



## PROGRAMME SUMMARY

### The Safe Homes and Respect for Everyone (SHARE) Programme in Rakai Uganda

#### PROGRAMME AT A GLANCE

The Safe Homes and Respect for Everyone (SHARE) intervention was a multi-component intimate partner violence (IPV) and HIV prevention programme integrated into the Rakai Health Sciences Programme (RHSP), which provided routine HIV prevention and treatment services.

- Community-based mobilization to change attitudes and social norms that contribute to IPV and HIV risk;

- A screening and brief intervention to reduce HIV-disclosure related violence and risks for women seeking HIV counselling and testing. SHARE aimed to reduce physical and sexual IPV and HIV incidence using two main approaches:

The SHARE programme succeeded in reducing the prevalence of both physical and sexual IPV, as reported by women, as well as population-level HIV incidence during the intervention period

#### BACKGROUND

There is a two-way relationship between IPV and HIV infection. IPV increases women's risk of HIV infection and limits their access to prevention, treatment and care. HIV positive women are also at higher risk of experiencing IPV.

In response, programmes such as Stepping Stones, IMAGE and SASA! have integrated both IPV and HIV prevention activities into their interventions. However, none demonstrated statistically significant decreases in both IPV and HIV outcomes.

The SHARE programme was launched in 2005 in Rakai District of Uganda, an area where the Rakai Health Sciences Programme (RHSP) operated. It aimed to integrate high quality, culturally appropriate violence prevention activities into the health and social support structure that was already

being provided by the RHSP. It was estimated that 1 in 5 new cases of HIV among women could be avoided if IPV was prevented in the communities.



#### SHARE: PROGRAMME OBJECTIVES

- To reduce levels of physical IPV
- To reduce levels of sexual IPV
- To increase the proportion of community members who agree IPV is not justifiable under any circumstances
- To raise awareness about women's rights
- To reduce HIV incidence
- To reduce sexual risk behaviours.





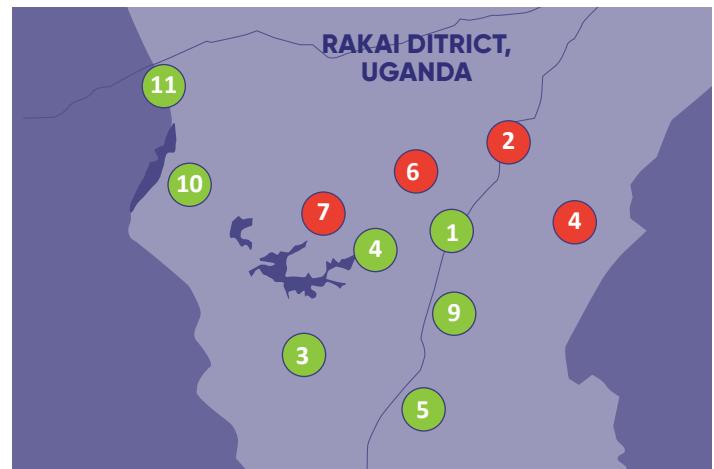
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## PROGRAMME CONTEXT

Rakai is a traditionally patriarchal society situated in southwestern Uganda. The results of a study undertaken prior to the SHARE intervention in 2002 showed that:

- HIV prevalence in Rakai was 16% women and 12% men.
- Approximately 30% and 24% of adult women reported lifetime physical and sexual IPV respectively.
- 14% of women 15–19 years experienced forced first sex.
- Most men and women believed a man was justified to beat his wife under certain circumstances.

SHARE was implemented in 4 out of the 11 study regions across the Rakai District in Uganda where RHSP operated. Each of the regions had 2–8 communities consisting of approximately 809 households. In total, 3236 Rakai Households received the SHARE intervention.



1. Kyotera
2. Kalisizo
3. Kibale-Rakai
4. Kabira
5. Kakuuto
6. katana
7. Buyamba
8. Lwanda
9. Kasasa-Sanje
10. Lyantode
11. Lwamaggwa

## PROGRAMME DESCRIPTION

SHARE was modelled after a community mobilisation approach for preventing IPV popularised in East-Africa by Raising Voices. This prevention approach is based on the Transtheoretical Model (TTM) of behaviour change, which aims to influence an individual's attitudes and decisions that occur over a course of time.

SHARE used five violence prevention strategies to target individuals, their friends and family, local institutions, opinion leaders, and government officials: advocacy, capacity building, community activism, learning materials, and special events. It adapted methodologies and materials from *The Resource Guide for Mobilizing Communities to Prevent Domestic Violence*- including the Community Activism Course of three workshops- and the *Stepping Stones* curriculum. SHARE was combined with pre-existing HIV support offered by RHSP.

SHARE core staff included three women and two men with post-secondary education and English and Luganda language proficiency. Before the launch of the intervention, they all received four intensive weeks of training on IPV prevention, gender, programme ethics, supporting survivors, HIV, and psychosocial counselling.

40 resident community volunteers were selected to work as local ambassadors of the projects. This team received training in IPV awareness and prevention and facilitated overall project implementation. Additionally, 12 community counselling aides (CCAs) were appointed to work as volunteers in SHARE regions. All 12 CCAs were trained to offer basic support to community members experiencing violence, including violence associated with seeking HIV services.



### RAKAI HEALTH SCIENCES PROGRAM'S ROUTINE HIV PREVENTION AND TREATMENT SERVICES

- Provision of free condoms
- Syndromic STI treatment
- General medical care
- Prevention of mother-to-child HIV transmission
- HIV prevention and general health education
- HIV monitoring and treatment: HIV+ people who accept voluntary counselling and testing referred for HIV care.
- HAART: Individuals started on standard first-line ART when they reach WHO stage IV disease or have a low CD4 cell count.

## COMPONENTS OF THE SHARE PROGRAMME

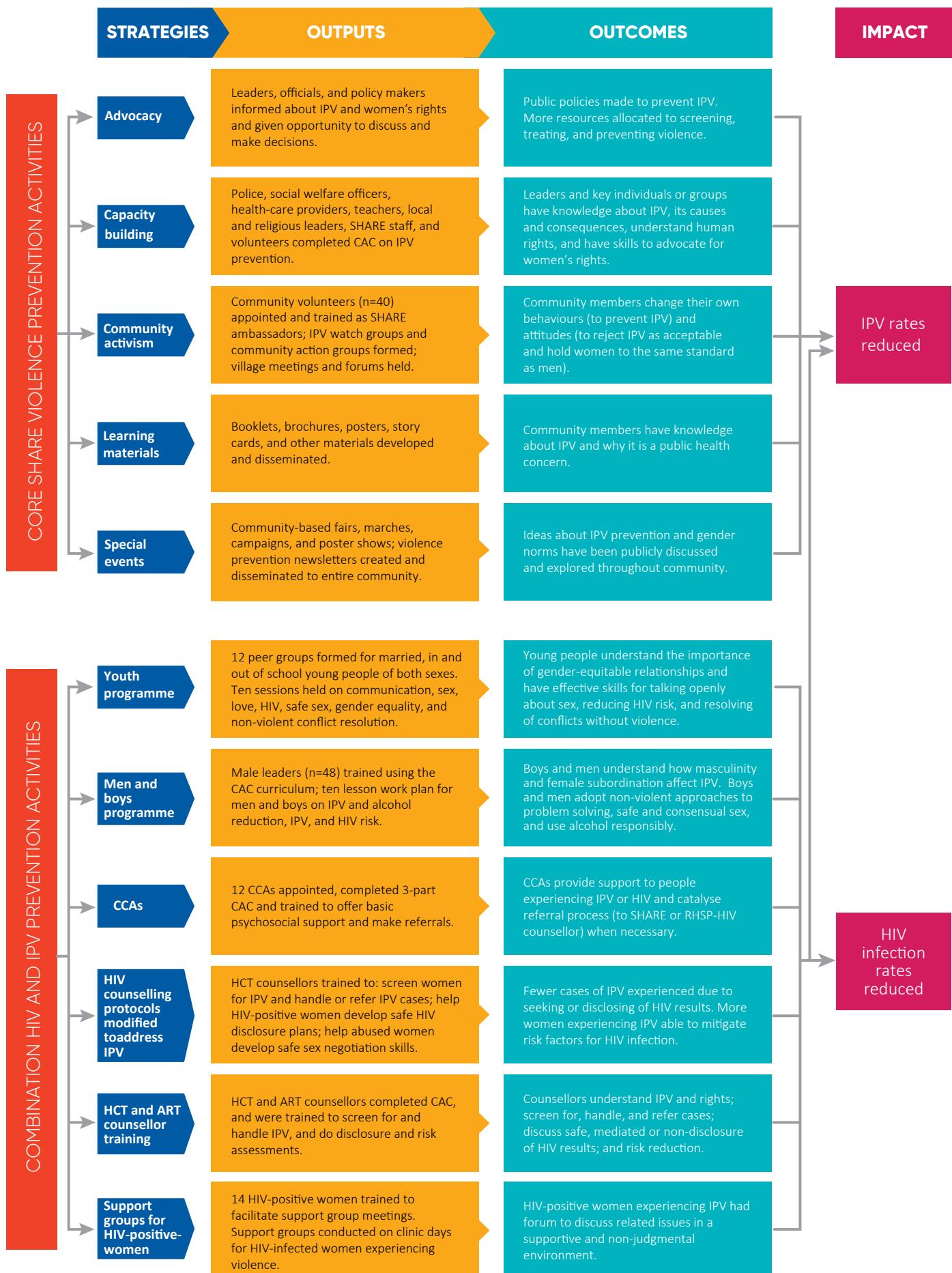
### Violence Prevention:

STRATEGY	ACTIVITIES	TARGET POPULATIONS
<b>Advocacy</b>	<ul style="list-style-type: none"> <li>• Workplace dialogues</li> <li>• Targeted local group seminars</li> <li>• Focused dialogues with opinion and local leaders</li> <li>• Professional network for service providers</li> </ul>	Leaders, officials, and policy makers were informed about IPV and women's rights and given the opportunity to discuss and make decisions in light of what they learned.
<b>Capacity building</b>	<ul style="list-style-type: none"> <li>• Staff development workshops</li> <li>• Training of resource persons and volunteers</li> <li>• Seminars</li> <li>• Targeted workshops and trainings on IPV, human and women's rights</li> </ul>	Police, social welfare officers, health-care providers, teachers, local and religious leaders, SHARE staff, and volunteers completed the Community Activism Course (CAC) on IPV prevention.
<b>Community activism</b>	<ul style="list-style-type: none"> <li>• 40 community volunteers were appointed and trained as SHARE ambassadors</li> <li>• Public booklet clubs</li> <li>• IPV prevention action groups</li> <li>• Door-to-door awareness activities</li> </ul>	Women and men, youth and children within the community.
<b>Learning materials</b>	<p>Development, adaptation, and distribution of:</p> <ul style="list-style-type: none"> <li>• Booklets and brochures</li> <li>• Posters</li> <li>• Story cards</li> <li>• Other educational materials</li> </ul>	General public, community members, local organisations, health care providers, and social service officers.
<b>Special events</b>	<ul style="list-style-type: none"> <li>• Local fairs</li> <li>• Public marches</li> <li>• Public campaigns</li> <li>• Open poster exhibitions</li> <li>• Community drama shows</li> <li>• Outdoor films and music events</li> </ul>	Community members, leaders, the general public, and local institutions.

### Combined HIV and IPV prevention activities:

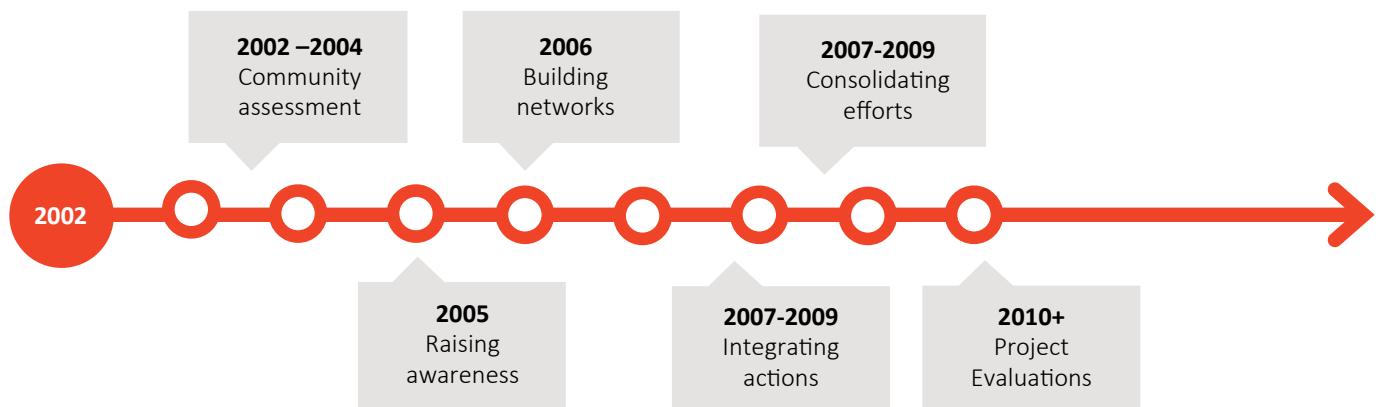
STRATEGY	ACTIVITIES	TARGET POPULATIONS
<b>Youth programme</b>	<ul style="list-style-type: none"> <li>• 12 peer groups were formed of young men and women</li> <li>• Ten participatory sessions were held on communication, sex, love, HIV, safe sex, gender equality, and non-violent conflict resolution, drawing on the Stepping Stones Curriculum.</li> <li>• Activities were facilitated by SHARE staff members.</li> </ul>	Married, in and out of school young men and women
<b>Men's and boy's programme</b>	<ul style="list-style-type: none"> <li>• 48 male leaders were trained using a ten-lesson curriculum adapted from the Family Violence Fund's on-line "Toolkit for Women with Men and Boys to Prevent GBV, and the core Community Activism Course.</li> <li>• These male leaders then worked with other men and boys through a programme known as Kojja (maternal uncle who offers pre-marriage guidance) on conflict resolution, alcohol reduction, IPV, and HIV risk.</li> </ul>	Male leaders  Men and boys within the community
<b>Community Counselling Aides (CCAs)</b>	12 Counselling Aides were appointed to assist the RHSP's paid counsellors, all of whom completed the 3-part CAC and were trained to offer basic psychosocial support and make referrals.	Community Counselling Aides (CCAs)  Women within the community.
<b>HIV counselling protocols modified to address IPV</b>	HIV Counselling and Testing (HCT) counsellors were trained to: <ul style="list-style-type: none"> <li>• Screen women for IPV and handle or refer IPV case,</li> <li>• Help HIV-positive women develop safe HIV disclosure plans</li> <li>• Help abused women develop safe sex negotiation skills.</li> </ul>	HIV Counselling and Testing (HCT)  Women within the community.
<b>HCT and ART counsellor training</b>	Testing and antiretroviral treatment (ART) counsellors completed the CAC, and were trained to: <ul style="list-style-type: none"> <li>• Screen for and handle IPV</li> <li>• Perform disclosure and risk assessments.</li> </ul>	HIV and ART counsellors  Women within the community.
<b>Support groups for HIV positive women</b>	<ul style="list-style-type: none"> <li>• 14 HIV-positive women were trained to facilitate support group meetings.</li> <li>• Support groups were conducted on clinic days for HIV-infected women experiencing violence.</li> </ul>	HIV Positive women

# THEORY OF CHANGE



## PROGRAMME TIMEFRAME

The entire process of designing and implementing SHARE took place between 2001 and 2009. Inspired by the TTM model for behavioural change, the programme followed a carefully phased approach at community level, comprising of an initial context analysis, relationship analysis, and planning at the community level. Thereafter were distinct phases of raising awareness, building networks, and catalysing ongoing action.



PHASE 1: COMMUNITY ASSESSMENT AND INTERVENTION PLANNING (2001-2004)	PHASE 2: RAISING AWARENESS (2005)
Conducted a pre-intervention assessment of the context of Rakai, in terms of the common perceptions and practices regarding IPV in communities.  Also involved setting up infrastructure and other resources, building relationships with community members and other key stakeholders.  Involved recruiting team members and providing training by Raising Voices and their partner organisation, the Centre for Domestic Violence Prevention (CEDOVIP), and they were given psychosocial support.	Aimed to raise awareness about IPV, its definitions, causes, and the negative consequences.  <b>Key activities included:</b> <ul style="list-style-type: none"><li>Advocacy targeting specific groups, local organisations, etc.</li><li>Capacity building were given to SHARE staff and volunteers, counsellors, etc.</li><li>Community activism to engage community members through various activities such as open discussions with couples, community action groups, etc.</li><li>Learning materials such as booklets, posters, stickers, story cards, and information sheets provided to the communities.</li><li>Special events such as public forums, community theatre, music and dance, newsletters, exhibitions, campaigns to explore ideas and values concerning IPV.</li></ul>
PHASE 3: BUILDING NETWORKS (2006)	PHASES 4 AND 5: INTEGRATING ACTION (2007) AND CONSOLIDATING EFFORTS (2008)
Aimed to prepare the community for attitudinal and behaviour change and encourage individuals and groups to collaboratively get involved in building networks and social support systems.	Aimed to make actions against IPV well integrated into the everyday life and workings of communities, and institutional policies and practices.



## MONITORING AND EVALUATION

- After each IPV and HIV prevention activity, the SHARE staff, volunteers, and partners compiled monitoring reports to record detailed information about the activities that took place and the lessons learned.
- Intervention summaries were written by the SHARE coordinator at the end of each month and compiled into full reports at the end of each phase. These documented the overall implementation experience and lessons learned and an assessment of how well the communities accepted the interventions and how ready they were to receive future behaviour and attitude change interventions.

- There were also mapping exercises to track whether and how the intervention strategies and activities were leading to the target outcomes and generating long-term impact.
- An impact evaluation was also implemented using a randomised controlled trial (RCT) with baseline surveys and two follow up surveys. It evaluated the past year reductions of IPV and HIV between SHARE intervention groups and control groups (see our Study Summary for the results of this evaluation).

## PROGRAMMING LESSONS

- Despite male-focused activities, many men perceived violence prevention to be a ‘women’s project’. To address this, the intervention team included men and women to stress the importance of working together. Local male leaders and volunteers were also recruited to serve as role models for IPV prevention and encourage engagement from men in the communities.
- It was also important to create space to address fears about whether preventing IPV might impact negatively on men. Nonetheless, fewer men than women took part in SHARE activities and SHARE did not significantly affect male perpetration of IPV over time. Therefore, further work is needed on how to effectively involve men in IPV prevention.
- There was also initial scepticism about the links between IPV and HIV. Project staff therefore delivered awareness raising activities about these links with time for dialogue and questions.
- The Community Counselling Aides were an important complement to the professional HCT counsellors. Located in close proximity to the beneficiary population, they could provide much-needed short-term mechanisms of support.

This onsite psychosocial support should be integral to violence reduction programmes.

- Most HCT counsellors felt that the HCT setting was an ideal opportunity to screen for and address violence, finding that their clients felt safe to disclose fears or experiences of abuse and benefited from the personalised safety planning. However, they felt that more than one session was needed to provide tailored support, so during implementation they started to see clients multiple times. In the future, it will be important to assess women’s experiences of HCT-based IPV screening and brief interventions so these can be further improved.
- Many of the staff implementing SHARE and RHSP were dealing with their own cases of abuse and/or HIV infection at home, but initially were not receiving the care they needed. An internal staff support system was therefore developed to offer counselling, risk reduction planning, and help in accessing care to staff and their partners as appropriate.

## SOURCE DOCUMENTS

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