Preventing Intimate Partner Violence in Uganda, Kenya, and Tanzania: Summary of a Joint Workshop by the Institute of Medicine, the National Research Council, and the Uganda National Academy of Sciences

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Louise Flavahan, *Rapporteur*

Forum on Global Violence Prevention

Board on Global Health

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This workshop summary has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published workshop summary as sound as possible and to ensure that the workshop summary meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this workshop summary:

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Although the reviewers listed above have provided many constructive comments and suggestions, they did not see the final draft of the workshop summary before its release. The review of this workshop summary was overseen by **Eli Y. Adashi,** Professor of Medical Science and Former Dean of Medicine and Biological Sciences at the Warren Alpert Medical School of Brown University. Appointed by the Institute of Medicine, he

was responsible for making certain that an independent examination of this workshop summary was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this workshop summary rests entirely with the rapporteur and the institution.

Acknowledgments

The Forum on Global Violence Prevention was established to develop multisectoral collaboration among stakeholders. Violence prevention is a cross-disciplinary field that could benefit from increased dialogue among researchers, policy makers, funders, and practitioners. As awareness of the insidious and pervasive nature of violence grows, so too does the imperative to mitigate and prevent it. The Forum seeks to illuminate and explore evidence-based approaches to the prevention of violence.

A number of individuals contributed to the development of this workshop and report. These include a number of staff members from the Institute of Medicine and the National Academies. The Forum staff, including Louise Flavahan, Kimberly Scott, and Rachel Taylor, put forth considerable effort to ensure this workshop and report's success.

The planning committee contributed several hours of service to develop and execute the agenda, with the guidance of Forum membership. Reviewers also provided thoughtful remarks in reading the draft manuscript. Finally, these efforts would not be possible without the work of the Forum membership itself, an esteemed body of individuals dedicated to the concept that violence is preventable.

This workshop was made possible through the support of a generous anonymous donor. The overall successful functioning of the Forum and its activities depends on the generosity of its sponsors. Financial support for the Forum on Global Violence Prevention is provided by the U.S. Department of Health and Human Services: Administration on Community Living, Office on Women's Health; Anheuser-Busch InBev; the Archstone Foundation; the Avon Foundation for Women; BD (Becton, Dickinson &

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Introduction[1]

Globally, between 15–71 percent of women will experience physical and/or sexual abuse from an intimate partner at some point in their lifetime (WHO, 2014). Too often this preventable form of violence is repetitive in nature, occurring at multiple points across the lifespan. In East Africa, the prevalence of intimate partner violence (IPV) is on the higher end of this spectrum, with in-country demographic and health surveys indicating that approximately half of all women between the ages of 15–49 in Uganda, Kenya, and Tanzania have experienced physical or sexual abuse within a partnership, making this workshop's focus particularly relevant (Kenya National Bureau of Statistics and ICF Macro, 2010; National Bureau of Statistics and ICF Macro, 2011; Uganda Bureau of Statistics and ICF Macro, 2012; WHO and London School of Hygiene and Tropical Medicine, 2010).

According to the World Bank, evidence shows that people subjected to IPV experience a wide range of both direct and indirect adverse health effects. Direct effects broadly include injury; chronic pain; increased association with hypertension, cancer, and cardiovascular disease; disability; sexual and reproductive health problems, such as an increased risk of

[1] The planning committee's role was limited to planning the workshop. The workshop summary was prepared by the rapporteur as a factual summary of what occurred at the workshop. Statements, recommendations, and opinions expressed are those of individual presenters and participants and are not necessarily endorsed or verified by the Forum on Global Violence Prevention, the Institute of Medicine, or the National Research Council, and they should not be construed as reflecting any group consensus.

contracting HIV, experiencing a miscarriage or premature birth; and even the loss of life. Indirect adverse health effects, although less conspicuous than their direct counterparts, are equally as important in their effects on both individuals and their communities. They include physical and psychological stress; anxiety; low energy; diminished social function; and behavioral impacts, such as alcohol or drug abuse (Duvvury et al., 2013). Furthermore, the World Bank explains that research suggests that victims of IPV are less productive over their lifespan, report higher rates of absenteeism, and access health systems more often and at greater cost than non-victims. These and related factors make IPV a burden on economies, resulting in high social and monetary costs that could substantially affect development (Duvvury et al., 2013).

Although there is a growing understanding of IPV as an important public health and safety issue, greater strides in prevention efforts have been challenging for a multitude of reasons, including a lack of good data on the nature and magnitude of IPV and its costs; a limited understanding of the regional and context-specific aspects of IPV; fragmented efforts and resources to address it; and long-held assumptions that violence is both inevitable and unpreventable. However, it is now widely accepted that preventing IPV *is* possible and can be achieved through a greater understanding of the problem; its risk and protective factors; and effective evidence-informed primary, secondary, and tertiary prevention strategies (for more information, refer to the following section titled "Definitions and Context").

To that end, on August 11–12, 2014, the Institute of Medicine's (IOM's) Forum on Global Violence Prevention, in a collaborative partnership with the Uganda National Academy of Sciences (UNAS),[2] convened a workshop focused on informing and creating synergies within a diverse community of researchers, health workers, and decision makers committed to promoting IPV-prevention efforts that are innovative, evidence-based, and crosscutting. This collaborative workshop also fulfills the Forum's mandate, which in part requires it to engage in multisectoral, multidirectional dialogue that explores crosscutting approaches to violence prevention (see Appendix A).

This workshop brought together a variety of stakeholders and community workers from Uganda, Kenya, and Tanzania to engage in a meaningful, multidirectional dialogue regarding IPV in the region. The focus on Uganda, Kenya, and Tanzania simultaneously reflects the workshop sponsor's

[2] The mission of the UNAS is to contribute toward improving the prosperity and welfare of the people of Uganda by promoting, generating, sharing, and utilizing scientific knowledge and information, and to give independent, merit-based advice to government and society, among others. Similarly, the IOM has equivalent aims to the U.S. government and other domestic and international stakeholders who seek its advice.

programmatic area of interest and the Forum on Global Violence Prevention's commitment to low- and middle-income countries. Furthermore, the regional focus highlighted the benefits of a collective effort to reduce IPV within East Africa, which can allow for the sharing of limited resources and data as well as best practices across borders in order to replicate evidence-informed interventions and prevention efforts within each nation.

The efficacy and benefits of a multilateral approach were raised time and again during the workshop and are featured prominently throughout this summary. Examples include the promise and widespread adoption of community interventions such as Uganda's successful Raising Voices campaign and models such as the LVCT Health approach.[3] Furthermore, the South African Medical Research Council's Sexual Violence Research Initiative (SVRI) has developed a series of interrelated primary-prevention-based interventions that are being tested throughout Uganda, Kenya, and Tanzania. With guidance from SVRI experts, local stakeholders are implementing and analyzing each intervention in order to produce IPV-prevention programming for use throughout the region, while remaining cognizant of the unique aspects of each country and the communities found within its borders.[4] These examples and those that follow in subsequent chapters have shown promise, through evaluation, in producing effective interventions tailored to the specific needs of the region. These efforts could reduce the overall burden of IPV borne by individuals and communities throughout Uganda, Kenya, and Tanzania.

DEFINITIONS AND CONTEXT

It is important to note that IPV is distinct from gender-based violence (GBV). Although often used interchangeably, the two terms denote different scopes and contexts of violence. IPV, as defined by the World Health Organization (WHO), is the behavior by an intimate partner, or ex-partner, that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors. Whereas GBV refers to abuse that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life. As the definition describes, GBV refers to violence specifically perpetrated against women and includes acts perpetrated by both strangers and non-strangers. IPV, often a form of GBV, describes a

[3] More information regarding these and other interventions are available in Chapter 5 of this workshop summary.

[4] More information is available at http://www.svri.org/primaryresearch.htm (accessed May 1, 2015).

narrower context of non-stranger, or intimate partner, violence that captures acts perpetrated against both women and men within an intimate or formerly intimate relationship. Although IPV includes violent acts committed against both sexes, the prevalence of IPV committed toward women is much higher than that against men, resulting in a disproportionate burden of IPV shared among women in the region.

The focus on IPV within the framework of this workshop was both deliberate and intentional. During the workshop, speaker Charlotte Watts stated that although the prevalence of non-partner violence is around 7 percent globally, approximately 30 percent of all females in an intimate relationship have experienced violence from their partner (Watts, 2013). Speaker Chi-Chi Undie went on to explain that research related to IPV is relatively new in this region, whereas GBV has received considerable attention throughout Uganda, Kenya, and Tanzania.

In addition to IPV, this workshop focused on points of primary, secondary, and tertiary prevention. In the context of public health generally, primary prevention refers to efforts made to prevent a disease or condition from developing in the first place. Secondary prevention attempts to detect and identify a disease or condition during its earliest stages in order to effectively manage the disease or condition, thereby reducing its impact. Meanwhile, tertiary prevention focuses on reducing or minimizing the consequences of a disease once it has developed (CDC, 2013).

In the context of IPV, primary prevention seeks to reduce the risk of experiencing or being exposed to IPV in the first place by addressing risk factors and social norms that promote this type of violence. Secondary prevention focuses on improving the detection of IPV and providing appropriate services to victims, and tertiary prevention focuses on strengthening institutional responses to IPV, thereby mitigating the adverse consequences of this form of violence.

ORGANIZATION OF THE REPORT

This report provides a summary account of the presentations given at the workshop. Opinions expressed within this summary are not those of the IOM, the National Research Council, the Forum on Global Violence Prevention, or their agents, but rather of the presenters themselves. Such statements are the views of the speakers and do not reflect conclusions or recommendations of a formally appointed committee. This summary was authored by a designated rapporteur based on the workshop presentations and discussions and does not constitute a full or exhaustive overview of the field.

The workshop summary is organized thematically, covering the major topics examined and presented during the 2-day workshop. The thematic

organization also allows the summary to serve as an overview of important issues in the field; however, such an organization results in some repetition, as themes are interrelated and the presented examples support several different themes and subthemes raised by speakers. The themes presented in this summary were the frequent and crosscutting elements that arose from the various workshop presentations. The report consists of an introduction (Chapter 1) and six subsequent chapters, which provide a summary of the workshop. The appendixes contain additional information regarding the agenda and participants.

The second chapter highlights the magnitude of IPV in this region of East Africa, while exploring some of the limitations of the available data, particularly in relation to the subpopulations of older women and adolescent girls and children.

The third chapter discusses a common thread found throughout the workshop and a crucial point of the IPV discussion within the region in greater detail: the complex and bi-directional relationship between IPV and HIV. And although this complex relationship was discussed at many points throughout the 2-day workshop and can be found at multiple points within this summary, the bulk of the discussion regarding IPV and HIV can be found within Chapter 3.

Chapter 4 focuses on a broad range of responses to the problem of IPV in the region by sector, namely the criminal justice, health, and social work responses. This chapter also contains a discussion on the complexities of screening for IPV in East Africa and what current science indicates in regard to its usefulness.

Chapter 5 features a variety of the successful community-based prevention efforts in the region. This chapter includes presentations from the extremely promising Uganda-based interventions: Raising Voices' SASA! program and the SHARE model, as well as the Kenya-based LVCT Health approach, among others.

Chapter 6 highlights the importance of connecting research, policy, and practice within the region to ensure that efforts to reduce the burden of IPV are coordinated across sectors.

Chapter 7 features a discussion of the workshop's final panel: The Way Forward. This discussion was designed to create a robust discussion among workshop participants while they reflected on the previous day and a half of presentations. The discussion produced possible ways forward for regional efforts regarding IPV. The appendixes contain additional information regarding the agenda and workshop participants.

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2

Intimate Partner Violence in East Africa

As speaker Charlotte Watts of the London School of Hygiene and Tropical Medicine explained, IPV will directly affect the lives of one-third of all partnered women throughout the world at some point in their lifetime (Watts, 2013; WHO, 2005). During her presentation on the intersection of IPV and HIV, Watts reminded us that although the region of East Africa is particularly affected by IPV, prevalence rates for this form of violence are high throughout the globe. It is not as if, she went on to explain, there is a culture on Earth that is insulated from violence generally and IPV in particular. And although analyzing and understanding the global context of IPV is important for any informed discussion on the topic, many speakers noted the incredible importance of approaching the problem of IPV in East Africa through an East African lens. It is not enough, they explained, to simply "copy and paste" effective interventions from other areas of the globe, or to scale successful models without regional study and application. The cultural context of the region demands a more focused and tailored approach, thus ensuring that any intervention effectively addresses the risk and protective factors associated with IPV in East Africa.

MAGNITUDE OF INTIMATE PARTNER VIOLENCE IN THE REGION

Setting the stage for the workshop's subsequent discussions regarding public health and policy interventions in the region, Jessie Mbwambo, a senior medical specialist, psychiatrist, and senior researcher at Muhimbili Hospital in Tanzania, discussed the magnitude of IPV in the region during

her keynote address. Mbwambo began by discussing the findings of the WHO's Multi-country Study on Women's Health and Domestic Violence against Women (WHO, 2005). Published in 2005, the study analyzed the prevalence of IPV throughout 15 sites spread across 10 different countries. Included in the study were two sites in Tanzania: the provincial town of Mbeya and the urban city of Dar es Salaam. In regards to IPV, the study asked more than 3,000 women in these areas if they had ever experienced physical violence, sexual violence, or physical and sexual violence at the hands of a partner.

The WHO Multi-country Study revealed that women in the provincial site of Mbeya reported higher levels of IPV across all three categories of violence than their counterparts in Dar es Salaam. In Dar es Salaam, 33 percent of women reported experiencing physical violence; 23 percent reported sexual violence; and 41 percent reported experiencing both. Meanwhile in Mbeya, a staggering 47 percent of women reported experiencing physical violence; 31 percent had experienced sexual violence; and 56 percent of women reported experiencing both. Mbwambo explained that this trend of higher rates of IPV in more provincial areas held true throughout the WHO Multi-country Study, as well as in studies throughout the region, regardless of size or scale. Mbwambo noted that although it is difficult to identify the causal pathways for these differences from the WHO study because it is a cross-sectional study, researchers can and have hypothesized that gender imbalances as well as prevailing cultural and societal norms surrounding the status of women may be stronger in more provincial regions thus contributing to the disparity.

Many speakers throughout the 2-day workshop further illuminated these hypothesized root causes and discussed how the cultural context of East Africa affects IPV. And although these hypotheses are compelling, Mbwambo highlighted that more work needs to be done in order to confirm and explore purported risk factors and causal links within this complex form of violence. The difficulty with this, Mbwambo reminded the audience, is that performing the necessary research to explore those causes and effects costs considerable resources that the region cannot devote to this field alone.

Mbwambo explained that, despite the limitations that might come from a cross-sectional study design, the findings from the WHO study are extremely reliable and, given its large scale, provide a wealth of data related to the study of IPV both within Tanzania and internationally. Unfortunately, the study is becoming increasingly outdated as time progresses. Performing such a large-scale study again, even if it were to focus only on more localized sites, would take considerable resources. Mbwambo suggested that researchers could reinvigorate the findings from the WHO Multi-country Study by employing secondary analysis techniques. By analyzing

the existing data for new answers regarding IPV in the region, research costs could be substantially reduced. However, even this reduced cost could strain the already limited budgets available for IPV research in the region. Mbwambo implored the audience and her colleagues to think creatively about the ways in which resources could be developed for projects like this in the future.

Given the resource constrained environment, Mbwambo went on to explain that researchers in the region often turn to national demographic and health surveys (DHSs), which include questions regarding IPV and related domestic violence issues. By ensuring that questions related to IPV are included in the DHS, researchers have been able to take advantage of an existing resource provided by country governments for their research purposes. Furthermore, because Uganda, Kenya, and Tanzania all have a national DHS, each country is able to collect more specific and relevant data for use in creating in-country interventions and programming. Additionally, the data is readily available for use by individuals in neighboring countries in East Africa, so although the data is unique to each country, it can be shared for the creation of larger, more regional data pools and comparative research as well as provide potential opportunities for collaboration and the sharing of best practices and resources.

Mbwambo shared the most recently collected prevalence data regarding IPV from each country's DHS. Each DHS asked partnered women to identify if they had ever experienced physical, sexual, or physical *and* sexual violence within the confines of a partnered relationship. It is important to note that Mbwambo highlighted the prevalence of violence against males in the context of a partnered relationship. She explained that although it is known that retaliation exists—a woman may defend herself from her husband's attacks or retaliate for prior abuses—it is not known what part of the story this explanation tells and whether or not there is something else happening. However, given the much higher rates of IPV against women, each country has made the conscious decision to focus their research and analysis on the women in these relationships. It is important to note that Mbwambo pointed out that the definition of the "partnership" relationship used in the DHS study is different and more restrictive than that used within the WHO Multi-country Study, and as such, the results are not directly comparable.

Mbwambo first discussed the findings of the most recent Ugandan DHS, collected in 2011 (Uganda Bureau of Statistics and ICF Macro, 2012). In terms of current spousal violence, 42 percent of women reported experiencing any form of physical violence. Forty-two percent of women also reported experiencing any form of emotional abuse, while approximately 27 percent reported currently experiencing any form of sexual violence at the hands of their spouse. These numbers rise precipitously when looking

at the historical context of women who have ever experienced these forms of spousal violence as opposed to those only currently experiencing them. Almost 50 percent of women surveyed reported ever experiencing physical violence; and just over 55 percent reported that they had experienced physical and/or sexual violence; whereas just over 30 percent of women surveyed reported ever experiencing sexual violence.

Mbwambo next shared data from the Kenyan DHS, which showed that 41 percent of women had experienced either physical or sexual violence within their partnership and 13 percent had experienced both concurrently (Kenya National Bureau of Statistics and ICF Macro, 2010). Additionally, when looking at the entire matrix of how these forms of violence manifest, nearly 47 percent of women had experienced either physical, sexual, or emotional violence within a partnership. These results were slightly higher in Tanzania, where 43.6 percent of women had experienced either physical or sexual violence within a partnership and nearly 13 percent experiencing them concurrently; more than 50 percent of women reported that they had ever experienced either physical, sexual, or emotional violence from a partner (National Bureau of Statistics and ICF Macro, 2011).

In terms of emotional violence, Mbwambo explained that it is often the case that proxies are used to identify these forms of abuse as they are often less visible than signs of physical or sexual violence. These proxies include controlling behaviors like a male partner wanting to know where his female partner was at all times; a partner accusing the woman of being unfaithful; the female partner not being permitting to meet with her female friends; not being allowed to make personal or financial decisions; not being permitted to visit with natal relatives; and threats of violence made toward individuals the female partner loves. These controlling behaviors indicate emotional abuse, and Mbwambo explained that, perhaps unsurprisingly, women who identify as experiencing these symptoms also report much higher prevalence rates of other forms of IPV than women who do not identify as experiencing them. Mbwambo was also quick to point out that were these alarming rates associated with the prevalence of an infectious or chronic disease, we would be working hard for a cure in spite of a resource constrained environment. Why, then, is the same not true for IPV and violence against women?

Another point raised by Mbwambo in her keynote address is the issue of why these rates are so high in the region; what is it about East Africa that allows for a high burden of violence against women to occur? This is a question that many speakers explored throughout the 2-day workshop as they described the context of East Africa and their experiences with prevention and treatment efforts in the region. For her part, Mbwambo started the conversation by highlighting the cultural norms prevalent in the region. She described the prevailing belief that cases of IPV are a private matter,

and one in which outside intervention is inappropriate, which in turn can lead to difficulty for victims who wish to access treatment or care outside of the family. Additionally, this belief can render laws and policies weak and ineffective as women are often discouraged from coming forward with their experiences of IPV. This is compounded by a lack of financial security among women in the region who depend on their spouses for support. Many workshop participants commented on the need for improved systems of financial and facilities support for women who desire to leave situations where they are victims of IPV.

In addition to a lack of financial security and safe exit strategies, Mbwambo explained that women often find a lack of support from natal relatives due to familial experiences with and tolerance of IPV. Furthermore, in many areas of East Africa, patriarchy dictates that children belong to the father's family, meaning that if a woman leaves her husband or seeks redress for cases of IPV, she might face losing her children. There is also the issue of bride-prices or dowries paid by the groom or the groom's family that can put undue pressure on a woman to remain in a violent relationship for the financial sake of her natal relatives.

Mbwambo further illuminated the culture of tolerance of IPV in the region when she explained that there is often a belief that a woman "deserves" to be beaten when she has not met her expected responsibilities as outlined by societal gender norms. What is especially telling is that these beliefs are often proffered by both men and women throughout the region which further perpetuates the cultural and social norms regarding the tolerance of IPV.

To change the culture of tolerance within the region, which could help reduce the overall burden of IPV, Mbwambo suggested multiple areas of focus for stakeholders in the region. Each of these areas was brought up repeatedly by subsequent speakers throughout the workshop, and is discussed in greater detail within this summary.

First, she touched on the need for more effective treatment and access within the health care sector. The present state of health care within the region too often leaves women unscreened, which means that they go undiagnosed and untreated. In line with this problem, Mbwambo discussed the need for increased infrastructure and capacity. Included in this area are human resources, as well as structural support and capital, but Mbwambo noted that the region must identify how it will move forward before it begins to expand its infrastructure and capacity—as she stated in her presentation, the region must walk before it can run. Another interesting point related to infrastructure that Mbwambo raised is the need to create safe exit strategies and places of shelter for women who desire to leave violent marriages and relationships. This sentiment was echoed strongly by workshop speaker Jacquelyn Campbell of Johns Hopkins University. Currently,

the region lacks such resources; however, given their success elsewhere, Mbwambo suggested it was worthwhile to consider their applicability in the East African context. Putting both safe exit strategies and shelters in place could also help overcome issues of financial instability that often roots women in violent relationships due to a feeling of dependency on a male partner.

Speaking of men, Mbwambo highlighted the need for their inclusion in this process. Engaging men in this dialogue is critical due to their role as "custodians of culture" within East Africa. Mbwambo explained that nothing moves forward in this region without the support of men and as such, they are necessary allies in the fight to reduce IPV in the region. Many of the community mobilization interventions shared at the workshop, and discussed in Chapter 5 of this summary, highlight this process as a critical aspect of their success within intervention sites.

Mbwambo explained that another sector of society that needs attention is the legal sector, because although there are many laws and policies in the region related to violence against women and IPV, they often lack strong enforcement and can be difficult to navigate for most women, which can render them ineffective. Mbwambo stated that these inefficiencies need to be identified and corrected so women can better access the services and protections these laws and policies are designed to provide.

Mbwambo explained that there is also a need to consider IPV within the context of East Africa. This goes beyond merely the cultural aspects of the region, with Mbwambo urging workshop participants to consider the region's high prevalence of HIV and hepatitis. Mounting evidence is showing the bi-directional relationship between IPV and HIV. Mbwambo explained that this relationship and the interventions used for the associated public health concerns should be taken into consideration by all stakeholders.[1]

Lastly, Mbwambo highlighted the need for researchers and those working in nongovernmental organizations (NGOs) alike to consider the benefits of performing economic analyses of their efforts. Many speakers throughout the program emphasized the importance of this approach, stating that those working in government face many competing interests when planning national budgets; often times it is a simple cost analysis that determines national priorities. Mbwambo recommended that the economic costs be calculated both for the overall costs of the burden of IPV within each nation in order to build a case for why governments and leaders should care, as well as analyses for the costs of taking successful interventions to scale, which could also help build support and encourage the development of the funding necessary for such efforts from government and other sources.

[1] This complex relationship and its effects on intervention efforts will be discussed in much greater detail in Chapter 3 of this summary.

INTIMATE PARTNER VIOLENCE AND ITS IMPACT ON CHILDREN

Although Mbwambo was able to share a relative wealth of data on the effects of IPV on women throughout the region, many workshop attendees raised issue with the lack of data on subpopulations, particularly in relation to older and younger populations. Speaker Sylvia Pasti, the Chief of Child Protection for the United Nations International Children's Emergency Fund (UNICEF) Uganda, opened her presentation on the effects of IPV on children throughout the region by noting the dearth of data on the subject. In fact, the DHS referenced by Mbwambo and many other speakers in their presentations only collect data on individuals ages 15–49, which many saw as a limitation on both the data and its applications. Despite these limitations, Pasti was able to share some relevant data from the Ugandan DHS. Pasti noted, as Mbwambo did as well, the differences in terminology regarding the constitution of a partnership between these surveys and the WHO reports. Pasti did not share any data from the WHO, so her use of partner violence pertains to the DHS-stylized definition of IPV.

According to the most recent Ugandan DHS, 56 percent of women and 55 percent of men ages 15–49 have experienced violence at least once since age 15. Furthermore, 56 percent of ever-married women have experienced physical and/or sexual violence from their current spouse or partner. Of the never-married women, the most common perpetrators of violence are teachers, followed by mothers and fathers, strangers, and then other family friends and relatives. Additionally 16 percent of women reported experiencing physical violence during pregnancy (Uganda Bureau of Statistics and ICF Macro, 2012).

Pasti reported that spousal violence is most common in relationships where the husband has little education, drinks to a high degree, where the woman has a higher level of education than her spouse, or where she is 1–4 years younger than her spouse. It is also the case, she explained, that spousal violence tends to commence early within a marriage. She noted that this is a particularly telling piece of information because within Uganda, approximately half of all women are married by the time they reach 18 years of age and of these women, half are married before age 15. The data also shows that 24 percent of teenagers in Uganda are childbearing. These statistics highlight the deficiencies in the current data pool. There are young women who fall outside of the DHS confines who are likely experiencing IPV and abuse given their engagement in a partnership. Additionally, Pasti pointed out that the effects of IPV can be felt by children in utero when their mothers experience violence. In fact, speaker Abigail Hatcher, Senior Researcher at the Wits Reproductive Health and HIV Institute, explained that children born to women who experience IPV during pregnancy experience a litany of adverse health effects, including

an increased risk of death that remains statistically significant through age 5.

Pasti explained that after birth, children living in a home where IPV is present are at a higher risk for abuse and neglect and children who grow up in violent homes are more likely to perpetuate violent behaviors themselves. This intergenerational quality of violence is particularly worrisome in light of the fact that, according to Pasti, violence is present in more than 50 percent of homes in Uganda. Pasti echoed the concerns of Mbwambo in regard to social norms related to violence against women. This culture of acceptance that Mbwambo and many other speakers touched upon was a strong undercurrent throughout the workshop when it came to exploring why IPV and violence against women exist throughout the region.

Pasti did credit the Ugandan government for the creation of multiple laws designed to prevent violence against women and protect children from the negative effects of violence, however, as many other speakers noted, the laws themselves either lack the necessary funding to realize their potential, or their enforcement is weak.

Outside of the justice sector, Pasti reported that several United Nations (UN) agencies, including UNICEF, have been working with the Ugandan government to support both national and district-level programming and interventions. One such program in particular is called the Child Help Line. Launched in June 2014, the line is a three-digit, no-charge, call-in service where anyone can report cases of violence against children. As of the time of this workshop, Pasti said that there had already been numerous reports of individuals using this service. UNICEF has also supported the implementation of another reporting service called Edutrak, which uses text messaging and mobile services to alert the Ministry of Education to cases of violence against children within schools—which is a problem within the country.

In addition to these UN-led efforts, Pasti highlighted the promise of community-driven interventions that work to influence the social norms surrounding violence against women. These programs have been implemented with positive effect throughout the region. In fact, many speakers shared the details of these interventions and those presentations are featured in Chapter 5 of this workshop summary.

Pasti closed her presentation by once again emphasizing the need for research and data related to the effects of IPV on children in the region. She also reiterated Mbwambo's point regarding the need for economic analysis of both the costs of IPV to society and of proposed interventions and programming that focus on this issue. Pasti suggested that the Health Management Information System and the Management Information System for police and the judiciary could be used as possible IPV data collection points. Taking advantage of these existing systems could help streamline research costs and processes.

LACK OF DATA REGARDING IPV IN ADOLESCENT AND AGING POPULATIONS

Pasti highlighted the lack of data related to the effects of IPV in children during her presentation on the same subject. The lack of data and research on specific age groups was further explored during the workshop's group discussion focused on IPV across the lifespan held on day 1.

Most of the workshop's discussions focused generally on women ages 15–49 due to the limitations of current data-collection practices. For instance, both the WHO's study on IPV and the regional DHS discussed throughout the workshop and this summary only surveyed men and women who fell within the 15–49 age bracket. And moderator Chi-Chi Undie of the Population Council explained that the workshop's planning committee had difficulty identifying individuals within the region who were performing research on IPV in adolescents and aging populations, i.e., those individuals whose age falls outside of the parameters set by the WHO and in-country DHS studies. As a result, instead of a panel of presenters as is customary at the IOM workshops, Undie moderated a discussion among workshop attendees and participants on the subject.

Despite the planning committee's difficulty in identifying regional experts in the fields of IPV amongst aging and adolescent populations, individual workshop participants engaged in a robust discussion that highlighted several small-scale studies from the region focusing on the prevalence of IPV within these age groups, as well as many of the challenges faced by researchers working in this field along with possible solutions to overcome those challenges.

In fact, the very first attendee to speak, Janet Seevy of the Medical Research Council at the London School, mentioned the research that her team was performing related to HIV in aging populations. Part of their research included interviews with questions related to IPV, given the strong relationship between IPV and HIV. Seevy explained that one of the key components of their program has been to enlist interviewers who are also in their 50s and 60s when engaging the aging population. This component in particular likely makes the older female interviewees feel more comfortable, thus allowing a greater opportunity to be open and honest about their experiences. Seevy went on to explain that although their research has only produced a small data set, it clearly shows that women in these age groups are experiencing physical, sexual, and emotional abuse within their partnerships.

Undie reflected more on this point of comfort between victims of IPV and health care providers or researchers when discussing matters of partner violence. She believes that this same problem likely exists in younger populations, with adolescents feeling uncomfortable with sharing their

partnered experiences with someone who reminds them of their parents. Simultaneously, the perception that children should not be engaging in sexual or romantic relationships might prevent health care providers from asking critical questions of their younger patients. Additionally, she highlighted that most IPV screening efforts, if they exist, are found within antenatal care settings, which leaves portions of the female population without a possible point of intervention. This is compounded by the fact that, often times, health care providers and those performing screenings are not as up-to-date on current research findings as they could be, meaning that they may miss signs of IPV in their patient populations. Specifically, Undie explained that her experiences and research have shown that most health care providers tend to conceptualize gender-based violence as primarily sexual in nature, which disregards the emotional and physical components of the complex relationships.

In regard to adolescents and IPV, participant Diana Garbsen, a researcher in Uganda, mentioned a large study undertaken by Pathfinder and Save with the support of Georgetown University's Institute for Reproductive Health, which seeks to analyze gender-based violence within this group to develop a data set for use in the prevention of IPV within this subpopulation.

Another speaker, Tom Mywanga from Child Aid Organization Kenya, stated this his organization, with the help of the South African Medical Research Council, has undertaken small-scale studies to determine a baseline related to dating violence among adolescents ages 12 to 14. Mywanga explained that his group experienced resistance from many parents when the study first began as they thought their children were not engaging in romantic relationships, and they worried that this program would encourage them to do so. However, the study showed that these relationships do in fact exist, and that violence is also found within them. Mywanga reiterated that the study was extremely small; however, his organization would be able to advise any efforts made to bring this sort of study to scale across Kenya so as to develop a more robust data set.

Building on Mywanga's statements, Anique Givas of the South African Medical Research Council and Sexual Violence Research Initiative explained that their work in South Africa regarding IPV in adolescents has produced a similar fear or worry in adults, parents, and teachers regarding young people and relationships. Givas explained that, in her experience, the anxiety stems more from reproductive health issues, such as unwanted pregnancy, as opposed to potential violence within a relationship. These programs, she stated, are incredibly important tools for primary prevention. She feels that if young people can be engaged at the earliest stages in their romantic relationships, then they can be educated on the features and dynamics of a healthy relationship so as to prevent violence from ever developing in the first place. She suggested that perhaps it would be wise

for those working with adolescent populations to engage the adults and parents in the community in their efforts so as to alleviate any anxiety and subsequent resistance.

Speaker Charlotte Watts of the London School of Hygiene and Tropical Medicine added that adolescent romantic relationships have a more nuanced nexus of complexities than other forms of relationships. This population is particularly vulnerable to multiple forms of violence, both partnered and non-partnered, and may even be experiencing the negative effects from their parent's experiences with IPV. This, along with their efforts to develop romantic partnerships for the first time, makes them a uniquely vulnerable sub-group, which is something that researchers should remain cognizant of when working with them.

Many participants raised the issue that children often do not feel empowered to share their experiences, which could result in the under-reporting of IPV in this age group. In fact, many participants pointed out the need for the inclusion of the Ministry of Education in prevention efforts, given the amount of time children spend in school and its potential as a place of primary intervention and education.

In her presentation regarding her organization's IPV intervention efforts, speaker Lina Digolo, the Care and Treatment Manager at LVCT Health, stated that evidence shows that women who experience IPV were far more likely to have experienced sexual violence at a young age than those women who do not experience IPV. This statistic points to the reality that violence and IPV exist across the lifespan and can greatly affect how a woman's experience with violence rises and falls across her lifetime. Although these populations are unique, and will likely require tailored approaches when it comes to research, policy, and practice, it is important that those working on these issues in the region remember the complex links between IPV and the various age groups found across the lifespan.

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3

The Intersection of IPV and HIV

Speaker Charlotte Watts, a professor at the London School of Hygiene and Tropical Medicine, explained that when thinking about the transmission of HIV and its link to violence most people assume the relationship exists in the realm of forced sex or sexual violence alone. However, the relationship is far more complex than this. Recent epidemiological data and studies prove that the spread of HIV and its connection to violence is multidirectional and results in multiple outcomes that exist on many levels.

Watts summarized a variety of studies in her presentation that highlight the current knowledge base and understanding of the intricate relationship between IPV and HIV. First she summarized a study from Rachel Jewkes at the Medical Research Council in South Africa. The evidence there showed that those women who have experienced violence have a significantly higher risk of contracting HIV than women who have not experienced violence. This trend holds true for women who are not necessarily experiencing violence but are in a highly unequal relationship (Jewkes et al., 2010). Watts explained that it is within this gender imbalance and unequal distribution of rights wherein partner violence and the increased risk of HIV coexist.

The next study Watts shared teased out different forms of violence and their relationship with HIV contraction. Using data collected in the city of Rakai, Uganda, researchers were able to echo the findings of the Jewkes paper in determining that women who experience violence face a significantly higher risk of contracting HIV (Kouyoumdjian et al., 2013). Researchers also analyzed the relationships between specific types of violence and HIV infection. Perhaps unsurprisingly, sexual violence showed a very significant relationship. However, the study also showed that physical

violence experienced without concurrent sexual violence showed a very similar relationship, meaning that it is not only sexual violence that increases a woman's risk of becoming HIV positive. Using data from global studies, Watts explained that this trend is found throughout the world—not just in East Africa. Notably, the Rakai study showed that even verbal abuse had a smaller, but statistically significant relationship with HIV infection (Kouyoumdjian et al., 2013; WHO, 2005; Ying et al., 2013).

As many speakers echoed in their presentations, the reasons behind these complex relationships are not entirely known. However, Watts explained that violence prevention researchers speculate that the causes are complex and multidimensional. In the instances of sexual violence, there may be cases of unprotected forced sex, or instances of lacerations or abrasions that increase the likelihood of HIV transmission. But beyond this, the power imbalance between men and women indicates that women who live in fear of violence within a relationship may be unable to negotiate condom use or other preventive measures, such as microbicides, that can help mitigate the risk of HIV exposure and spread.

Looking at this relationship from another angle, it was explained that the men who perpetrate violence are shown to be more likely to engage in other risky behaviors that increase their chances of HIV infection. These behaviors include concurrent sexual partners and engaging in commercial sex. The male perpetrator's increased risk trickles down to his female partner, thus increasing her overall risk of contracting HIV. Furthermore, the WHO Multi-country Study reported that Tanzanian women in violent relationships asked their partner to use a condom more often than women in nonviolent relationships; however, men in those same violent relationships are more likely to refuse condom usage than those in nonviolent relationships. Watts explained that this shows that not only are women in violent relationships aware of an increased risk of sexually transmitted infections, but also that the men in these relationships exert power over their partners in a multitude of ways—not only through the use of violence. Furthermore, this need to exert power in a relationship, she stated, points to a strong sense of masculinity and expectations that these men hold in relationships. Watts went on to posit that any effective HIV intervention or prevention programming would have to address physical, sexual, and verbal abuse, as well as concepts of gender equity and masculinity. The relationship between violence and HIV is so strong, that to attempt to tackle one without the other would be ineffective.

Many speakers pointed out that the dynamics in violent relationships may also cause a woman to ignore her HIV status due to a fear that she may be subjected to violence if she tests positive. As a result, the violence not only increases her likelihood of exposure to HIV, but it also decreases her likelihood of accessing treatment or care should she contract it. Speaker

Rose Apondi, a Public Health Specialist at the Centers for Disease Control and Prevention, also explained that gender-based violence is both a cause and effect of HIV. This bi-directional relationship is yet another indicator that both HIV- and IPV-prevention efforts could benefit from coordinated programming. The relationship appears to work in both directions, as keynote speaker Christine Ondoa, the Director General of the Uganda AIDS Commission, noted in citing preliminary results from the community-based SASA! intervention[1] showing that reducing IPV in a community by 18 percent can reduce new HIV infections by 36 percent.

DIFFICULTIES AND SOLUTIONS FOR DEVELOPING A COORDINATED IPV AND HIV PREVENTION APPROACH

Despite the success of SASA!, many workshop speakers explained that, overall, it has been difficult to identify the best ways to prevent both IPV and the spread of HIV within the region. This is caused by a variety of factors that were discussed by many speakers and public commentators. In her keynote address, Ondoa emphasized the need for a collaborative approach—for policy makers to work closely with academics and organizations like UNAS to develop effective, evidence-based programming to reduce the burden of IPV and HIV in the region. Apondi raised this point again, stating the need for a coordinated, multisector approach. She explained that the problem is not contained within any one ministry of the government or sector of society; instead it cuts across multiple ministries and sectors, thus demanding a complex and collaborative solution.

Speaker Samuel Likindikoki, a Lecturer and Medical Specialist at Muhimbili University, raised the issues found within current research and data that make it extremely difficult to develop a case for increased resources and funding streams—which are necessary to any successful intervention efforts. He worried that current data is conflicting, showing that advocacy, screening, and criminal justice efforts are ineffective. Watts pointed out that this is more than likely due to the poor quality of the studies, which results in unreliable data. Likindikoki reminded the audience that it is important to have clear and convincing data in order to produce effective, evidence-based programming in order to create and maintain prevention and intervention programming.

This call for data was echoed by many speakers and commentators across the entirety of the workshop. But as Mbwambo explained in her keynote address, these efforts will require resources, meaning that this

[1] See Chapter 5 for more information regarding the SASA! intervention and approach to IPV and HIV prevention.

group needs to identify a clear message for their governing bodies to raise the necessary resources for programming.

Apondi reminded the audience that it is not only data or monetary resources that are lacking. Often times, health centers are extremely understaffed, resulting in a lack of capacity to perform effective screening efforts, much less intervention and prevention programs. She went on to reinforce a point made by Likindikoki in his presentation regarding economic analyses. Likindikoki suggested that operational research must be undertaken in order to put a dollar amount on both the current burden of IPV in the region and the potential costs of prevention and intervention efforts. It is this financial argument, Apondi claims, that will make the biggest impact with policy makers and provide the attention needed from crosscutting sectors of government. She also made the point that NGOs have a strong role to play with both research and policy efforts as well as community health initiatives. In fact, other speakers shared successful initiatives showing promise in regard to IPV and HIV specifically, but also toward IPV more generally—which, as noted earlier, can help reduce the overall burden of HIV within a community too.

SUCCESSFUL INTERVENTIONS

Two such examples of successful interventions that were presented at the workshop are the SHARE model and the approach undertaken by LVCT Health.[2]

Workshop speaker Lina Digolo of LVCT Health explained that the Kenya-based NGO focuses on producing quality health research for the Kenyan government to build policies around. Its most recent work focuses on the intersection of IPV and HIV by assessing the prevalence, acceptability, and feasibility of IPV screening within its existing HIV testing and counseling (HTC) settings. Already, LVCT is seeing promising outcomes from the initial portion of a three-phase study. These promising results provide not only a strong basis for the next phases of intervention and prevention strategies within the study, but also help to develop the foundational evidence for why the Kenyan government should begin to fund health programs and interventions that seek to prevent IPV both and HIV simultaneously.

Speaker Jennifer Wagman of the Uganda-based SHARE program explained that the SHARE model uses a community mobilization approach to prevent and screen for IPV while reducing the associated risk factors that can lead to HIV infection. By building on existing infrastructures within the

[2] More information regarding the LVCT and SHARE models and studies can be found in Chapter 5 of this summary.

region and using evidence-based methods developed by Raising Voices and the stepping stone approach, SHARE has been able to develop multiphased programming that is used in concurrence with existing HIV prevention and treatment efforts within the region. Results of their studies show that the program is effective in reducing women's overall experiences of IPV while also decreasing overall HIV incidence rates. These promising results indicate that the SHARE model may be effective in other settings, too.

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4

Responding to Intimate Partner Violence and Its Consequences

Many workshop speakers and participants throughout the 2-day program commented on the multidirectional and multisectoral nature of IPV in the region. This in coordination with the complexities of IPV and its effects on the region have made developing effective and streamlined responses across governments, NGOs, and various sectors of society challenging. However, there are a multitude of positive efforts being made across a wide variety of sectors throughout the region. This chapter will highlight some of those efforts, including a discussion on screening efforts as well as barriers to accessing services and responses from the criminal justice, social work, and health sectors.

SCREENING FOR IPV IN EAST AFRICA

Speaker Chi-Chi Undie, an Associate at the Population Council, Kenya, explained that the routine screening for IPV in a given population remains a point of contention within the prevention community. Conflicting evidence regarding the efficacy of these efforts has left many in the region unsure of what to do in terms of screening efforts, including researchers and health workers wondering what the actual benefits of screening are and how they can be measured or evaluated.

In terms of measuring or evaluating the benefits of screening, Undie asked what evidence should carry more weight: that from a randomized controlled trial (RCT) or sources of evidence that are more qualitative in nature, reflecting a patient-centered approach that is difficult to capture within an RCT. Undie also cited the barriers to screening and care that are

presumed to exist throughout the region despite a lack of evidence that they truly mitigate screening efforts. She went on to explain that these issues and questions need to be explored in a more regional context in order to ascertain whether or not screening for IPV is an effective and beneficial use of limited time and resources throughout the region.

Undie explained that the driving force behind the notion that basic screening and intervention efforts for IPV are ineffective, is a 2013 study from Rachel Jewkes, titled "The End of Routine Screening" (Jewkes, 2013). Undie explained that this study reviewed three separate papers analyzing the efficacy of basic screening efforts. Jewkes' conclusion, Undie stated, was that the time for performing the routine screening and identification of abused women and the provision of a standard intervention has ended. Jewkes contends that these efforts are ineffective and do not make the best use of available resources. Undie explained that these conclusions have been shared broadly throughout the IPV-prevention field despite the fact that the studies reviewed by Jewkes are from developed nations, meaning that perhaps those findings do not translate to the East African context.

Additionally, Undie went on to explain that one of the papers analyzed by Jewkes conceded that had the women who screened positive for IPV been referred to a more effective intervention or treatment program, the outputs measuring efficacy might have been very different. To Undie, this means that there is still a need for research in the region to identify effective interventions that can enhance screening measures and subsequent referral pathways, thereby reducing the burden of IPV. Undie also emphasized the need for data synthesis that goes beyond RCTs. These studies are certainly effective tools; however, in order to gain a better understanding of the whole picture, it is important that researchers and health workers in the region understand their strengths and limitations as they analyze conclusions surrounding IPV screening efforts. It is also important to recognize that other sources of data and information can help fill any gaps left over from RCTs alone. Based on this, Undie contended that decisions regarding IPV programming and screening should be made based on a broad range of study designs and data.

Beyond Jewkes' conclusions, Undie explained that there are many people and organizations throughout the East African region who believe that screening is an unrealistic method of intervention due to perceived barriers that may or may not actually exist, because they have never been studied or rigorously evaluated. Undie stated that these perceived barriers include

- Lack of provider capacity to offer basic support to survivors;
- Lack of operational referral systems and linkages;
- Lack of resources (to protect confidentiality, etc.);
- Client and provider unwillingness to be screened/to screen routinely; and

- Client and provider attitudes toward violence which might undermine screening and intervention efforts.

Undie explained that each of these perceived barriers affects the feasibility of IPV screening efforts and will require research and data to be overcome.

To that end, Undie shared three non-RCT studies from the region illustrating her position that Jewkes' conclusion regarding routine IPV screening may not be the appropriate fit for this region and that the perceived barriers threatening these programs might not be as damaging as some believe they are.

The first of these studies focused on an urban setting in the Temeke District Hospital in Dar es Salaam, Tanzania (Laisser et al., 2011). In this study, health care providers were trained in screening efforts and instructed to screen the first three clients they interacted with over a period of time. A total of 102 women were screened and of those, nearly 50 percent screened positive for IPV. The main finding of this study was that screening efforts by health care providers is entirely feasible within urban settings in Tanzania, despite perceptions regarding capacity and provider or willingness to actively engage in screening efforts.

Undie then shared the findings of a study from rural Kenya and South Africa that looked at the efficacy of screening efforts during antenatal care that might help reduce the burden of IPV borne specifically by pregnant women (Turan et al., 2013). Workshop attendees also had the benefit of hearing from the study coordinator Abigail Hatcher, a Senior Researcher at the Wits Reproductive Health and HIV Institute, who shared the study's findings in greater detail.

Hatcher explained that when pregnant women experience IPV, deleterious health outcomes are not limited solely to the mother. Evidence has shown that the children of these women also experience a significant burden of negative health effects. Hatcher highlighted that children born to a mother who experienced IPV during her pregnancy are at a much greater risk of death through age 5 when compared to children born by IPV-free mothers. She also explained that screening for IPV during antenatal care is a crucial opportunity as it takes advantage of a time period where women are regularly accessing medical care. However, it is also important that these screening efforts are paired with an effective referral; otherwise, the effects will be minimal.

Bearing this in mind, Hatcher and her colleagues began their study by assessing the existing violence prevention resources within their two study locations: the rural Nyanza province in Kenya and the urban setting of Johannesburg, South Africa. Their initial research showed that resources existed in both areas; however, often neither the women in the region nor

their health care providers were aware of their existence. Additionally, they learned that women were reluctant to use referral services when it required them to seek formal justice against their husbands. In many cases this is not a realistic option for these women due to a dependence on their spouses and often their desire to remain within the marriage, but to end their experiences of IPV.

Based on this preliminary research in the Nyanza province, Hatcher and her team constructed a four-phase study analyzing the efficacy of antenatal IPV screening. The first stage focused on building local partners, which helped develop the necessary infrastructure. Then, they trained the local health care providers within the study clinics. After training was completed, the screening and intervention efforts began, and Hatcher and her colleagues continually assessed and refined the approach.

Hatcher explained that the first phase proved incredibly helpful to the overall success of the group's intervention. Using tools from Raising Voices in Uganda, local partners were identified and cultivated. This process allowed for community members and stakeholders to identify the problems related to IPV in this context and help develop solutions. According to Hatcher, one of the more innovative outcomes of this process was the development of robust referral trees (which included individuals and resources within local government, criminal justice, the clinic, and other IPV-prevention organizations) and the use of lay health workers as community referral persons. These individuals helped guide women who screened positive for IPV through the referral process, thus ensuring they were able to take advantage of the network built by Hatcher and her team.

Upon completion of the pilot program, wherein 134 women were screened in an antenatal setting, a brief analysis was undertaken. Of these, 37 percent screened positive for IPV, or the risk of IPV, and most women who screened positive were successfully connected with a community referral person who assisted them in accessing the necessary resources. The results of the pilot were so positive that workers within the clinics took the initiative to expand the screening program and extend referrals to other areas of the clinic.

The main challenge that the analysis unearthed was that screening efforts appeared to drop off over time, meaning that efforts to refresh clinic staff in the screening procedures and their importance would be of use in future programs to ensure that this trend does not continue. Despite this challenge, Hatcher explained that this approach appears to be highly useful and feasible even in rural settings which are perceived to be more resource constrained than urban settings.

Hatcher went on to explain that in the more urban Johannesburg, a similar screening and referral program has been implemented, called Safe and Sound. Like its cousin in Nyanza, the Safe and Sound program

benefitted from preliminary research that informed its eventual operation. This research suggested that although women in this area are aware of informal help such as family, friends, and the church, they are often unaware of some of the more helpful referral services, such as social work, counselors, and NGOs. This helped the Safe and Sound program to focus their referral tree on these more helpful resources. Hatcher explained that it took a considerable amount of time in the urban setting to develop the connections and capacity necessary for the referral tree due to the higher volume of clients in the area.

Training materials have been developed that not only help Safe and Sound workers establish and maintain the referral network, but also help them explain it to their patients. This manual should be available to the public sometime in 2015 and will allow for the sharing of best practices and program expansion.

Hatcher and her colleagues hope to reach approximately 600 women with their Safe and Sound program and, with the support of the WHO, are aiming to complete the preliminary stages of an RCT by the end of 2015. These findings should help establish whether or not this program shows promise to help reduce the burden of IPV and its deleterious effects in pregnant and postpartum women.

Hatcher emphasized the importance of enhanced referral services such as their guided referrals using community lay persons or reimbursement for travel, because, often, the referral alone is not enough. These enhanced efforts help ensure that women who are experiencing IPV are able to access the services they need.

This finding was echoed by Undie in the final study that she shared: a Population Council study that she oversaw (Undie et al., 2014). This particular study took place in an urban setting at Kenyatta National Hospital in Kenya. Like the studies mentioned previously, health care providers were trained and instructed to perform screenings for IPV. Those women who screened positive were connected with a "supported referral"—a client advocate who escorted the women to the on-site GBV clinic. For purposes of study analysis, clients were identified as compliant—meaning they screened positive, were referred, and went through the referral process—or noncompliant—meaning they screened positive, were referred, and for whatever reason, did not follow through with the referral process. Screening efforts were implemented in three different clinics within Kenyatta National Hospital: antenatal care, HIV comprehensive care, and the youth center.

Prior to the study's implementation, Undie shared that many health care providers were skeptical that their female clients would be willing to discuss their experiences with IPV—a perceived barrier cited by Undie earlier in her presentation. However, their simple screening with three questions that focused each on physical, sexual, and psychological IPV showed that women

would, in fact, self-identify as experiencing IPV. The women who screened positive, and were subsequently identified as compliant or noncompliant based on their referral uptake, later participated in in-depth interviews and focus groups and provided feedback regarding the intervention and helped assess its efficacy. The study also kept track of service statistics.

Undie explained that of the approximately 1,200 women screened at the Kenyatta National Hospital, about 8 percent identified as experiencing some form of IPV. Of these women, nearly 80 percent were referred to the GBV clinic, and 40 percent of the women referred actually presented at the clinic for treatment. In addition to these general results, additional details regarding the prevalence of IPV within the study population were gathered. The most commonly identified form of IPV among the women who screened positive was psychological, with a total of 72 percent, followed closely by sexual, at 60 percent, and physical, at 52 percent. Approximately 62 percent of the women who screened positive for IPV identified as experiencing two or more forms of violence concurrently. This composite presentation of IPV was highest among HIV-positive females. Additionally, the study results showed that a disproportionately high number of women between the ages of 18 and 24 identified as victims of IPV; more than 38 percent of all women who screened positive fell in this age range, yet this subpopulation accounts for only 3 percent of the total sample size. This, Undie noted, illustrates the fact that there is a problem of IPV among younger women in the region.

Undie emphasized the need for confidentiality among clinic staff to ensure female patients feel their identity and information is being protected. There were a few instances throughout the study where a receptionist spoke too loudly within a clinic and perhaps inadvertently revealed a woman's experience with IPV, which can be detrimental to the program's goal as it might dissuade women from sharing their experiences and engaging in the referral process. Undie stated that this underscores the need to perform rigorous training of program staff at every level.

Undie explained that the program might also benefit from tweaks in operation that could resolve cases of noncompliance, that is, those women who were referred but never presented for IPV services. The study showed that the reasons for noncompliance were mainly systemic and included things such as the GBV clinic being closed during the time that a client was referred. In most cases, these women wanted to take advantage of the IPV services, but were unable due to programmatic constraints. Undie stated that the program will need to adapt in order to be responsive to their needs.

In addition to these cases of noncompliance, there were also instances where a woman screened positive for IPV, but never received a referral. Most of these cases, Undie explained, occurred in the antenatal care setting, which sees a high volume of clients on a daily basis. As a result, health care

providers might be distracted by other patients after screening, precluding them from providing a referral. Bearing this in mind, Undie noted that screening may not be appropriate in every setting.

Despite these issues, Undie reported that, overall, health care providers demonstrated the capacity to screen and refer. These are promising results that she claims indicate routine screening for IPV is feasible, even in resource constrained settings. Additionally, clients and providers are highly accepting of screening efforts. In fact, many women who received referrals reported high levels of satisfaction with the IPV treatment they received. Undie indicated that researchers in the region should not lose sight of these opinions and responses, especially when accounting for who defines the benefit of a given screening or intervention effort.

Undie explained that each of the studies highlighted in her presentation demonstrate that when it comes to IPV screening in East Africa, Jewkes' conclusion that screening is an ineffective and unnecessary model may not be the correct fit. "The jury," she said, "is still out." It is up to researchers and public health providers in the region to continue exploring this question in order to develop the best answer for East Africa.

BARRIERS TO ACCESSING SERVICES

Undie outlined the perceived barriers to treatment in her presentation on screening for IPV, and Datius Rweyemamu of the University of Dar es Salaam further illuminated this topic in his presentation regarding access and barriers to care and services for IPV survivors in Tanzania, which featured the results of an in-country study (McCleary-Sills et al., 2013).

Using key informant interviews and focus group discussions, the researchers sought to identify and understand both the community perceptions surrounding GBV/IPV as well as the barriers to accessing treatment. Additionally, the study aimed to profile the range of GBV/IPV services available throughout three regions in Tanzania: Dar es Salaam, Iringa, and Mbeya, as well as the gaps and opportunities within those service options. The districts were selected based on their mix of urban and rural locales, as well as their concentration of available services. Furthermore, the study group took care to include a vast array of individuals in their sample, including community members, health care providers, and representatives from government, public safety, and social welfare among many others.

The study divided community perceptions of violence into three categories: acceptable, less acceptable, and unacceptable forms of violence. According to those surveyed, acceptable forms of violence included forced sex in a relationship and physical abuse by a husband or partner. Additionally, less visible forms of violence, such as economic abuse and restricting a female partner's freedom were also considered acceptable. Respondents

indicated that less acceptable forms of violence included the refusal to acknowledge a biological child and/or the refusal to provide child support as well humiliating a female partner in public. The unacceptable forms of violence against women identified by study participants included rape by a stranger, threatening a female with a weapon or using one against her, severe physical abuse, and forced anal sex. In her keynote address from day 1, described in Chapter 2 of this summary, speaker Jessie Mbwambo of Muhimbili University explained how difficult it was for a female victim of IPV to gain the support of her birth family to leave her abusive spouse. Here, Rweyemamu shared a quote from his study interviews in which a 25-year-old female from Dar es Salaam explained that in cases of forced anal sex, parents will immediately tell their daughter to get a divorce and welcome her back into the family home. However, as Mbwambo explained, this support does not extend to the forms of violence perceived as more acceptable by community members. Rweyemamu also shared that young women are less tolerant of GBV and that young men tend to be more educated about the issues of GBV than their older counterparts.

In terms of existing services for victims of IPV and GBV, Rweyemamu stated that family and social networks tend to be the first source of help and support. In fact, it is usually only in cases where the issues cannot be resolved within the family that attempting to access external sources of support is considered acceptable. Those external sources include local government authority, the legal sector, and the health sector, as well as the civil society sector, which encompasses religious leaders and groups and NGOs. Often times when a family cannot resolve an issue of IPV or GBV, the second point of support accessed by the victim is that of the local government. This option, Rweyemamu explained, can be difficult to navigate due to the multiple levels of local government. There is, at the sub-village level, the Ten Cell leader. At the village level, there is the Village Executive Officer or Street Leader. Above this, at the Ward level, is the Ward Executive Officer, and finally at the District level, there is the Social Welfare Officer. Each level has a different level of resources available to victims of IPV and GBV. And the process of moving through to the higher levels of local government—where there tend to be more options and resources—requires a referral letter from each of the lower levels in succession. Meaning that to reach the Social Welfare Officer at the District level, a woman would need to have seen her Ten Cell Leader and received a referral to engage with the Village Executive Officer or Street Leader who would then need to provide her with a referral letter to the Ward Executive Officer, who would ultimately provide the referral letter to the District level. At every level, the woman will be asked if she consulted with the lower authorities; if the answer is "no," she will be sent back down the chain. This process can

become cumbersome and timely. Rweyemamu explained that this makes the system itself a barrier to accessing services and care for victims of violence.

The legal and health sectors can be equally difficult to navigate for female victims of violence. Rweyemamu explained that, despite many of the strong policies and laws that have been passed in Tanzania, it is challenging for women to take advantage of them because of the need for referrals to access the police and court systems. And although the health sector has specialized clinics and health care providers who are trained to treat cases of violence against women, there remains difficulty in accessing those services via referral. Lastly, although civil society may be accessible to female victims, there are cases where the help provided is inadequate or inefficient, or in some cases women may not even be aware they exist.

Rweyemamu took the time to highlight the main barriers to accessing treatment or care within each sector the study analyzed. Norms related to shame and the privacy of family matters present problems for women wishing to share their experiences of violence both within the family and social networks as well as outside of it. Within the local government authorities, as mentioned before, the structural hierarchy and system of referrals can be extremely difficult to navigate, often leaving victims of IPV and GBV without support. Corruption, Rweyemamu claimed, is seen throughout the justice sector as well as the health sector. Additionally, the health sector sees issues with quality of care being compromised because of a lack of payment by patients. Lastly as mentioned before, although civil society may be more readily accessible for some victims, the services rendered may not be the appropriate or effective solutions for the problems experienced.

Rweyemamu shared the study's recommendations with the audience, which included addressing the sociocultural norms that negatively affect a victim's ability to seek redress for the violence they have experienced as well as the structural barriers that also affect this ability. Rweyemamu also advocated for the improvement of the quality and provision of GBV/IPV treatment and care as well as the streamlining of the referral system and an increase in access to the justice system for victims of IPV/GBV. His suggestions to achieve these goals included the use of community mobilization efforts, developing a network of trained resource providers, coordinating the efforts of key stakeholders, and enhanced training for health care providers to increase and integrate screening efforts within existing health systems.

Many of the workshop speakers who shared interventions throughout the region expressed similar recommendations and programmatic efforts that highlight these approaches. These similarities help strengthen the sharing of best practices among the communities and countries of East Africa to help lessen the burden of IPV.

HEALTH SECTOR RESPONSE

The Regional Response

In the conclusion of her presentation on IPV screening efforts, Undie mentioned the connection to the East African health sector and how it can help reduce the burden of IPV. Workshop Presenter Odongo Odiyo of the East Central and Southern African Health Community (ECSA) elaborated on this point by explaining how the ECSA functions to improve health and reduce the negative effects of IPV and GBV in the region.

Odiyo explained that, with support from the Population Council, the U.S. Agency for International Development (USAID) Africa, and Africa for Health, the ECSA, an intergovernmental organization, serves 10 countries throughout Eastern, Southern, and Central Africa. Established by the respective health ministers from each region, the ECSA oversees seven different programmatic areas, with the program focusing on family and reproductive health housing the issues of IPV and GBV. The ECSA holds an annual best practices forum wherein the health ministers and other members of the ECSA are able to discuss issues pertaining to the health sector and possible solutions or guidelines for implementation. The ECSA then works with member states to either adopt or adapt those guidelines for in-country needs.

Odiyo shared that this process was first undertaken for IPV- and GBV-related issues in 2010, with a specific interest in child sexual abuse. Then, in 2012, the screening for IPV was a heavily discussed topic at the best practices forum, which led to the passing of a resolution recommending the integration of screening efforts related to IPV and other forms of violence with existing sexual and reproductive health and HIV/AIDS-related care. These recommendations reflect many of the presentations seen throughout the 2-day workshop. They also further highlight the strength of intergovernmental relationships and the sharing of best practices throughout the region, which was also recommended by a number of speakers.

Subsequent annual best practices forums have highlighted the progress being made in this area throughout ECSA member states and have allowed the group to expand their potential impact and reach. For instance, Odiyo highlighted the current development of advocacy tools for the prevention of IPV, as well as the introduction of new methods to track the successes of member states' efforts in this area so as to continue improving the health sector's contribution to prevention efforts. The ECSA's efforts in convening regional leaders within the health sector to produce a coordinated response to health related issues, including IPV, show promise in producing lasting change within the East African region.

The WHO's Response

Further expounding on the health sector's response, speaker Olive Sentumbwe-Mugisa, a Family Health and Population Advisor for the WHO, Uganda, provided information regarding the WHO's clinical and policy guidelines for responding to IPV and regional programming. Sentumbwe-Mugisa began her presentation by sharing the WHO data that reiterated many of the points raised by other speakers, including the high burden of IPV in East Africa, the relationship between IPV and HIV, and the ill-effects of IPV on pregnant women and their offspring. She went on to explain the processes by which the WHO develops its recommendations. The recommendations are in a state of continual evolution, which is a direct reflection of the WHO's commitment to being responsive to the findings of researchers in the region.

As described by Sentumbwe-Mugisa, the process of developing recommendations is an extremely large undertaking due to the complexities of the health sector and the broad variety of stakeholders involved. The first regional steps in producing guidelines for the health sector involved adapting the 2004 WHO report on the Clinical Management of Rape Survivors for the needs of East Africa (WHO, 2004). Additional subjects were covered in order to better suit the region's needs, such as networking, counseling and communication, as well as the background to gender.

In the past year these regional guidelines have been under review, with revisions being made in light of new guidance from the WHO and elsewhere. Sentumbwe-Mugisa explained that the 2013 release of the WHO's report on *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines* has been particularly influential (WHO, 2013). The report highlighted six key areas of focus:

1. Women-centered care;
2. The identification and care of survivors of sexual assault;
3. Clinical care for survivors of sexual assault;
4. Training of health care providers on IPV and sexual violence;
5. Health care policy and programming; and
6. Mandatory reporting of IPV.

Additionally, Sentumbwe-Mugisa shared the six steps identified to improve program planning and evaluation:

1. Getting started;
2. Define and describe the nature of the problem;
3. Identify potentially effective programs;
4. Develop policies and strategies;

5. Create an action plan to ensure delivery; and
6. Evaluate and share learning.

These steps and recommendations were shared at a WHO workshop in June 2014, hosted in Entebbe, Uganda. Seven countries from the region were invited to attend, including Kenya, Uganda, and Tanzania. Within the workshop, each country was able to analyze the recommendations within the context of their own country's needs and demographics in order to best adapt them. This approach allowed for the countries to work collaboratively as they shared best practices and data while still working toward internal solutions.

Sentumbwe-Mugisa pointed out some commonalities across the seven countries present at the workshop. Most striking, perhaps, was that although each country appeared to have strong GBV/IPV legal and policy frameworks in place, the enforcement of those laws and policies was weak. These findings strongly support other speakers' in-country experiences of barriers to access and treatment, such as Rweyemamu's explanation of the Tanzanian experience discussed earlier in this chapter.

Additionally, Sentumbwe-Mugisa explained the importance in having a budgetary line-item related to GBV/IPV at a country level, which signifies political commitment and government support of the issue. Unfortunately, as she explained, most countries in the region (barring Rwanda) lack government-sector budgets. The idea of referrals and referral systems were well explored during the June workshop in Entebbe, as they were throughout this 2-day workshop. And although they do appear to show promise for the region, Sentumbwe-Mugisa highlighted that there are a lack of resources at the country level to train health care providers and workers to develop those referral services. Instead, she suggests that implementing institutions will likely have to bear the burden of finding and allocating those resources. And although this may seem daunting, other speakers, such as Undie and those found earlier in this chapter, have explained that referrals are an effective and feasible method of intervention in resource constrained settings, meaning that it is perhaps a worthwhile undertaking.

Sentumbwe-Mugisa explained that the WHO workshop and the evaluation of in-country research continues the feedback loop of policy and guideline development at the WHO. The recommendations shared by Sentumbwe-Mugisa will continue to evolve as the field of study grows, ensuring a responsive and effective methodology for creating adaptable and meaningful guidance.

CRIMINAL JUSTICE SECTOR RESPONSE

As mentioned by Sentumbwe-Mugisa in her presentation on the health sector's response to IPV/GBV, although most countries in East Africa have passed strong laws and policies purporting to protect women from violence, the implementation and enforcement of these policies is lacking. Speaker David Batema, a judge within the High Court of Uganda, discussed this issue in greater detail during his presentation on the Criminal Justice Sector's response to IPV. Batema explained that the constitution of Uganda is one of the most gender-sensitive in all of Africa, with specific articles in place to protect human rights and prevent discriminatory action—including gender-based violence, as well as provisions specifically in place to safeguard the rights of Ugandan women. Since adopting its current constitution in 1995, Batema explained that Uganda has passed a vast array of laws that relate to the protection of women's rights and, thereby, the prevention of violence against women. These include a Domestic Violence Act, an act prohibiting the practice of female genital mutilation, as well as an act aimed at preventing the trafficking of persons.

In addition to these domestic laws, Batema stated that Uganda is a signatory to multiple international legal resolutions and declarations (including both the UN's Convention on the Elimination of All Forms of Discrimination Against Women, and its Declaration on the Elimination of Violence Against Women), and that Uganda is also subject to multiple regional legal instruments that can be used to protect the rights of women (such as the Goma Declaration, the East African Community Treaty, and the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa).

Despite the abundance of policies and laws in place, consistent enforcement of those laws and policies remains a problem. Batema explained that this is likely due to both a lack of understanding and awareness as well as prevailing cultural norms throughout the region. Batema spent some time discussing what he termed "a culture of silence," in which IPV has always been viewed as something that is to be kept both secret and private. It is, as Rweyemamu explained in his presentation regarding barriers to treatment and care, a burden to be borne within the family. Seeking outside help and resolution in the form of public discussion of IPV, Batema added, has not been a common practice in the region.

To overcome these issues within the criminal justice sector, Batema advocated for extensive training programs and open discussions about the rights of women for those working in this sector. Batema noted that he himself has been instrumental in the creation and implementation of many training programs that seek to explain not only women's rights, but the Ugandan laws that protect these rights. This in turn should allow police

officers and magistrates alike to effectively analyze issues of violence against women and effectively enforce the laws designed to protect victims. Batema explained that enforcement and education regarding these laws should help breakdown the culture of silence described in his presentation.

Batema also encouraged stakeholders from multiple sectors to work together to develop infrastructure that will allow for continued growth in the field of women's rights. This includes the extension of the education programming Batema mentioned as well as building referral networks for victims of IPV and facilities where those victims can access the services they need. It is not enough, he explains, that the laws exist. Uganda's constitution requires that the country also provide the facilities and opportunities necessary to enforce its constitutional provisions. Batema also pushed for the use of alternative dispute resolution and mediation as opposed to traditional court trials and criminal charges. This is because, as many speakers highlighted in their speeches, it is often the case that women do not want their husbands or partners to go to jail. These women just want the violence to stop. Batema contends that these approaches could be a more effective solution to meet that end goal.

However, in cases where criminal redress is sought, Batema was clear that the state of Uganda needed to enforce standard punishments that fit the crimes committed. Too often, he explained, men have gotten away with minimal prison terms for crimes against women, meaning that there is little deterrent. Educating magistrates in this regard could produce the results that Batema discussed.

Additionally, Batema, like other speakers, urged the countries in the region to work together to solve the problem of violence against women, this includes the extradition of the accused perpetrators of these crimes to face punishment should they seek safe harbor in a neighboring country. These relationships can also help build coalitions and streamline any processes related to the creation of new treaties and declarations while simultaneously developing the opportunities to share best practices and research—a recommendation heard throughout the 2-day workshop from many speakers and participants.

Batema's presentation highlighted the extensive progress that has been made in legal and criminal justice sectors throughout the region; however, there is still much work to be done to ensure that these legal protections live up to their purported promise.

SOCIAL WORK SECTOR RESPONSE

Anna Swai of the Tanzania Association of Social Workers began her presentation on the social work sector's response to IPV in Tanzania by first explaining what the role of social work is. According to the International Federation of Social Workers, and quoted directly by Swai, the "social work

profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work" (International Federation of Social Workers, 2012).

Swai went on to explain that it is the role of the social worker to interact with many different people in society and to intervene when people need support. The manifestation of that support can be broad, ranging from psychological support to directing individuals to treatment, shelter, or other resources within the community. The causes precipitating the need for this support can also be broad; however, Swai focused her presentation to the context of IPV in Tanzania.

Swai highlighted many of the same facts from the WHO Multi-country Study Women's Health and Domestic Violence against Women as Mbwambo did in her keynote presentation which is featured in Chapter 2 of this summary. The study found a high incidence of IPV amongst women and girls in Tanzania across the lifespan. Swai explained that the study showed that a mere 20 percent of women who experienced physical IPV ever sought help from health care services (WHO, 2005). Furthermore, between the two sites located in Tanzania, Mbeya and Dar es Salaam, 60 percent of women who experienced IPV never accessed any formal service or person of authority for help in any capacity (WHO, 2005). Many of the reasons behind the difficulties in accessing treatment for IPV were explored by Rweyemamu in his presentation on barriers to care, which has been summarized earlier in this chapter. Swai's presentation picked up where Rweyemamu left off with further recommendations for the social work sector to help reduce barriers and increase access to care for victims of IPV in Tanzania and throughout East Africa.

Swai cited many of the same concerns as Batema. She explained that although there are laws in Tanzania that are designed to protect women and children from violence, they are all still very new laws, and their interpretation and implementation is lacking, which means that they are often unhelpful in providing services and treatment to victims. As Batema explained, it is not enough that the laws exist, it requires an engaged criminal justice sector to enforce them effectively, and the facilities and opportunities necessary to fulfill the law's intention. In this regard, like many other speakers, Swai highlighted the lack of resources available in country. This includes a dearth of evidence-based programming, current data, and the need to develop a strong and educated workforce. Swai explained that this lack of resources results in a limited understanding of women's health, which is a barrier to providing effective treatment opportunities in the region.

In practice, social workers in the region address issues of IPV and family violence in three main ways: through case management, the provision of services and support, and through leadership and community engagement.

Case management involves connecting victims to useful agencies and resources within their community, which would include connecting them to a referral system if available, as discussed by other speakers. Unfortunately, as Swai explained, often these referral systems are underdeveloped in the region.

The provision of services and support can occur in a variety of settings, including within the health care sector and counselling or therapy settings; however, within Tanzania, there are very few hospital-based social workers or schools, which is often a main point of access for treatment. Swai explained that this also contributes to the lack of resources available to victims of IPV and family violence.

Lastly, leadership and community engagement occurs in multiple ways and includes things like advocacy; policy development; human services management; teaching; learning from social science research, which can inform the practice of social work; and interacting with government offices and ministries. Within Tanzania, social workers have had a difficult time contributing to the policy process, which can result in less efficient policies and outcomes for those within the field. Swai also explained that there is a need for organized community advocacy and lauded the SASA! approach to social and community change, discussed in Chapters 3 and 5 of this summary, as a positive program for the social work sector.

The overarching problem that Swai identified in relation to these approaches is a lack of skilled social workers who can implement these and other evidence-based methods of intervention and practice. According to Swai, building strong associations and coalitions of social work organizations throughout the region and internationally will help tremendously in this aspect. She went on to explain that although the Tanzanian Association of Social Work has been in existence for more than 30 years, it has been on "life support" for much of that time and has only recently began the process of developing into a robust association thanks to support from the American International Health Alliance.

Swai expressed her hope that this relationship and the support of the University of Chicago will allow Tanzania to continue to develop their educational programs for future social workers. Within each program's curriculum, she explained, will be vital information regarding IPV and its prevention. There are also efforts under way to produce continuing education for social workers. Additionally, Swai highlighted the need for social workers to become actively engaged in research throughout the region in order to implement evidence-based research and practice. To this end, Swai emphasized the need for social work organizations throughout the region

to collaborate in these efforts to increase cross-border sharing of data, resources, and evidence-based prevention strategies.

Although Swai's presentation showed a field in the early stages of growing, she noted that, should these strategies be implemented, the social work sector could become a strong force in the field of IPV prevention in East Africa.

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5

Community Intervention Efforts to Reduce IPV in the Region

As workshop moderator Karim Nanji, a professor of pediatrics at the School of Medicine at Muhimbili University in Tanzania, explained, much of the work within IPV has focused on the collection of hard data and one-on-one screening efforts. However, it is important to think about the ways that communities can inform both the prevalence of IPV and its prevention. Some of the most promising prevention efforts, both in terms of efficacy and cost-effectiveness, are those that implement a community-mobilization approach. These approaches directly engage with and challenge the prevailing social norms within the region that lead to the acceptability of violence against women discussed throughout the workshop. A few of these programs and interventions have been touched upon briefly elsewhere within this summary. This chapter will explore these programs in more depth to provide a better understanding of their operation.

MENKEN

Referenced elsewhere in this summary, speaker Charlotte Watts of the London School of Hygiene and Tropical Medicine explained in her presentations that IPV and GBV are often extreme manifestations of gender inequality. As the following discussions will show, the power of community mobilization efforts to influence these inequities and other prevalent social norms in a short period of time is enormous. In his presentation, Francis Nyagah of the MenEngage Kenya Network (MenKen) outlined his organization's approach to reducing gender inequality and the associated risk factors in Kenya by engaging and educating men across the country.

MenKen is an alliance or network of organizations working together to engage men and boys in GBV reduction and HIV prevention. Broadly, MenKen has five focus areas:

1. The prevention of GBV;
2. The promotion of sexual and reproductive health (with the specific aim of reducing the prevalence of HIV/AIDS);
3. Positive fatherhood;
4. Building the capacity of organizations and institutions working to engage men and boys in GBV and HIV/AIDS reduction; and
5. Building partnerships with other organizations, institutions, and governments.

In addition to these overarching areas of focus, Nyagah highlighted the two main undertakings of MenKen as of August 2014. The first aims to expand the organization's more general work of engaging men and boys in reducing GBV and sexual exploitation as well as preventing HIV and promoting gender equality. The second area focuses on educating and engaging men in Kenyan laws and policies related to GBV and gender equality.

Nyagah went on to explain that although men account for half of the population in the country, they are the overwhelming majority of IPV perpetrators. Furthermore, the influence and power held by men in communities, relationship, and families is disproportionately high. Seeking to explore these dynamics in a more scientific fashion with the aim of developing effective programming specific to the organization's focus areas, MenKen developed a descriptive cross-sectional study that used a survey to assess a myriad of factors related to GBV, including childhood experiences; health services access and condom use; sexual partners; opinion on laws related to violence against women; and male privilege in the community throughout four different sites in Western Kenya. Purposive random sampling was undertaken to identify the four sites due to their higher prevalence of IPV. Both qualitative and quantitative measures of data were used to assess the survey results.

Some of the more stark findings that Nyagah shared from the study included attitudes related to sexual behavior and violence toward women. Of the men surveyed, 23.4 percent felt that men have a right to sex even when a woman does not consent. Twenty-eight percent felt that women who are raped have done something careless to put themselves in that situation. Just over one-quarter of the men surveyed agreed that in some cases, women want rape to occur. And almost 40 percent felt that when women do not physically fight back, it is not rape. Additionally, 4 percent of men surveyed volunteered that they had raped a woman. These statistics highlight the need for a shift in the attitudes of men in the region. What

is promising, however, is that the majority of men surveyed did not agree with these positions.

In addition to these perceptions and attitudes, the survey results revealed risky sexual behaviors that may leave both men and their partners vulnerable to HIV infection. Of the men surveyed, 48.5 percent reported that they never used condoms. In fact, only 13.4 percent of men reported always using condoms. Additionally, outside of their intimate partnerships, 22 percent of men had one other sexual partner; 14.5 percent had two others; and 6.5 percent had three others. One-night stands outside of the confines of an intimate partnership were also fairly prevalent, with 27.6 percent reporting having one incidence; 7.3 percent having two; and roughly 4 percent reporting three incidences. It was noted elsewhere in the workshop that men who do not use protection and engage in extra-marital sex/commercial sex were at a heightened risk for both transmitting HIV and perpetrating IPV.[1]

Outside of sexual behaviors and attitudes, the survey also brought to light the need for education and enforcement of the country's GBV-based laws. Only 45 percent of survey participants were aware that any such laws existed in Kenya. Additionally, Nyagah pointed out that Kenyan law does not recognize the rape of a wife by her husband. This lack of legal protection reinforces the cultural belief that men have a right to sex.

By using the data culled from this survey and other resources along with the focused mission of the organization, interventions were designed by MenKen for implementation by their partners and affiliates throughout the region. MenKen developed their interventions based on the ecological model. This was due to their belief that merely changing or altering the behavior of men on an individual basis is not enough—they must change the entire culture surrounding violence and the ways that communities and societies act in complicity with the existing culture.

First and foremost, MenKen sought to develop their methods for engaging men in changing this culture of violence. The organization believes there are three ways in which they are able to achieve this. The first is through their direct counseling programming. It is here that men who are perpetrators of IPV or GBV are able to take advantage of education and counseling provided by MenKen and their affiliated organizations in order to reform their behavior.

The second is to engage non-perpetrating men as supportive partners, or allies, of the cause. Nyagah explained that by bringing these men onboard, families and communities can begin the process of opening themselves up to change. Even if these supportive partners are not actively

[1] For more information on the complex, bi-directional relationship between IPV and HIV, see Chapter 3.

engaging in intervention efforts, their passive support makes both the community and the process stronger.

Lastly, there are what MenKen has termed "agents-of-change." These are men who are active participants in challenging the current culture of inequality and violence against women in order to create change at every level of the ecological model.

Nyagah explained that in the interventions led by MenKen, the last method of change is the most prominent. Volunteers (predominantly male) from within the community are actively sought to participate in community mobilization efforts as "community change agents." After recruiting these agents, MenKen trains them in a wide variety of community mobilization strategies and skills and then supports them in their efforts to engage other men in their communities in order to develop a network of supportive partners. Another program, entitled MenCare, seeks to engage fathers in childcare. Each of these methods for engaging men in the discourse on GBV works to challenge the "culture of silence" that has existed for too long.

In addition to community mobilization efforts, MenKen has an active referral network that allows both survivors and perpetrators to access the help and support they need. This support goes beyond medical care and counseling; it connects survivors to the resources they need to seek legal recourse against their attacker if that is what they desire. MenKen is also working to directly strengthen Kenyan policies related to violence against women by helping law makers construct more efficient and effective laws that can be enforced throughout the country.

Although a formal review of the myriad of interventions undertaken by MenKen has yet to be completed, Nyagah noted that preliminary feedback and results are promising. Many local and religious leaders have embraced the organization and its efforts, praising the positive outcomes they are seeing so far. Additionally, Masinde Muliro, a university in Western Kenya, has seen a reduction in IPV prevalence since MenKen began community mobilization efforts there. MenKen's active engagement of lawmakers resulted in the 2013 Protection Against Domestic Violence Bill and subsequent amendments. MenKen expects to complete a follow-up survey to assess the effects of their efforts in their target communities sometime in the near future. In the meantime, the organization is working to expand their reach by coordinating with other organizations and governments in the region by sharing best practices and participating in open and honest discussions about IPV, HIV, and what men can do.

SHARE

Described briefly in Chapter 3, the SHARE program uses community mobilization techniques and existing HTC as points of IPV intervention

within Uganda. Many researchers and presenters throughout the 2-day workshop highlighted the complex, bi-directional relationship between IPV and HIV. It is this relationship that inspired the SHARE program to develop a community-based intervention program that addresses both public health problems simultaneously. For more information regarding the relationship between IPV and HIV in the region, refer to Chapter 3.

Speaker Jennifer Wagman, a postdoctoral fellow at the University of California, San Diego, and SHARE researcher, identified the four broad pathways for the HIV–IPV relationship that informed the SHARE intervention. Foremost in these pathways is the direct relationship of forced sex and HIV, wherein the forced encounter causes abrasions and lacerations in the genital region creating a higher risk for HIV transmission. Additionally there are indirect methods, such as gender inequality and social norms condoning violence against women; the clustering of risk factors that increase individual men's and women's risk of IPV and HIV; and the disclosure of a positive HIV status, which may increase an individual's likelihood of experiencing IPV.

These four pathways informed the SHARE intervention, which includes a community-level mobilization approach that seeks to change attitudes, social norms, and behaviors related to IPV and HIV risk as well as IPV screening and brief intervention efforts to promote safe HIV disclosure and risk reduction among women seeking HIV counseling and testing services. Wagman explained that this approach not only took advantage of the existing resources within the Rakai district, but also helped shape an intervention that has ultimately shown much promise in the reduction of both IPV and HIV within a given community.

Wagman explained that the researchers and public health specialists behind the SHARE program developed a cluster randomized trial to test the efficacy of their intervention. There were 11 clusters in total, and all clusters were embedded in the Rakai Community Health Cohort Study. This study, which began in 1994, spans 50 communities across the district of Rakai and allowed SHARE researchers to use the existing infrastructure to support their intervention and analysis. Of the 11 existing clusters, 7 were in the control arm and 4 were in the intervention arm. Within the control arm, there were 6,111 participants, and the intervention arm had 5,337 participants. Both the control and intervention groups received the standard HIV treatment and care provided at HTC locations throughout Rakai as a part of the established Rakai Health Sciences Program. The intervention arm, however, also received the SHARE program.

Building on the successful foundations of the Ugandan Raising Voices/SASA! campaign and the ecological model, the intervention program consisted of five consecutive phases implemented from 2001–2009 and used the following strategies: advocacy, capacity building, community activism,

distribution of learning materials, special events, men's programming, and youth programming.

The first phase of the program, lasting from 2001–2004, consisted of a community assessment in which data was collected to measure the magnitude, determinants, and consequences of IPV in study locations. Upon completion of this assessment, the intervention phases (two through five) rolled out from 2005–2009. These phases consisted of raising awareness, building networks, integrating actions, and consolidating action. The main focus of the latter phases was to design, implement, and test interventions to see what worked in the communities to reduce IPV and HIV—meaning that the aforementioned cluster randomized trial occurred within these phases. Upon completion of all testing phases, a final evaluation was performed in 2010.

Wagman explained that, in addition to using the existing physical infrastructure of the Rakai health system, the intervention also built on the existing HIV-intervention programming by encouraging all of its community mobilizers and health workers to include violence prevention messages in coordination with their existing HIV-prevention messaging. This included their screening efforts. HTC and antiretroviral therapy (ART) counselors at both intervention and control sites were trained to include brief IPV-screening efforts in all sessions with clients and to offer referrals or a temporary support system when needed. These efforts were taken slightly further within the intervention arm of the study where enhanced screening measures were implemented.

These enhanced measures included two main toolkits for women who have either recently discovered they are HIV positive or have self-identified as being in a violent relationship within their IPV screening. For women who are HIV positive, the ART and HIV counselors were trained to perform a brief assessment of their risk of being subjected to violence should they disclose their status to an intimate partner. Based on the results of this assessment, counselors were trained to provide an intervention that includes different strategies and prevention methods to reduce this risk. Furthermore, women who were identified as currently being in violent relationships were offered an enhanced intervention designed to build their self-efficacy to negotiate condom usage and promote safe sex within their relationship.

It is important to note that each of these screening and intervention efforts was designed to be brief to ensure that the counselors did not become overwhelmed by the new methods, which could lead to a drop-off in these services.

SHARE researcher Gertrude Nakigozi discussed the results of the final evaluation, which included an association with a significant reduction in forced sex, a reduction in emotional IPV, increased HIV disclosure, and a reduction in HIV incidence (Wagman et al., 2015).

Additionally, Nakigozi shared that these findings likely contributed to an overall reduction in the burden of IPV and HIV for the women of Rakai. This was despite the fact that the intervention did not significantly reduce other risk factors thought to be associated with HIV such as alcohol and condom use, multiple sexual partners, or physical and sexual IPV.

Bearing all of these conclusions in mind, Nakigozi suggested that HIV-prevention programs in the region would benefit from integrating IPV prevention efforts to their protocols. Nakigozi also stated that the SHARE team felt their approach could be effective in other settings, once additional follow-up testing and evaluations were completed.

LVCT HEALTH

Also mentioned briefly in Chapter 3 was Kenya's LVCT post-rape care programming that, like the SHARE program, has been developing new interventions that link IPV and HIV screening within existing health care structures.

LVCT's most recent undertaking is a long-term, three-phase IPV study, with phase one having just been completed as of the August 2014 workshop. Lina Digolo, the Care and Treatment Manager at LVCT, shared this exciting project with the audience. She explained that, like the SHARE program, LVCT is attempting to use existing community settings such as HTC sites as potential IPV screening locations. Phase one of their study served as a preliminary feasibility assessment and basic screening. The results were overwhelmingly positive with more than 90 percent of women and health care providers surveyed showing acceptance of the screening efforts. These methods also proved feasible for integration with health care workers' current workload in terms of time, resources, and available skills.

What was less promising, however, was the low uptake of referral efforts amongst identified victims of IPV. Of the 47 percent of women who were identified as victims, only 29 percent actively engaged in the referral process, and of those who did engage, only 24 percent were happy with the services they received. Digolo explained that LVCT researchers believe this is because of the passive nature of the referral services—patients were only handed a letter with information once identified as victims of IPV. This concern directly relates to the recommendations made by some speakers in Chapter 4 related to the usefulness of active referrals.

The next phase of the project, which is ongoing, will address this issue by introducing an intervention with enhanced screening methods at their testing sites and facilities. The enhanced screening will not only identify victims of IPV, but also the magnitude and chronicity of their suffering. Additionally, the intervention will include on-site counseling that researchers hope will reduce the overall risk of IPV for those who identify as victims,

but also those women who do not identify as victims, but who might be at risk for future incidences of IPV.

The third and final phase of the LVCT program will integrate a community-based intervention, perhaps similar in structure to those mentioned in this chapter, that researchers hope will further enhance intervention and prevention efforts across Kenya.

One of the more unique aspects of LVCT's approach is their commitment to a multsectoral, collaborative approach. Digolo explained that their efforts to provide trainings related to IPV go far beyond health care providers. They have provided training to police officers, members of the judicial system, and community-based health care workers. Additionally, LVCT strongly believes in the sharing of best practices throughout the region and has actively engaged with the governments of Botswana, Malawi, and Ethiopia to create tailored versions of their programs within each country to ensure the programming meets local needs.

These relationships speak directly to one of the key findings Digolo shared with the audience: the need for strong governmental leadership and support. Digolo explained that state governments should be engaged in any intervention from implementation to evaluation in order to ensure its success but also to ensure that any data produced can be effectively used to justify measures for bringing interventions to scale. Digolo also cited the need to remain cognizant of the diversities within each country throughout the region that might necessitate adaptations of successful programs to meet local needs.

She also emphasized the need to integrate programming efforts when feasible—many speakers advocated for the need for coordinated HIV- and IPV-prevention efforts, but Digolo reminded the audience of the relationship between violence against children and violence against women, where studies show that boys who are victimized as youths often become perpetrators of IPV in adulthood and that girls who experience violence are more likely to be victims of IPV once they reach adulthood. The connections between forms of violence across the lifespan and how experiencing violence as a child increases the likelihood of experiencing or perpetrating other forms of violence—including IPV—in later life is a complex relationship that one workshop speaker, Nduku Kilonzo of the Kenya National AIDS Control Council, described as a vicious cycle. Multiple speakers noted that finding ways to link intervention efforts that address multiple forms of violence across subpopulations and age groups may be one way to help end that cycle.

Digolo explained that prevention efforts and programs related to IPV would benefit tremendously from the effective and thorough training of the community and health workers who will be delivering the interventions. She explained that taking the time to do so can help address issues of

capacity and ensure that the most effective version of a planned intervention is provided to target audiences.

Lastly, Digolo emphasized the need for more local research and the translation of that research into policy—which includes translating research findings into formats that are accessible for a policy making and government audience—and the scaling up of interventions so as to further reduce the impact and magnitude of IPV within the region, as noted by multiple speakers.

SASA!

Intervention

SASA! is a community-mobilization-based intervention that seeks to address and change the social norms within a community that perpetuate violence against women and cause an increased risk of HIV. Workshop speaker Tina Musuya, the Executive Director of the Center for Domestic Violence Prevention in Uganda, provided the introduction and background for the SASA! presentation. She explained that SASA not only forms the acronym for the four phases of their intervention, but also means "now" in Swahili, because, as Musuya explained, the time to end violence against women is now. SASA! is the result of a collaborative effort between the Uganda-based organization, Raising Voices; the Center for Domestic Violence Prevention (CEDOVIP); and the London School of Hygiene and Tropical Medicine. CEDOVIP implemented the intervention itself with technical assistance and monitoring from Raising Voices, while the London School of Hygiene and Tropical Medicine performed an in-depth analysis of the program's outcomes and effects.

SASA! takes on this complex and complicated issue through the use of a four-phase intervention where each phase builds on the last. The first phase is the **S**tart phase, followed by the **A**wareness phase, then **S**upport, and finally **A**ction. Musuya took the time to explain the overarching principles of the SASA! program which include process, reach, and content. SASA!'s creators felt strongly that the program must be phased in systematically by leaders from within the community itself, not from outsiders. Furthermore, they believed it was necessary to maintain intense exposure within SASA! communities so a critical mass of reach could be met, which they feel resulted in greater impact. Lastly, the creators of the program were cognizant of the language used within the discourse of IPV, and were sure to create content that would engage the intervention audience as opposed to antagonizing them with accusatory or alienating language.

The Start phase of the SASA! program focuses on the community itself. SASA! workers learn about the community and begin to recruit community

activists (both men and women) who will help administer the intervention protocols. Learning about the community goes well beyond demographics and prevalence of IPV within a community; Musuya explained that the SASA! organizers and community activists take the time to forge relationships with local leaders and institutions within the community to develop support and infrastructure for the upcoming programming efforts. This phase also begins the training process for community activists who are able to begin challenging some of their own beliefs about men's and women's equality within their communities.

The Awareness phase continues this training process by allowing staff people and community activists to gain confidence in their ability to effect community-wide change. Musuya explained that this process is critical for the community workers because they will be confronting extremely complex and potentially divisive subjects with their neighbors and community-members. This includes the need for workers to learn the "language of power" that both Musuya, and co-presenter Lori Michau, the cofounder and co-director of Raising Voices, discussed. Michau explained that discussions within the community that speak strictly about IPV remain quite shallow as it is not something that everyone can connect to. However, addressing the problem of IPV as one of power—of feeling powerless and powerful—helped shift the dynamic of the conversations. This allowed for individuals within the community, and particularly men, to more actively engage in the dialogue and change processes due to increased understanding of the gender inequality and surrounding issues of violence against women.

The awareness phase also creates a platform for these discussions through the use of a myriad of informal community activities. These include community conversations, door-to-door discussions, quick chats, trainings, public events, poster discussions, community meetings, film shows, and soap opera groups amongst many other activities. Michau explained that as many as 15 different activities were occurring every day in SASA! communities. This total immersion speaks to the programmatic goal of reaching a critical mass within the community in order to effectively shift social norms and attitudes. Musuya explained that over the course of the SASA! trial (~2.8 years), more than 400 community activists engaged more than 260,000 community members through the use of more than 11,000 of these informal activities.

Following the Awareness phase is the Support phase. Throughout this phase, community members are strongly supported by SASA! staff and activists in their efforts to change; this includes celebrating the changes being made. This phase also deepens the relationships between individual community members while strengthening the community as a whole.

The Support phase (along with the conclusory phase) are indicative of SASA!'s efforts to move beyond simply raising awareness of IPV. Musuya

explained that many interventions and programs in the past have raised awareness regarding violence against women, but do little more beyond this. To effect actual change, interventions should try to move beyond awareness into action.

To this end, the SASA! program concludes with the Action phase in which community members are encouraged to try new behaviors and work as a whole to foster an environment in which members are empowered to make positive changes.

Evaluation

To test the efficacy of their program, Raising Voices and CEDOVIP in Uganda reached out to the London School of Hygiene and Tropical Medicine to perform an evaluation. Watts shared their findings (Abramsky et al., 2014).

Watts explained that the program showed immense promise overall, with study sites consistently showing that community attitudes and responses to violence against women have improved. Watts and her team used mixed methods to fully interrogate the data from multiple angles. These methods included a cluster RCT (eight clusters in total throughout two divisions in Kampala, with four receiving the intervention and four acting as controls); qualitative research that included in-depth baseline and follow-up interviews; operations research, including process reports, impact monitoring, and rapid assessment surveys; and an economic costing survey to help provide detailed costs analyses for the purposes of scaling up intervention efforts and making the case to policy makers regarding this particular intervention's success.

To assess the SASA! intervention, Watts and her team focused on the following six outcomes:

1. The acceptability of men's use of physical violence against their partner;
2. Acceptability of when a woman can refuse sex;
3. Experience of physical acts of violence from partner in the past year;
4. Experience of sexual acts of violence from partner in the past year;
5. Women's perceptions of appropriateness of responses experienced; and
6. Reported sexual concurrency (multiple sexual partners) in the past year by men.

Outputs one and two were measured in both men and women, while outputs three, four, and five were measured in women only, and output six in men only.

The past-year levels of physical violence (output three) were 52 percent lower in the SASA! intervention communities than in the control group; the intervention communities also showed a lower level of past-year sexual violence (output four), but the difference was less marked than in that seen in the physical violence output. Additionally, the intervention group showed less supportive attitudes toward the acceptability of violence (output one), and saw significant positive shifts in the social acceptance that women can sometimes refuse sex (output two).

Although sexual concurrency (output six) remained high in both the intervention and control communities, it was significantly lower in those communities exposed to the SASA! intervention, 27 percent versus 45 percent in the control communities. Lastly, women in the intervention communities reported higher levels of perceived appropriate responses to violence against women (output five).

Watts noted that although the past-year levels of physical violence (output three) showed a big effect, it was not statistically significant. This is due in large part to the nature of the study. Within a cluster RCT, the data points are the clusters themselves, meaning that there were only four paired clusters representing data points within this trial. It is this small data set that confounds the significance of this result. Despite this, Watts explained that there is strong consistency across all study outputs which is a strong indicator that the program has met its hypothesized effects.

The study also measured the effect of exposure to intervention activities in order to ascertain whether or not direct exposure was necessary for the program's success. Watts shared that for most of the outcomes around attitudes, there was not a significant difference between those community members who had direct versus indirect exposure to SASA!, which is supportive of the social diffusion model upon which SASA! was based. Watts did note, however, that for women who experienced IPV, direct exposure to SASA! was more effective than the indirect social diffusion of SASA! messages.

The SASA! program is one that holds much promise for future interventions, especially in terms of its implementation and costs. The SASA! program depends upon members of the community for its implementation as opposed to external experts or an NGO. Michau explained that this feature was key to the program's success because there was already an established level of trust among community members and neighbors prior to the study's launch. This program was able to take advantage of those networks for the social diffusion of primary messages. Watts explained how this approach is indicative of where the field of violence prevention needs to move in the future, as there simply are not enough resources and financing to support one-on-one interventions. Programs like SASA! and the other community-based approaches shared at the workshop and described in this

chapter show extreme promise in producing meaningful change with broad reach at a reduced cost.

Michau also explained that these programs can change the way we think about violence prevention. For so long, she stated, preventing violence and changing the ways that people think about violence was thought to require time and investment across generations. She explained that the SASA! program, however, showed significant shifts in key violence prevention outputs in 2.8 years, meaning that reductions in violence are attainable in this generation. The overwhelmingly positive response to the SASA! program and its approach is demonstrated by its widespread applications. Michau stated that the program has been expanded across Uganda, and has been implemented in many other sub-Saharan countries in Africa. Additionally, the program has been adapted for other settings, including sites in Ethiopia, Haiti, and Mongolia. Michau shared that the SASA! program has also seen an adaptation for the faith-based communities in Uganda, which is another potential mechanism for increasing impact and reach given the high degree of influence held by faith-based stakeholders throughout the region, as noted by multiple speakers.

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6

Connecting Research, Practice, and Policy

Many speakers throughout the 2-day workshop either mentioned or directly addressed the interface of research, practice, and policy, explaining that this complex nexus of factors should be working harmoniously to ensure that the most effective approaches to IPV treatment and prevention are being employed, with each of the three factors informing the other two. Unfortunately, this has not always been the case throughout the region. Speaker Jessie Mbwambo, a researcher from Muhimbili University, mentioned that for too long in the region, researchers have completed their data collection and analysis and essentially moved on to their next project or study, simply expecting that the results will be taken up by community workers or policy makers. This approach is ineffective and unsustainable. Instead, many participants spoke of collaboration and an approach that fosters the sharing of research, best practices, and policy across borders.

THE LVCT MODEL

LVCT Health, a Kenya-based NGO focusing on HIV prevention, has already been featured in this summary discussing their approach to HIV- and IPV-integrated intervention efforts. In addition to creating programming, LVCT has developed an effective model for interacting with the research, policy, and practice nexus in Kenya. As mentioned previously, LVCT operates based on three pillars: (1) conducting studies, mostly in operations research, information from which they use to (2) inform policy, after which LVCT takes the time to look at how to (3) use the evidence base and policies to bring their work to scale throughout Kenya. This

process requires considerable interaction between governmental agencies and NGOs, but it can lead to better management of the related issues.

For instance, of the 28 operational studies completed by LVCT since its founding, 10 have resulted in tangible policies and other programming efforts. Speaker Lina Digolo explained there is often no overlap between the perceived societal problems of researchers, programmers, and policy makers. In fact, Digolo explained that it is often the case that policy makers and governmental actors will first ask, "Is this even an issue?" Or "Does this intervention that you are suggesting even work?" Because, as Digolo stated, "they [policy makers] are not going to invest in things that they don't understand."

Many speakers pointed out that politicians and policy makers have different goals and priorities from researchers and public health workers. Their priorities extend into every aspect of society and governance, and as such, they need to be convinced that IPV, or any issue for that matter, deserves attention, support, and funding. Speaker Nduku Kilonzo, Director of the Kenya National AIDS Control Council, stated in her keynote address regarding the East African response to IPV, "if we want to make intimate partner violence prevention . . . an issue [big] enough to get the response that we are looking for, we must start to speak to the politicians, or rather to the things that are important for politicians." This necessitates that researchers and those working in public health take the time to deliver tailored and unified messages to their policy makers that have, as workshop speaker Jacquelyn Campbell summarized, "clear, articulate messages . . . that are supported by data."

Edward Kirumira, Principal of the College of Humanities and Social Sciences at Makerere University and workshop moderator, highlighted the fact that researchers need to develop the communication skills necessary to be able to promote their issues and work with various constituents, and think carefully about both what they are asking for and how they are asking for it.

This process of communication goes two ways: speaker Francis Nyagah of MenKen noted that politicians were able to learn from his organization what language to use within their laws and policies in order to produce the desired change in society. Many speakers noted that although there are many laws in the region that are purportedly designed to protect women from violence, in practice they tend to be ineffective. Many speakers indicated that this could be a result of a lack of understanding of both the problems of IPV and their potential solutions. Digolo explained that an interactive and evolving relationship, such as the one developed by LVCT in which research informs policy, policy informs practice, and each group is responsive to the needs and developments of the other sectors of the interface, could produce more effective results for each facet of the IPV-prevention community.

BUILDING THE CASE

The process of building a case for IPV-prevention efforts includes the task of performing costing studies for the various interventions and proposals that researchers and programmers will be presenting to various policy makers and politicians. Many speakers echoed this sentiment in their presentations and highlighted this aspect of their evaluation design as being a key-step toward scaling up evidence-based prevention efforts.

Kilonzo explained, however, that building the case for policy makers goes beyond a simple economic analysis. Researchers and programmers must also take into consideration the idea of cost-effectiveness. Which intervention is going to deliver the best results for the lowest costs? Kilonzo stated that if the cost of the intervention is too high in relation to its effects or benefits, it will not receive funding. It is important to consider the return on investment across a multitude of factors, including the health and well-being of women, the infrastructure or capacity that a given intervention promises to build, as well as the actual costs saved to society in terms of reduced health care or criminal justice costs and the ability of healthy women to contribute to their community free from IPV. Performing this sort of analysis will require additional inquiry into the societal costs of IPV at the national level. Many of these costs remain unknown and would be helpful in developing a case for funding and support.

Related to the overall costs of a proposed intervention, Kilonzo suggested that researchers and public health programmers alike should think critically about how their intervention operates in order to identify the crucial elements to its success. Should there be negotiations or proposed budget cuts, researchers and intervention programmers need to be prepared to identify what elements absolutely cannot be cut from their programming in order to ensure the efficacy of their work. Conversely, considerations should made to identify the portions of a given intervention that could be removed with minimal effect on overall outcomes or success should the subject of budgetary concerns be raised by politicians.

In addition to the actual costs of a given intervention, many speakers highlighted the need to address or calculate the costs to society of IPV—that is the cost of doing nothing—which could also be persuasive to policy makers. These costs and considerations would likely be expansive in nature given the broad reach of IPV and its effects, including criminal justice costs, health care costs, and costs to families and communities.

Kilonzo explained that outside of financial concerns there must be an identifiable agency or group within the government that is responsible for the proposed IPV initiatives and can serve as a coordinator for the various aspects of a proposed intervention or program. This is no small undertaking given the incredible complexity of IPV with causes and effects that

ripple into countless sectors of society. Although this makes it an appealing problem to solve given its reach, it also means that no one group or system within the government is willing to take responsibility for its oversight.

Related to this, Kilonzo explained that targets and goals must be set, both for the government involvement as a whole and individually for the sectors involved so an effective approach can be identified, measured, and adjusted as needed. Having a clear plan of action and a sense of how the program could operate will be extremely beneficial in making a case to policy makers.

THE VALUE OF A COORDINATED APPROACH

Kilonzo highlighted the need for those working in IPV prevention to identify top priorities and to subsequently develop a common agenda to share with their respective governments. Having a united front and a common agenda, she explained, will help bring together individuals from multiple sectors to work together with a common understanding regarding the issue and the identified target areas within it. This also helps bring into focus the government's participation. Kilonzo explained that national governments like to have a result that they are working toward, one that, when finished, they are able to identify and explain the tangible impact of their involvement and efforts.

Additionally, Kilonzo noted that this approach can help individuals focus on the top challenges for IPV prevention and focus on implementing targeted and effective solutions together instead of a more piecemeal approach. She went on to explain that this could also result in a more concentrated use of available funding streams, allowing for more money to be put toward priority objectives, while those issues identified as less urgent can be moved to the backburner for future research and intervention programming efforts.

Kilonzo stated that achieving this level of cooperation across the different stakeholders and sectors throughout the region will require effort from multiple sectors within each country and throughout the region. Kilonzo and other speakers highlighted the benefit and value of convening communities of practice across sectors, including research, programming, and policy in order to engage in a meaningful dialogue regarding IPV and its surrounding issues. Those individuals agreed that workshops similar to this and related efforts should be continued throughout the region in order to establish a strong network between countries that encourages the sharing of data, research, programming, and best practices. In addition, building on the work of other countries and developing intergovernmental and intragovernmental relationships will be important steps in reducing the burden of IPV within the resource constrained environment of East Africa.

7

The Way Forward

There was much discussion throughout the workshop regarding next steps and proposed ways forward for the problem of IPV in East Africa. Many of those suggestions have been shared in previous chapters of this summary. This final chapter will recapitulate some of those suggestions as well as highlight some of the discussion points from the workshop's closing panel.

RESEARCH

In her keynote address, Nduku Kilonzo, the Director of the Kenya National AIDS Control Council, explained that there needs to be a shift in research, one that moves away from international sources and studies toward more localized studies in terms of modeling, identifying surveillance points and surveillance data needs. She also highlighted the need for increased mentorship and long-term training of young scientists and researchers in the region to ensure the sustainability of research efforts in East Africa.

Cost Analyses

Many speakers also highlighted the need to include economic analyses as a common part of all intervention review and analysis in order to develop a case for policy makers and for the purpose of developing a plan for scaling up intervention practices.

Linking IPV to Other Public Health Issues and Research Activities

There were repeated calls from many speakers and participants alike to link research efforts across multiple factors related to IPV. This would mean bringing together researchers exploring issues of IPV and HIV as well as those who are studying the effects of chronic exposure to violence and the impact of IPV on children and families. Some participants noted that this could produce a broader pool of data, particularly related to subpopulations and it might also shed some light on the causal pathways of IPV both in terms of perpetrators and victims, which is another area that some participants raised as one needing further research.

Collecting and Analyzing Data on New Populations and Groups

Workshop moderator Ian Askew, the Director of Reproductive Health Services and Research at the Population Council, also pointed out that there was an apparent lack of evidence presented regarding perpetrators of IPV, particularly in relation to why they perpetrate these forms of violence. He suggested it might be worthwhile to invest some time and research into that question to develop subsequent primary prevention efforts for this population.

Many workshop participants also highlighted a need to expand research perimeters to include subpopulations across the lifespan, including aging populations and adolescents. These efforts appear to be under way, but some participants within this workshop indicated the studies were small and would likely require further efforts and resources to bring them to scale.

Collaboration Across Sectors

Keynote speaker Jessie Mbwambo of Muhimbili University also suggested that researchers should be willing collaborators with individuals from other sectors, including community workers, such as public health specialists, social workers, and policy makers, not only so these groups can help develop study designs and illuminate findings, but also so these same collaborative groups can work together to develop effective and innovative programming that would not have been possible otherwise. There were a few commenters within the closing panel's discussion who shared their own experiences with multidisciplinary teams in the field of IPV prevention, each of whom lauded the approach and stated how much further it pushed the science and the programming efforts than had there been a team of like-minded individuals from only one discipline or sector. Mbwambo stated that she expected difficulties with this in practice given the siloed approach

to violence prevention and IPV; however, she urged her colleagues and the workshop's participants to think creatively about the ways they can adopt this strategy in their own work to help break down those siloes.

Many participants also explained that researchers should be mindful of their dissemination and information sharing efforts. Some explained they had difficulty accessing data to inform intervention or programming efforts. They suggested that this issue could be resolved through collaborative efforts such as those just described, but there were also additional calls for broader dissemination and access to data and research in general within the region to facilitate future prevention and programming efforts.

COMMUNICATION EFFORTS

There was much discussion surrounding communication efforts within IPV prevention. Many of these points focused on the varying degrees of understanding of IPV across sectors and the unique language used within each sector. Many commenters felt that there needed to be increased communication across all sectors working on the issue of IPV generally, but also that there needs to be a system of standard operating procedures, languages, and best practices to better facilitate interactions and collaborations across disciplines.

Perhaps most prevalent in the workshop discussions on this subject were points related to communications with policy makers. Some participants and speakers suggested that researchers and programmers should become well versed in the language and drivers of policy in order better situate their needs, issues, and priorities within a policy context to garner the attention they deserve.

Keynote speaker Nduku Kilonzo explained that making a case to policy makers requires developing an articulate "ask" that is strongly rooted in the available evidence and delivered in a language that policy makers understand. This area, she explained, is a prime example of why economic and cost analyses are so important for moving forward in IPV-prevention efforts, because often the language of policy makers centers on the limited resources and funds available versus the costs of the proposed intervention efforts before them. By changing tactics to focus on this reality, she suggested, researchers and programmers could be in a better position to deliver effective arguments in the case for IPV funding and support.

TRANSNATIONAL COLLABORATION

The need to collaborate that was urged by many participants throughout the workshop extends beyond multidisciplinary approaches into transnational efforts to share research, data, and best practices. In fact, some

collaboration already exists, such as the East, Central, and South African Health Communities discussed in Chapter 4 of this summary. Many commenters suggested that these approaches increase the data pool and knowledge base, but also present opportunities to share in the costs of prevention efforts, thus somewhat alleviating the pressures of the resource constrained environment. Sharing of information includes the widespread dissemination of successful programming efforts and studies. Workshop speaker and professor at Johns Hopkins University, Jacquelyn Campbell, echoed this sentiment when discussing the upcoming release of many of the study results for interventions featured in this workshop—particularly for those related to the LVCT and SASA! interventions.

INVESTING IN COMMUNITY MOBILIZATION AND POPULATION-BASED PREVENTION

The impact of population-based interventions and efforts to mobilize communities to influence and change societal and cultural norms regarding violence against women was repeatedly raised throughout the 2-day program. The presentations from each of the speakers in Chapter 5 on this subject show that these efforts hold promise in the region for IPV prevention and reduction while simultaneously helping to develop a strong sense of ownership amongst East African communities as these programs are often implemented and driven by local community members and leaders. Many participants lauded these efforts, with some specifically citing the success of the SASA! program in reducing the prevalence of IPV and HIV within a matter of years, shattering the previously held notion that changes in social and cultural norms and their impact on violence against women would require substantial efforts across generations of community members.

Speaker Charlotte Watts also mentioned that the resource constrained environment precludes the opportunity to perform one-on-one interventions that are time consuming and expensive. Instead, she explained, larger-scale and more population-based methods are a more attractive and cost-effective method of increasing reach and impact despite limited capacities and resources.

Many participants and speakers suggested that primary prevention efforts be undertaken among young people to prevent IPV from developing within their relationships in the first place. Some participants suggested that community mobilization efforts could help in this respect by opening dialogues across communities. However, some other participants noted that it could be useful to develop more targeted interventions that focus on this population with the inclusion of their parents or caretakers as opposed to entire communities in order to preempt some of the concerns and barriers related to younger populations and IPV raised in Chapter 2 of this summary.

ADVOCACY

Finally, many speakers throughout the workshop discussed their desire and perceived obligation to contribute to the discourse on IPV and policy efforts through the use of advocacy. These efforts, many claimed, are instrumental in the process of creating the necessary public and political wills to influence the field of IPV work and the prevalence of this form of violence in the region. Many speakers and participants suggested that individuals working in this field should think critically about their communications efforts and develop tailored advocacy efforts for each of the sectors of society that they interact with in the fight to reduce the burden of IPV in East Africa.

Appendix A

Workshop Statement of Task

Intimate partner violence and HIV/AIDS in East Africa are public health and human rights problems with far-reaching and associated consequences. A growing evidence base is demonstrating the intersection of these two pervasive problems, including significant overlap in prevalence, as well as increased HIV risk behavior and barriers to testing as a result of experiences or fear of intimate partner violence (IPV). Furthermore, stigma and discrimination associated with both IPV and HIV/AIDS increase the vulnerability of victims and result in underreporting. The Institute of Medicine (IOM) Forum on Global Violence Prevention will hold a joint workshop with the Uganda National Academy of Sciences on the intersection of IPV and HIV/AIDS in East Africa. To raise awareness and effectively reach stakeholders within the region, the workshop will be held in Uganda.

The public workshop will be organized by an ad hoc planning committee to examine:

1. The evidence base demonstrating the intersection between IPV and HIV/AIDS; and
2. Promising and innovative approaches to prevention.

The committee will develop the workshop agenda, select and invite speakers and discussants, and moderate the discussions. Experts will be drawn from the public and private sectors as well as from academic organizations to allow for multilateral, evidence-based discussions. Following the conclusion of the workshop, an individually authored summary of the event will be prepared by a designated rapporteur.

Appendix B

List of Speakers and Their Presentation Titles by Chapter

CHAPTER 2

Speaker	*Presentation Title*
Jessie Mbwambo Senior Specialist Psychiatrist and Senior Researcher, Muhimbili University	Keynote Address: *The Magnitude of Intimate Partner Violence in Uganda, Tanzania, and Kenya: Considerations to Improve Prevention and Mitigation*
Silvia Pasti Chief, Child Protection, UNICEF Uganda	*Effects of Intimate Partner Violence on Children*
Workshop Participants	Facilitated Discussion: *What Are We Learning About Addressing Intimate Partner Violence Across the Lifespan?*

CHAPTER 3

Speaker	*Presentation Title*
Charlotte Watts Professor, Social and Mathematical Epidemiology, London School of Hygiene and Tropical Medicine	*The Intersection Between Intimate Partner Violence and HIV*

Samuel Likindikoki Lecturer and Medical Specialist, School of Medicine/Head, Department of Psychiatry and Mental Health, Muhimbili University	*Implications for Research and Intervention Design*
Christine Ondoa Director General, Uganda AIDS Commission	Keynote Address: *A Policy Perspective on Addressing Intimate Partner Violence as a Public Health and Human Rights Issue*
Rose Apondi Public Health Specialist, Centers for Disease Control and Prevention	*Implications for Policy Making and Service Delivery*
Lina Digolo Care and Treatment Manager, LVCT Health	*Model of Post-Rape Care: LVCT Health Kenya*
Jennifer Wagman Postdoctoral Fellow, University of California, San Diego	*Public Health Approach to IPV and HIV Prevention: The SHARE Project*
Gertrude Nakigozi Rakai Health Sciences Program, Uganda	

CHAPTER 4

Speaker	***Presentation Title***
Chi-Chi Undie Associate, Population Council, Kenya	*Screening for Intimate Partner Violence in the Region*
Abigail Hatcher Senior Researcher, Wits Reproductive Health and HIV Institute	*Linking IPV Screening to Services and Care Through Referral Networks*

Datius Rweyemamu Department of Sociology, University of Dar es Salaam	*Access and Barriers to Care and Services for IPV Survivors: Experience from Tanzania*
Odongo Odiyo Manager, Family and Reproductive Health, East, Central, and Southern Africa Health Community	*Health Sector Response: Eastern, Central, and Southern Africa Health Community Regional Policy and Programming Efforts to Prevent and Respond to IPV*
Olive Sentumbwe-Mugisa Family Health and Population Advisor, WHO Uganda	*Health Sector Response: WHO Clinical and Policy Guidelines for Responding to IPV and Regional Programming Efforts*
Hon. Justice Batema Ndikabona David Akky High Court of Uganda	*Efforts by the Criminal Justice Sector to Respond to IPV*
Anna Swai Tanzania Association of Social Workers	*Efforts Within the Social Work Sector to Respond to IPV*

CHAPTER 5

Speaker	*Presentation Title*
Fredrick Nyagah National Coordinator, MenEngage Kenya Network	*Engaging Men and Boys in Preventing Gender-Based Violence and Promoting Gender Equality: MenKen*
Jennifer Wagman Postdoctoral Fellow, University of California, San Diego	*Public Health Approach to IPV and HIV Prevention: The SHARE Project*
Gertrude Nakigozi Rakai Health Sciences Program, Uganda	*Public Health Approach to IPV and HIV Prevention: The SHARE Project*
Lina Digolo Care and Treatment Manager, LVCT Health	*Model of Post-Rape Care: LVCT Health Kenya*

Tina Musuya Executive Director, Center for Domestic Violence Prevention, Uganda	*Promoting Gender Equality and Changing Social Norms: SASA! Approach*
Lori Michua Co-Founder and Co-Director, Raising Voices, Uganda	*Promoting Gender Equality and Changing Social Norms: SASA! Approach*
Charlotte Watts Professor, Social and Mathematical Epidemiology, London School of Hygiene and Tropical Medicine	*Promoting Gender Equality and Changing Social Norms: SASA! Approach*

CHAPTER 6

Speaker	*Presentation Title*
Lina Digolo Care and Treatment Manager, LVCT Health	*Model of Post-Rape Care: LVCT Health Kenya*
Nduku Kilonzo Director, Kenya National AIDS Control Council	Keynote Address: *Improving Intimate Partner Violence Prevention and Response in Uganda, Kenya, and Tanzania*

CHAPTER 7

Speaker	*Presentation Title*
Workshop Participants	Moderated Discussion: *The Way Forward*

Appendix C

Workshop Agenda

Preventing Intimate Partner Violence in Uganda, Kenya, and Tanzania: A Joint Workshop of the Uganda National Academy of Sciences, the U.S. Institute of Medicine, and the U.S. National Research Council

August 11–12, 2014

Sheraton Kampala Hotel, Rwenzori Ballroom
Ternan Avenue
Kampala, Uganda

Workshop Approach: Using an ecological framework that focuses on points of primary, secondary, and tertiary prevention and intervention, this 2-day workshop will focus on intimate partner violence (IPV) in Uganda, Kenya, and Tanzania and the far-reaching consequences of IPV as both a public health and human rights problem. Within this context, the workshop will address IPV and the intersection with HIV, the unique needs of individuals experiencing IPV across the lifespan, responding to IPV from screening to care, the role of social norms and community engagement in prevention, societal level policies and implications, and overall how to improve intervention and decrease IPV prevalence. The workshop will be an opportunity to explore promising and potential prevention models.

Workshop Objective: The objective of this workshop is to inform and create synergies within a diverse community of researchers, implementers, and decision makers committed to promoting IPV prevention efforts that are evidence-informed, innovative, and cross-sectorial.

Context for the Workshop: As defined by the World Health Organization (WHO), IPV refers to behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors. IPV is recognized as a global human rights and public health issue. In the 2005 WHO Multi-country Study on Women's Health and Domestic Violence against Women, between 15 percent and 71 percent of women at 15 different sites in 10 developing countries reported physical or sexual violence or both. Of the 10 countries in the WHO Multi-country Study, Tanzania had one of the highest prevalence rates (Uganda and Kenya were not included in this multicountry study but, in other prevalence studies, Uganda and Kenya also have shown to have significantly high rates of IPV). A more recent analysis from the WHO with the London School of Hygiene and Tropical Medicine and the Medical Research Council analyzed existing data from more than 80 countries and found that globally almost one-third of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner. Globally, more than one-third of all murders of women are committed by intimate partners. Evidence shows that women subject to IPV experience a wide range of serious negative physical, mental, sexual, and reproductive health outcomes, and may have increased vulnerability to HIV. Additionally, the social and economic costs of IPV are high and affect all levels of society.

Although there is growing understanding of IPV as an important public health and safety issue, making greater strides in prevention has been challenging for many reasons, including a lack of good data on the nature and magnitude of violence and its costs, limited understanding of regional and context-specific factors, fragmented effort and resources to address it, and assumptions that violence is both inevitable and cannot be prevented. However, preventing IPV is possible and can be achieved through a greater understanding of the problem, its risk and protective factors, and effective evidence-informed primary, secondary, and tertiary prevention strategies.[1]

This workshop is being convened by the Uganda National Academy of Sciences (UNAS) and the U.S. Institute of Medicine (IOM) and the

[1] Primary prevention aims to reduce risk of experiencing or exposure to violence by addressing risk factors and social norms that promote IPV. Secondary prevention focuses on improving the detection of IPV and providing appropriate services, and tertiary prevention focuses on strengthening institutions to respond thereby mitigating the adverse consequences of IPV.

U.S. National Research Council Forum on Global Violence Prevention. The UNAS and the IOM/NRC are both independent, unbiased scientific organizations. The mission of the UNAS is to contribute toward improving the prosperity and welfare of the people of Uganda by promoting, generating, sharing, and using scientific knowledge and information, and to give independent, merit-based advice to government and society, among others. Similarly, the IOM/NRC has equivalent responsibilities to the U.S. government and other domestic and international stakeholders who seek its advice.

As a convening activity of the IOM/NRC established in 2010, the Forum on Global Violence Prevention works to reduce violence worldwide by promoting research on both risk and protective factors and encouraging evidence-based prevention efforts. Given the unbiased reputations of the UNAS and the IOM/NRC and the established body of work of the IOM/NRC Forum on Global Violence Prevention, these entities are in a unique position to facilitate dialogue and exchange among a wide range of global experts and diverse stakeholders on preventing IPV.

This workshop was organized by an appointed planning committee who, with the assistance of the IOM/NRC and the UNAS staff, developed the workshop agenda and sessions, and selected speakers and discussants. Following the conclusion of the workshop, an individually authored summary of the event will be prepared by a designated rapporteur.

DAY 1: Monday, August 11, 2014

8:00 a.m. **Registration**

8:30 a.m. **Welcome**
Nelson Sewankambo
President
Uganda National Academy of Sciences

8:35 a.m. **Opening Remarks**
Jacquelyn Campbell, *Workshop Co-Chair*
Professor and Chair
Johns Hopkins University School of Nursing

Edward Kirumira, *Workshop Co-Chair*
Principal
College of Humanities and Social Sciences
Makerere University

8:45 a.m. **Keynote Address: A Policy Perspective on Addressing Intimate Partner Violence as a Public Health and Human Rights Issue**
Christine Ondoa
Director General
Uganda AIDS Commission

9:30 a.m. **Keynote Address: The Magnitude of Intimate Partner Violence in Uganda, Tanzania, and Kenya: Considerations to Improve Prevention and Mitigation**
Jessie Mbwambo, *Workshop Planning Committee Member*
Senior Specialist Psychiatrist and Senior Researcher
Muhimbili University

10:15 a.m. **TEA BREAK**

Session I. Understanding and Addressing the Intersection Between Intimate Partner Violence and HIV

A growing evidence base is demonstrating the intersection of IPV and HIV infection, including significant overlap in prevalence, as well as increased risk behaviors and barriers to testing as a result of experiences or fear of IPV. Furthermore, stigma and discrimination associated with both IPV and HIV increase the vulnerability of victims and result in underreporting. Pervasive gender inequalities, especially violence against women, have been recognized by The Joint United Nations Programme on HIV/AIDS and the WHO as a driver of the HIV epidemic. In sub-Saharan Africa, more than half of the people living with HIV/AIDS are women. Although there is research that reveals the links between IPV and HIV, important gaps still remain in understanding the complexities of these intersections across social contexts and among different populations. This session will explore the evidence for IPV as both a risk factor for and consequence of HIV infection and how better understanding of the intersection between IPV and HIV can inform and improve the prevention and response to both epidemics. Presentations will focus on the implications of the intersection for research, intervention design, and policy making in the region.

Session Moderator: Jessie Mbwambo, *Workshop Planning Committee Member*
Senior Specialist Psychiatrist and Senior Researcher
Muhimbili University

10:45 a.m. **The Intersection Between Intimate Partner Violence and HIV**
Charlotte Watts
Professor, Social and Mathematical Epidemiology
London School of Hygiene and Tropical Medicine

11:05 a.m. **Implications for Research and Intervention Design**
Samuel Likindikoki
Lecturer and Medical Specialist, School of Medicine
Head, Department of Psychiatry and Mental Health
Muhimbili University

11:25 a.m. **Implications for Policy Making and Service Delivery**
Rose Apondi
Public Health Specialist
Centers for Disease Control and Prevention

11:45 a.m. **Moderated Discussion with Workshop Participants**

12:30 p.m. **LUNCH**

(PRESS CONFERENCE)

Session II. Effects of Intimate Partner Violence on Children

The effects of IPV reach beyond those who are direct victims or perpetrators. Exposure to violence has been shown to be associated with negative health, social, and economic outcomes as well as future experiences of violence. With IPV, often those who are exposed to it are children within the family or household where IPV occurs. Children who grow up in families where they are exposed to violence may suffer a range of behavioral and emotional disturbances. Exposure can also be associated with perpetrating or experiencing violence later in life. This session will illuminate the effects of exposure to IPV on children, including evidence of the effects of exposure to violence on child health and development and welfare in both the short term and later-life effects. Additionally, the session will include discussion on the implications and opportunities for designing interventions and implementing policies that address both IPV and violence against children.

Session Moderator: Karim Manji, *Workshop Planning Committee Member*
Professor in Pediatrics, School of Medicine
Muhimbili University

1:30 p.m. Silvia Pasti
Chief, Child Protection
UNICEF Uganda

Session III. What Are We Learning About Addressing Intimate Partner Violence Across the Lifespan?

IPV occurs at different stages across the lifespan, from adolescence to late life, and presents unique characteristics and challenges within these subpopulations. IPV may present in the form of dating violence, dowry abuse, marital rape, or elder abuse. Those who experience IPV in an earlier life stage may be more likely to experience it again at a later stage. However, there are limited data and number of interventions in general, but particularly within the region, that address the specific needs of individuals experiencing IPV in either early or late-life stages. This moderated plenary discussion explores what is being learned through research, policy, and interventions in IPV about the characteristics and vulnerabilities of specific populations across the lifespan and how research and interventions can begin to target the needs of adolescents and the elderly who experience IPV.

2:00 p.m. **Facilitated Discussion with Workshop Participants**

Session Facilitator: Chi-Chi Undie, *Workshop Planning Committee Member*
Associate
Population Council, Kenya

2:50 p.m. **TEA BREAK**

Session IV. Approaches for Responding to IPV and Its Consequences: From Screening to Care

Screening for IPV can potentially improve identification of individuals in need of care and the quality of care they receive, and provide health care professionals with needed information on the causes and risks of other health conditions IPV victims may be experiencing. Furthermore, screening can be an opportunity to provide support and link victims with services they need. Evidence on screening effectiveness is growing in developed countries and is emerging in the region. However, to respond effectively to IPV and its consequences, acceptability and feasibility of screening need to be assessed. Furthermore, services need to be available that can provide necessary care and treatment for those who screen positively. This panel session will focus on the acceptability and feasibility for screening in the region through an exploration of evidence from readiness assessments,

current screening efforts, evidence on effectiveness within the region, and experiences and lessons learned from outside the region from implementing and promoting screening. Additionally, the session will address access to services for those who have experienced IPV, gaps in service provision, and will highlight promising approaches to integrating IPV and HIV prevention and care.

Session Moderator: Edward Kirumira, *Workshop Co-Chair*
Principal
College of Humanities and Social Sciences
Makerere University

3:20 p.m. **Screening for Intimate Partner Violence in the Region**
Chi-Chi Undie, *Workshop Planning Committee Member*
Associate
Population Council, Kenya

3:40 p.m. **Experience of Implementing IPV Screening in the United States**
Jacquelyn Campbell, *Workshop Co-Chair*
Professor and Chair
Johns Hopkins University School of Nursing

4:00 p.m. **Access and Barriers to Care and Services for IPV Survivors: Experience from Tanzania**
Datius Rweyemamu
Department of Sociology
University of Dar es Salaam

4:20 p.m. **Model of Post-Rape Care: LVCT Health Kenya**
Lina Digolo
Care and Treatment Manager
LVCT Health

4:40 p.m. **Linking IPV Screening to Services and Care Through Referral Networks**
Abigail Hatcher
Senior Researcher
Wits Reproductive Health and HIV Institute

5:00 p.m. **Moderated Discussion with Workshop Participants**

5:30 p.m. **ADJOURN DAY 1**

DAY 2: Tuesday, August 12, 2014

8:00 a.m. **Registration**

8:45 a.m. **Welcome and Review of Day 1**
Jacquelyn Campbell, *Workshop Co-Chair*
Edward Kirumira, *Workshop Co-Chair*

Session V. Community Engagement in Intimate Partner Violence Prevention

To better understand and prevent IPV, upstream interventions that address social norms and community perceptions of gender roles and power dynamics within relationships are needed. Yet, few interventions are designed to explicitly address social norms through primary prevention strategies. This session will illuminate several interventions within the region that are engaging communities and attempting to change social norms that promote behaviors that contribute to IPV. Panelists will present their intervention strategies and models, focusing on evidence-informed approaches and context-specific considerations for design, implementation, and program improvement; how impacts and effectiveness are being measured; and lessons learned and/or potential opportunities for scaling up or developing intervention strategies within the region.

Session Moderator: Karim Manji, *Workshop Planning Committee Member*
Professor in Pediatrics, School of Medicine
Muhimbili University

9:00 a.m. **Public Health Approach to IPV and HIV Prevention: The SHARE Project**
Gertrude Nakigozi
Rakai Health Sciences Program, Uganda

Jennifer Wagman
Postdoctoral Fellow
University of California, San Diego

9:25 a.m. **Promoting Gender Equality and Changing Social Norms: SASA! Approach**
Tina Musuya, *Workshop Planning Committee Member*
Executive Director
Center for Domestic Violence Prevention, Uganda

Lori Michua
Co-Founder and Co-Director
Raising Voices, Uganda

Charlotte Watts
Professor, Social and Mathematical Epidemiology
London School of Hygiene and Tropical Medicine

9:50 a.m. **Engaging Men and Boys in Preventing Gender-Based Violence and Promoting Gender Equality: MenKen**
Fredrick Nyagah
National Coordinator
MenEngage Kenya Network

10:15 a.m. **Moderated Discussion with Workshop Participants**

10:45 a.m. **TEA BREAK**

Session VI. Engagement of and Response from Various Sectors in Intimate Partner Violence Prevention

IPV is caused by multiple factors that interact across ecological levels and social context; it cannot be sufficiently addressed by one sector on its own. Engagement and collaboration of diverse sectors are needed to more effectively prevent IPV and respond to its consequences. This session will focus on regional policy-level approaches to IPV prevention, including efforts to improve the health sector response, legal protections, and access to social services. Discussions will explore potential opportunities for collaboration or sharing best practices for policy responses to IPV across Tanzania, Kenya, and Uganda.

Session Moderator: Ian Askew
Director, Reproductive Health Services and Research
Population Council

11:15 a.m. **Health Sector Response: Eastern, Central, and Southern Africa Health Community Regional Policy and Programming Efforts to Prevent and Respond to IPV**
Odongo Odiyo
Manager, Family and Reproductive Health
East, Central, and Southern Africa Health Community

11:35 a.m. **Health Sector Response: WHO Clinical and Policy Guidelines for Responding to IPV and Regional Programming Efforts**
Olive Sentumbwe-Mugisa
Family Health and Population Advisor
WHO Uganda

11:55 a.m. **Efforts by the Criminal Justice Sector to Respond to IPV**
Hon. Justice Batema Ndikabona David Akky
High Court of Uganda

12:15 p.m. **Efforts Within the Social Work Sector to Respond to IPV**
Anna Swai
Tanzania Association of Social Workers

12:35 p.m. **Moderated Discussion with Workshop Participants**

1:00 p.m. **LUNCH**

2:00 p.m. **Keynote Address: Improving Intimate Partner Violence Prevention and Response in Uganda, Kenya, and Tanzania**
Nduku Kilonzo
Director
Kenya National AIDS Control Council

Session VII. The Way Forward

The objective for this closing session is to examine through various perspectives how to improve the prevention of and response to IPV in Uganda, Tanzania, and Kenya. The focus will be on making progress in three areas: research, policy making, and program development. Questions to be addressed include: Based on what we know, what are the most important research questions that need to be addressed? How do we communicate more effectively with various constituencies that need to be involved in multisectorial prevention and response? How do we mobilize the various sectors and stakeholders who have important roles in research, program and policy development, financing, and implementation? Where are opportunities to coordinate or collaborate across countries to improve IPV prevention in the region? What are the significant barriers, and how can they be overcome? What are the priority items for the prevention agenda going forward? Panelists will be asked to draw from their own expertise as well as the key messages they have heard throughout the workshop presentations and discussions.

Session Moderator: Jacquelyn Campbell, *Workshop Co-Chair*
Professor and Chair
Johns Hopkins University School of Nursing

2:45 p.m. **Where Do We Go from Here?**

Nelson Sewankambo
President
Uganda National Academy of Sciences

Tina Musuya, *Workshop Planning Committee Member*
Executive Director
Center for Domestic Violence Prevention, Uganda

Jessie Mbwambo, *Workshop Planning Committee Member*
Senior Specialist Psychiatrist and Senior Researcher
Muhimbili University

Ian Askew
Director, Reproductive Health Services and Research
Population Council

4:30 p.m. **ADJOURN**

Appendix D

Workshop Speaker Biographies

Honorable Justice Batema Ndikanbona David Akky serves as a Justice on the High Court of Uganda.

Rose Apondi, M.P.H., is a Public Health Specialist with the Center for Disease Control and Prevention in Uganda.

Ian Askew, Ph.D., is the Director of Reproductive Health Services and Research within the Council's Reproductive Health Program. Dr. Askew coordinates the Council's research and technical assistance activities for strengthening reproductive and maternal health services through its country offices across Africa, Asia, and Latin America. Based in Nairobi since 1992, Dr. Askew has three decades of experience in implementing and managing implementation research on a wide range of reproductive health issues. Dr. Askew is also Co-Director for the Council's *Strengthening Evidence for Programming on Unintended Pregnancy* research consortium, and is Leader of the Reproductive Health Supplies Coalition's *Market Development Approaches* Working Group. Dr. Askew's professional interests include health systems strengthening and research; strengthening and evaluating quality of care; innovative health financing mechanisms; integrating reproductive health with other health services; improving community-based health services; responding to the consequences of sexual and gender-based violence; and abandonment of female genital mutilation/cutting.

Jacquelyn Campbell, Ph.D., R.N. (*Workshop Co-Chair*), is a national leader in research and advocacy in the field of domestic violence or intimate

partner violence (IPV). Her studies paved the way for a growing body of interdisciplinary investigations by researchers in the disciplines of nursing, medicine, and public health. Her expertise is frequently sought by national and international policy makers in exploring IPV and its health effects on families and communities. As a nurse educator and mentor, Dr. Campbell leads by example in inspiring new generations of nurse researchers at the Johns Hopkins University School of Nursing. Her B.S.N., M.S.N., and Ph.D. are from Duke University, Wright State University, and the University of Rochester, respectively. She teaches an undergraduate and M.S.N. elective in Family Violence as well as in the Ph.D. program and is the Principal Investigator of an National Institutes of Health–funded (T32) fellowship that provides funding for pre- and postdoctoral fellows in violence research. Elected to the Institute of Medicine (IOM) in 2000, Dr. Campbell also was the IOM/American Academy of Nursing/American Nurses' Foundation Senior Scholar in Residence and currently serves as co-chair of the IOM Forum on Global Violence Prevention. Other honors include the Pathfinder Distinguished Researcher by the Friends of the NIH National Institute for Nursing Research; Outstanding Alumna and Distinguished Contributions to Nursing Science Awards, Duke University School of Nursing; the American Society of Criminology Vollmer award, and being named 1 of the inaugural 17 Gilman Scholars at Johns Hopkins University. She is a current member of the Board of Directors for Futures Without Violence and has served on the board for the House of Ruth Battered Women's Shelter and four other shelters. She was also a member of the congressionally appointed U.S. Department of Defense Task Force on Domestic Violence.

Lina Digolo, M.B.B.S., M.Med., is a pediatrician with more than 10 years work experience in HIV, sexual, and reproductive clinical and program management. She holds a master's of Medicine Degree in Pediatrics and bachelor's degree in Medicine and Surgery from the University of Nairobi and is currently pursuing an M.S.C. in Epidemiology from the London School of Hygiene and Tropical Medicine. Dr. Digolo is currently the Care and Treatment Manager at LVCT Health, a local nongovernmental organization in Kenya, where she provides oversight for the HIV treatment, gender and gender-based violence, and blood safety programs. She is actively involved in the design, implementation, and dissemination of operations research studies conducted with the institution and has vast experience in gender-based violence advocacy and policy development. As an active member of the National Gender and Reproductive Health Technical Working Group in Kenya, she ensures the locally generated evidence is used to inform the development of policy documents and national standards. She is currently a principal investigator in the following IPV related research study: (a) the acceptability and feasibility of IPV screening in voluntary counselling and

testing settings in Kenya, and (b) integration of IPV screening and counselling models in HIV clinical settings in public hospitals in Kenya.

Abigail M. Hatcher is a Senior Researcher at Wits Reproductive Health and HIV Institute. Her mixed-methods research centers on designing and testing behavioral and structural interventions for IPV among women and male partners. Based in Johannesburg, Ms. Hatcher is a Co-PI for a World Health Organization–funded trial of an empowerment counseling intervention for IPV in pregnancy (PI: Garcia-Moreno). She also serves as a Co-Investigator for a NIH-funded home-based couples intervention among pregnant women and male partners in Kenya (PI: Turan). Ms. Hatcher previously led a process evaluation of the Intervention with Microfinance for AIDS and Gender Equity (IMAGE), explored the effects of a gender-transformative program on men's use of IPV, and examined linkage to HIV care among newly diagnosed individuals. Ms. Hatcher currently manages a team of eight researchers in Johannesburg and mentors qualitative researchers in Johannesburg, San Francisco, and Kisumu, Kenya. She has published and peer reviewed for international journals and is frequent contributor to the Sexual Violence Research Initiative. As a Ph.D. candidate in the Wits School of Public Health, Ms. Hatcher is using quantitative and qualitative methods to explore the effects of IPV on prevention of mother-to-child transmission uptake among pregnant and postpartum HIV-positive women.

Nduku Kilonzo, Ph.D., is the new Director of the Kenya National AIDS Control Council (NACC). A Ph.D. holder in Tropical Medicine Gender and Health from the University of Liverpool, Liverpool School of Tropical Medicine (LSTM), Dr. Kilonzo has been involved in the development of innovative, quality-assured HIV Testing and Counseling program in Kenya, Malawi, Botswana, and Cote d'Ivoire (Ivory Coast). Her primary research and publications have been in the area of sexual violence and HIV. Her work has provided evidence for the development of integrated public health facility post-rape care services that are currently offered in more than 250 hospitals in Kenya and HIV prevention interventions. Dr. Kilonzo has more than 20 peer-reviewed publications and book chapters and has been the team leader in developing the Kenya National HIV Testing and Counseling Report 2011/12. She is currently an Advisor in Gender and Rights Advocacy Panel to the WHO, an editor of *Reproductive Health Matters*, and a member of the Public Health Association of Kenya. Prior to joining the NACC, Dr. Kilonzo was the Executive Director of LVCT Health (formerly Liverpool VCT Care & Treatment, a local Kenyan NGO offering care and treatment to more than 40,000 individuals, testing to 1.2 million annually, performing research, and advocating policy reforms). She was the Executive Director for the past 6 years.

Edward Kirumira, Ph.D. (*Workshop Co-Chair*), trained at Makerere University, Exeter University in the United Kingdom, the London School of Hygiene and Tropical Medicine, and the University of Copenhagen, Denmark, in collaboration with Harvard University in the United States. Dr. Kirumira specialized in Population and Reproductive Health with extensive research work in HIV/AIDS, emergent diseases and international health issues, family relationships, health seeking behavior, poverty, and rural development studies. He is also a visiting senior researcher to a number of European and African universities. Dr. Kirumira is the Treasurer, Uganda National Academy of Sciences (UNAS), UNAS Fellow & Council member, and Chairperson of the UNAS Forum on Health and Nutrition. He is the Principal of the College of Humanities and Social Sciences at Makerere University and a Professor of Sociology in the Department of Sociology. He was the Dean of Faculty of Social Sciences since 2003 and before that was the Head of the Department of Sociology, Faculty of Social Sciences, for 5 years. Dr. Kirumira chairs the Resource Mobilization and Planning Committee of Uganda Central coordinating mechanism for the Global Fund for HIV/AIDS, tuberculosis, and malaria country program and has offered technical advisory role to national, regional, and international bodies. His interest is in population and reproductive health, with more than 15 years of HIV/AIDS research and programming. Other areas include program development, monitoring, and impact evaluation.

Samuel Likindikoki, M.D., is a Lecturer and Head of Department of Psychiatry and Mental Health at Muhimbili University. He is also a Medical Specialist [Psychiatrist] working with Muhimbili National Hospital situated in Dar es Salaam, Tanzania. Dr. Likindikoki is a researcher focusing on areas of HIV prevention and the intersections between HIV/AIDS and mental health. Some of the topical areas he is interested are HIV as it relates to gender-based violence, mental health and concurrency partnerships; key populations such as people who inject drugs, men who have sex with men and female sex workers. Dr. Likindikoki has participated in a number of collaborative research efforts: at Johns Hopkins Bloomberg School of Public Health he was part of a formative study on key populations, a study on strategic assessment for possible HIV combination prevention, a formative assessment for concurrency partnership in the context of HIV prevention, and a study to evaluate campaign communication materials for HIV prevention; at the London School of Hygiene and Tropical Medicine he researched women empowerment and partner's violence; at the Medical Research Counsel of South Africa he studied gender-based violence prevention in schools and he participated in parenting studies. Dr. Likindikoki works with the MUHAS-based Tanzania AIDS Prevention Program (TAPP) as the GBV and Alcohol Intervention program area lead. He has also spearheaded

the integration of GBV and OH interventions among people attending HIV testing and counselling services.

Karim Manji Premji, M.P.H., M.Med., did his B.Sc. in Udaipur, India, and was selected to join MKCG Medical College in Orissa under a Tanzanian government scholarship in 1981. As soon as he completed his internship, he joined the then Muhimbili University College of Health Sciences (University of Dar es Salaam) as a Resident in Pediatrics, and thereafter, there was no looking back. He joined as lecturer in March 1992 after completion of M.Med. in Pediatrics. He received the Commonwealth University Scholarship for fellowship in neonatal medicine, which he pursued at the Hammersmith Hospital, Royal Postgraduate Medical School, London. He was promoted to Senior Lecturer in 1997 and to Associate Professor in 2001. In the year 2003, he completed his master's in Public Health from Harvard School of Public Health and was promoted to Full Professor in 2006. He maintains the record of having been granted Full Professorship at the youngest age. As a student he was a recipient of awards and scholarships, and as a researcher, he has undertaken several large-scale research studies. He has participated in several national and international committees; of particular interest are his membership in National PMTCT committees. He served the university as Associate Dean of Postgraduate Research for 3 months before becoming the Deputy Registrar during the founding of MUHAS from January 2004 to October 2007 and now is the Dean, School of Medicine. He has more than 95 publications and continues to publish, and has 3 books to his credit. Recently, he was nominated as an eminent scientist in the Tanzania Academy of Sciences as a fellow.

Jessie Mbwambo, M.D., is Senior Medical Specialist Psychiatrist II and Senior Researcher at Muhimbili University College of Health Sciences and Muhimbili National Hospital in Dar es Salaam, Tanzania. Dr. Mbwambo holds a medical degree from the University of Dar es Salaam, and her Diploma in Psychiatry from University of Manchester, Victoria. In 2005, she served as the head of the Tanzania research team member for the WHO's Multi-country Study on Women's Health and Domestic Violence against Women. Dr. Mbwambo's research and expertise focuses on HIV intervention and prevention, in youth and adults, as well as the relationship between HIV and violence against women.

Lori Michau, M.A., is the Co-Founder and Co-Director of Raising Voices, a nonprofit organization based in Kampala, Uganda, working to prevent violence against women and children. She also spearheaded the creation of the GBV Prevention Network, now coordinated by Raising Voices, with more than 700 members in the Horn, East, and Southern Africa.

Ms. Michau is also a founding member of the Center for Domestic Violence Prevention (CEDOVIP) and prior to her work in Uganda, was the Program Development Coordinator at Jijenge! Women's Center for Sexual Health in Mwanza, Tanzania. Ms. Michau has extensive experience in community mobilization and has developed comprehensive methodologies for violence prevention that are being used in more than 50 countries in Africa and beyond. Ms. Michau is the author of numerous articles and program tools, including the *SASA! Activist Kit for Preventing Violence Against Women and HIV.* Ms. Michau received her M.A. in Human Rights from Makerere University in Uganda and has been based in East Africa since 1995.

Tina Musuya, M.A., is the Executive Director for CEDOVIP, with extensive experience in working with communities, institutions, and policy makers to prioritize violence prevention in Uganda. Ms. Musuya is responsible for all programmatic oversight for CEDOVIP work. She brings 9 years of leadership experience in activism for promoting women's rights in Uganda, with special skills in community mobilization for prevention of violence against women. She is proactive and bears a track record of mentoring willing individuals into "everyday activists" who stand up and act to prevent violence against women in their own relationships and communities.

Gertrude Nakigozi, M.P.H., M.B.B.S., holds a bachelor's degree in human medicine and surgery from Makerere University Medical School, and a master of Public Health from Johns Hopkins Bloomberg School of Public Health. She works with Rakai Health Sciences Program as head of clinical services, where she oversees provision of HIV care and treatment to HIV positive adults and children in Rakai district. She is also involved in HIV and reproductive health research.

Fredrick Nyagah is the National Coordinator of MenEngage Kenya Network (MenKen) since its inception in 2006. MenKen is a national alliance organizations and individuals with interest in engaging men and boys in sexual and reproductive health, gender equality, positive fatherhood, and prevention of gender-based violence and HIV and AIDS. It also builds capacity of other organization in the engaging men and boys. The network works closely with government and is affiliated to MenEngage Global Alliance and Africa Regional Network. He is also the Program Coordinator of Healthy Outcomes through Prevention Education (HOPE) Program, which is implemented by CHF International (changing to Global Communities) with partnership with the Ministry of education Science and Technology. The program seeks to improve HIV and AIDS knowledge, attitudes, and practices among primary and secondary school-aged students through peer, school, and community-based interventions. He has also worked in EngenderHealth

as a Regional Program Associate for the Global Men as Partners/Gender program; Program Officer in Men as Partners (MAP) Program in Kenya and as a Senior Program Officer for CHAMPION (Channeling Men's Positive Involvement in a National HIV/AIDS response) project in Tanzania. Before joining EngenderHealth, he worked for Action Aid-Kenya as a Research and Policy Coordinator and for Family Health Options Kenya (formerly Family Planning Association of Kenya) as a Youth Program Officer. He holds a bachelor's degree in Education and is working on his thesis for his master's degree in Health Management from Kenyatta University.

Odongo Odiyo, M.Med., has 33 years of clinical and research experience in Obstetrics and Gynecology. Currently he is the Manager, Family and Reproductive Health with East, Central, and Southern Africa (ECSA) Health Community. He has been a passionate campaigner for human rights especially for those due to political orientation. He has been involved in fighting for the rights of inmates and political detainees in Kenya since 1998. Dr. Odiyo has been involved in conducting postmortems of torture victims and representing their cases in courts of law (he has trained in Crime Scene Investigations). He was involved in the development of post-rape care form. He took lead in the development of regional GBV and child sexual abuse (CSA) policy, guidelines in the clinical management of CSA, and literature review on CSA in sub-Saharan Africa (2009–2011). He has spearheaded the implementation of these instruments at the country level. He also took lead in the development of documentaries on GBV and CSA to lobby for mobilization of resources to support regional response and prevention of GBV and CSA. He was instrumental in the introduction, and eventual recommendation, on IPV to the health ministers and eventual passing of resolution on IPV in 2012. Currently he is involved in the implementation of ministerial resolution on IPV, and other ministerial resolutions on GBV and CSA. Future plans include documenting physical and psychological sequelae of all forms of violence in war-torn countries and recommending appropriate responses and prevention.

Christine Ondoa, M.B.B.S., M.Med., M.P.A., is the Director General of Uganda AIDS Commission. She commenced her duties in February 2014 following her appointment by the President of the Republic of Uganda. Dr. Ondoa brings with her a rich academic background plus a wealth of experience in medicine, health, policy design and implementation, public health service delivery, and program administration and management, in addition to advocacy and leadership skills. She has served in key regional, national, and international positions. Before her appointment to the Uganda AIDS Commission, she was the Minister of Health in 2011 to 2013. She later served as a Senior Presidential Advisor to the President of

Uganda on public health issues, besides serving as a board member of the Global Alliance for Vaccines and Immunization. Dr. Ondoa also served as the Executive Director of Mbarara Regional Referral Hospital, Director of Jinja Regional Referral Hospital, and she was the Regional Pediatrician for the West Nile region based in Arua Regional Referral Hospital. Dr. Ondoa has worked with several international organizations such as the WHO; Gavi, the Vaccine Alliance; the U.S.-funded President's Emergency Plan for AIDS Relief (PEPFAR); AIDS/HIV Integrated Model District Program (AIM); Save the Children; and the United Nations International Children's Emergency Fund (UNICEF), where she served in different capacities ranging from coordinator to trainer. Furthermore, Dr. Ondoa coordinated Uganda's national Malaria Control Program, the HIV/AIDS Program, and the Uganda National Expanded Program on Immunization for a number of years. She holds a bachelor of Human Medicine and Surgery, a master's of Medicine in Pediatrics and Child Health, with additional training and experience in pediatric HIV/AIDS. On top of that, she holds a master's in Management Studies in Public Administration and Management, as well as several postgraduate certificates in leadership. Furthermore, she has carried out extensive research on topical public health themes such as HIV/AIDS and health service delivery, among others. She also belongs to several professional medical bodies.

Silvia Pasti is the Chief of Child Protection for UNICEF Uganda.

Datius Rweyemamu, Ph.D., is a specialist in adolescent sexual and reproductive health with extensive research on HIV/AIDS, adolescent sexuality, media communication, and malaria. Currently, he is a lecturer at the University of Dar es Salaam teaching Social Research Methods, Gender, and Population Development as well as Sociology of Sexuality. Dr. Rweyemamu is also a co-PI for the 4-year project named *Media, Empowerment and Democracy in East Africa-MEDIeA*, a project jointly implemented by three universities: University of Nairobi (Kenya), Roskilde University (Denmark), and University of Dar es Slaam (Tanzania). Dr. Rweyemamu is also one of the co-authors of the publication *Help-Seeking Pathways and Barriers for Survivors of Gender-based Violence in Tanzania*. With support from Global Fund and in collaboration with National Institute for Medical Research (NIMR), Dr. Rweyemamu is also currently doing research for the study "Assessing Health Systems Financing and Quality Services for Youth Living with HIV and AIDS in Tanzania." He is a graduate of the University of Dar es Salaam, Tanzania, and he holds a doctoral degree in Sociology and a master's degree in Demography from the same institution. His publications, particularly on sexuality, HIV/AIDS, gender norms, and malaria, appear both in local and international journals.

Olive Sentumbwe-Mugisa, M.B.B.S., has her basic training in Medicine and has specialized in Obstetrics and Gynecology. She has had 14 years of active clinical practice and now 16 years with the WHO in Uganda as the Family Health and Population Advisor. She has worked majorly on policies, guidelines, and programs with the Ministry of Health in the area of reproductive health with all its components as laid down at the Cairo Conference on Population and Development. In Uganda we have been working on gender and GBV issues for about 8 years, looking at issues of mainstreaming gender in health and focusing on GBV for service delivery as well as human rights and health. We are currently reviewing our training manuals and service standards as well as advocacy packs using the available data both in Uganda and outside it.

Anna Swai is a member of the Tanzania Assoication of Social Workers.

Chi-Chi Undie, Ph.D., is an Associate with the Population Council's Reproductive Health program in Nairobi. Since joining the Council in 2009, Dr. Undie's research has had a primary focus on sexual and gender-based violence (SGBV) and married adolescent girls. She coordinates and provides technical support to the Population Council-led Africa Regional SGBV Network—an active network of partners from across the East and Southern Africa region who have been developing, implementing, and evaluating core elements of a comprehensive, multisectoral response model. Her work on SGBV has had wide influence on policy and practice, leading to the passage of a resolution calling for the integration of IPV screening into sexual and reproductive health and HIV and AIDS services throughout East, Central, and Southern Africa. Her SGBV work has recently been extended to refugee settings and to meeting the needs of child survivors of sexual violence in the region. Before joining the Council, Dr. Undie was a Ford Foundation postdoctoral fellow and, later, an associate research scientist at the African Population and Health Research Center. There she led the center's sexuality program and conducted several sexual and reproductive health research projects. She holds an interdisciplinary doctoral degree in Language, Literacy, and Culture.

Jennifer Wagman, Ph.D., M.H.S., is a social scientist whose research integrates behavioral theory and infectious disease epidemiology. Her primary interests lie in examining the relationship between (and learning how to effectively respond to) women's risk for IPV and sexually transmitted infections (STIs), primarily in sub-Saharan Africa. In June 2013 Dr. Wagman completed her Ph.D. at the John Hopkins Bloomberg School of Public Health. In August 2013 she began a postdoctoral fellowship training program in substance use, HIV, and related infections (T32 DA 023356; PI:

Strathdee) in the Division of Global Public Health at the University of California, San Diego, School of Medicine. As a postdoctoral fellow she is extending her research agenda to investigate the role of alcohol and substance abuse on the overlapping epidemics of IPV and HIV infection in sub-Saharan Africa.

Charlotte Watts, Ph.D., is Head of the Social and Mathematical Epidemiology Group and founding director of the Gender, Violence and Health Centre, in the Department for Global Health and Development. Originally trained as a mathematician, with further training in epidemiology, economics, and social science methods, she has more than 15 years experience in international HIV and violence research, and brings a strong multidisciplinary perspective to the complex challenge of addressing HIV and violence against women. Dr. Watts has more than 120 publications in peer-reviewed journals, and manages a large portfolio of research, including research director of the United Kingdom Department for International Development–funded STRIVE structural drivers HIV drivers Research Programme Consortium, and Chair of the Expert Working Group to Assess the Global Burden of Inter-Personal Violence against Women. She was a Core Research Team Member for the WHO Multi-country Study on Women's Health and Domestic Violence, and a senior researcher on the IMAGE violence prevention study in South Africa. She has served on Expert Consultations for The Joint United Nations Programme on HIV/AIDS, the WHO, the World Bank, and UNICEF, was a member of the coordinating committee for the IOM on the contagion on violence, and has been on the Track C organizing committee for several International AIDS conferences. She is a member of the Peer Review Board for the UK Economic and Social Research Council, and has reviewed grants for NIH, the United Kingdom Medical Research Council, the South African MRC, CIMH, and the European Union.