key discussion topics. The key discussion topics for Phases 4 and 5 adapted from the *Resource Guide* (Michau & Naker, 2003) and are outlined below.

Phase 4 discussion topics	Phase 5 discussion topics
• There are nonviolent ways of resolving conflicts. • Problems are best resolved and decisions are best made when alcohol is not involved. • It is the responsibility of each person to be nonviolent in her/his words and actions. • It is the responsibility of the community that all girls and boys go to school. • Creating violence-free homes is challenging but achievable and has rewards for everyone. • The community can work together to change attitudes and behaviors that hurt women and violate their rights.	• Change can become regular practice if practical measures are established to standardize and enforce change. • Change requires regular reinforcement for it to become normalized. • Nonviolence benefits women, men, children, families, and the community, but ultimately is an issue of justice and women's human rights. • Education benefits both girls and boys and everyone has the right to go to school.

Continued education and capacity building. During Phase 4, the SHARE CVs, SHARE partners, Resources Persons, and RHSP departmental heads underwent CAC workshop number 3 on advocating for women's rights. Resource Persons developed conceptual "tools" for taking violence reports and subsequently storing them (e.g., intake forms, computer entry screens where applicable, and secured storage receptacles) and for handling and referring violence cases appropriately. We helped to establish long-term action plans for key players so they could continue to promote women's rights and prevent IPV. SHARE presented policy recommendations at the district level and worked with CVs to develop local bylaws related to prevention of violence.

Challenges, Lessons Learned, and Recommendations

Similar to individuals, behavior change at the community level takes a long time to achieve and is coupled with many challenges. This section discusses some of the main challenges experienced by SHARE and the main lessons learned. Key recommendations are provided for other groups conducting IPV prevention work, particularly in sub-Saharan Africa (Table 4).

One of the most important steps for implementing a strong and successful violence prevention project is carefully selecting and training staff members with the skills and personality characteristics to face and effectively handle the numerous obstacles that will emerge during the course of the project. Most SHARE team members had at least a university degree and all were selected for their maturity, independent thinking skills, gender sensitivity, and progressive attitudes toward the importance of gender equality and women's rights. Despite these credentials, however, we recognized some staff members might have been experiencing violence in their own lives and were likely exposed to many of the beliefs and attitudes we were trying to dispel via SHARE. It was vital to the success of our project, and certainly will be to that of others who plan to

Table 4. Recommendations.

- Carefully select and train project staff before initiating any violence prevention intervention work;
- Offer consistent personal and professional support for staff development, health and mental well-being;
- Introduce the project before its outset and have it endorsed and approved by necessary gatekeepers;
- Establish partnerships with key people and groups in intervention regions;
- Become part of a network of other groups and organizations doing violence prevention and women's health work;
- Involve men and boys in violence prevention activities and continuously encourage their active participation;
- Engage community members in all aspects of the project and promote "community ownership" of positive change.

conduct similar interventions, to provide support for the personal and professional development of all personnel from the start. Support systems were put in place for staff to discuss their own experiences with violence and their anxieties about talking publicly about (the controversial topic of) IPV, as well as support for dealing with the emotional challenges of working with victims of abuse in the community. A referral network was established for staff to talk with RHSP (or external) counselors. In addition, internal mechanisms were set up for ongoing staff support and training through weekly check-ins and staff development meetings.

The introduction of new ideas is often met with resistance. During the raising awareness phase, our team encountered many slow acceptors as well as opposition from the various targeted societal sectors. Some people feared SHARE was undermining cultural values and/or disrespecting important customary and religious traditions. We successfully alleviated most concerns by properly introducing the project before its implementation and gaining the endorsement and approval of necessary gatekeepers. In addition, we established and partnered with key people in intervention regions and strongly recommend that other prevention programmers do the same. We encourage those implementing IPV prevention projects to work closely with trusted local opinion leaders from the start. Leaders should be invited to actively participate in project activities. This is often a slow, time-consuming process at the beginning, but well worth it as it ultimately expedites acceptance of project activities. SHARE felt the community become more supportive of and involved with the project as collaboration increased with leaders who endorsed the SHARE mission and goals and put them into practice in their own lives and organizations. Likewise, establishing collaborations with other groups and organizations had many benefits for SHARE. Being a part of a network helped project staff make connections with like-minded groups and individuals and learn from each other. This was particularly helpful for SHARE staff, since we were all doing IPV work for the first time in Rakai. By discussing issues with other members of our network we learned of many opportunities, gained support of our work from others with an existing

presence in the region, and significantly expanded our understanding of the IPV problem from a broader perspective.

Men's involvement was also initially a challenge because many male community members feared that SHARE aimed to ostracize and castigate men. Further, some men felt it would be stigmatizing if their peers found out they were participating in a project perceived to be about women's issues. We were able to dispel many of these concerns by working with male role models and placing extensive efforts on getting men and boys involved in the project. Priority was placed on framing SHARE as a project for the community as opposed to casting it as a "women's rights" or "women's empowerment" project, which initially excluded and discouraged men's involvement. Our messages and activities emphasized the importance of working with women *and* men to prevent the public health problem of IPV. Although it took time, our efforts to encourage men and boy's participation in SHARE effectively contributed to a sense of male "ownership" of the problem.

Many authorities had traditional attitudes and biases against women. Likewise, numerous organizations (e.g., police and social welfare officers) were initially reluctant to handle cases of IPV because they personally viewed partner violence as a private problem best handled within the home. Similarly, existing policy and law were obstacles. Although violence in general was outlawed, the government repeatedly refused to enact legislation that specifically outlawed domestic violence. The only domestic violence by-law in Uganda was passed in Kampala in October 2007, which reflects how much work is still needed before VAW is recognized by the national government as a human rights and public health issue that merits specific laws.

A major strength of this intervention was community participation and promotion of "ownership" of positive change. SHARE engaged key players from different groups in the community, which built momentum and contributed to sustainability of violence prevention efforts. By engaging community members and putting them in positions of leadership, SHARE was not only able to run from start to finish but many activities initiated by the intervention later expanded into self-sustaining projects. Even though SHARE ended in 2009, activities initiated by key community players are still in progress.

Next Steps

The final step of the public health approach to prevention is to scale-up effective and promising interventions and evaluate their impact (CDC, 2009). Data from an effectiveness trial to evaluate SHARE are currently being analyzed to assess the intervention's impact on victimization and perpetration of IPV, attitudes about the acceptability of VAW, and the reach of the intervention's activities.

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