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Process evaluation of the SHARE intervention for preventing intimate partner violence and HIV infection in Rakai, Uganda

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ABSTRACT

The Safe Homes And Respect for Everyone (SHARE) intervention introduced an intimate partner violence (IPV) prevention approach into Rakai Health Sciences Program, an established HIV research and service organization in Uganda. A trial found exposure to SHARE was associated with reductions in IPV and HIV incidence. This mixed methods process evaluation was conducted between August 2007 and December 2009, with people living in SHARE intervention clusters, to assess awareness about/participation in SHARE, motivators and barriers to involvement, and perceptions of how SHARE contributed to behavior change. Surveys were conducted with 1407 Rakai Community Cohort Study participants. Qualitative interviews were conducted with 20 key informants. Most (77%) were aware of SHARE, among whom 73% participated in intervention activities. Two-thirds of those who participated in SHARE felt it influenced behavior change related to IPV. While some felt confident to take part in new IPV-focused activities of a well-established program, others were suspicious of SHARE's motivations, implying awareness raising is critical. Many activities appealed to the majority (e.g., community drama) while interest in some activities was limited to men (e.g., film shows), suggesting multiple intervention components is ideal for wide-reaching programming. The SHARE model offers a promising, acceptable approach for integrating IPV prevention into HIV and other established health programs in sub-Saharan Africa.

1. Introduction

Intimate partner violence (IPV) is linked with HIV infection (Campbell et al., 2008; Maman, Campbell, Sweat, & Gielen, 1982; UNAIDS, 2013) and several combination approaches have been implemented to reduce both outcomes. The Safe Homes And Respect for Everyone (SHARE) intervention, conducted in Rakai, Uganda (Wagman et al., 2012; Wagman et al., 2016), reduced IPV and HIV incidence (Wagman et al., 2015). Thus, the SHARE model could inform other HIV programs' efforts to offer dual programming to reduce violence and HIV acquisition; and could be adopted, at least in part, as a standard of care for HIV programs in sub-Saharan Africa. Little is known, however, about perceptions of SHARE, motivations and barriers to participation in specific SHARE activities, and insights about the program's influences on behavior change. This paper aims to lessen that gap by presenting findings from an evaluation of the process of implementing SHARE.

Full details on the SHARE intervention and evaluation trial have been published previously (Wagman et al., 2012; Wagman et al., 2016; Wagman et al., 2015). Briefly, SHARE integrated IPV prevention into Rakai Health Sciences Program (RHSP), an organization that conducts HIV prevention trials, laboratory/clinical research and qualitative studies; and provides health education, HIV counseling and testing and HIV medical care. SHARE was modelled on a community mobilization approach developed for IPV prevention in East Africa; (Michau & Naker, 2003), based on the Transtheoretical Model (TTM) of behavior

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change; (Prochaska & Velicer, 1997) borrowed methods from Stepping Stones; (UNESCO, 2016) and provided enhanced HIV post-test counseling services to address violence against women (King et al., 2016).

We conducted a trial (Wagman et al., 2015) to estimate if SHARE would reduce IPV and HIV incidence in individuals enrolled in the Rakai Community Cohort Study (RCCS), an HIV surveillance cohort (Grabowski et al., 2014; Wawer et al., 1998). Exposure to SHARE was associated with reductions in female RCCS participants' reports of past year IPV, and HIV incidence in the total study population (Wagman et al., 2015).

This paper examines how community-level activities were delivered and assesses perceived quality of their implementation. We present mixed methods findings on levels of awareness about and participation in SHARE activities among residents of intervention communities; main reasons people decided to participate or not participate in SHARE; and people's perceptions of how exposure to SHARE motivated behavior change. Lastly, we provide recommendations on how interventions can be designed to maximize intended benefits and strengthen effectiveness.

2. Methods

2.1. SHARE community mobilization activities

SHARE was implemented during five TTM-structured phases: (a) 2001-04: Community Assessment; (b) 2005: Raising Awareness; (c) 2006: Building Networks; (d) 2007: Integrating Action; and (e) 2008-09: Consolidating Efforts. SHARE used five community-level strategies: Advocacy, Capacity Building, Community Activism, Learning Materials, and Special Events (Table 1). Advocacy and Capacity Building strategies were designed for implementation among specific target groups, whereas Community Activism, Learning Materials, and Special Events were designed for implementation at the community-level so anyone could participate.

The current evaluation focuses primarily on assessing how the community-level intervention activities were delivered and perceived by people living in the intervention regions.

2.2. Mixed methods data collection and research ethics

We conducted survey and qualitative in-depth interviews in Luganda, in private by same sex interviewers. All interviewers were trained using the World Health Organization's guidelines for safe and ethical research on domestic violence (WHO, 2001). The study was approved by the World Health Organization's Ethics Review Committee, the Uganda Virus Research Institute's Science and Ethics Committee and the Uganda National Council of Science and Technology. The RCCS was approved by the Western Institutional Review Board (Olympia, WA, USA). All participants provided written consent.

2.3. Quantitative participants and procedures

Survey data were collected (June 2008 through December 2009) from 1407 RCCS participants. During the study period, RCCS was conducted in 50 Rakai communities aggregated into 11 clusters. RCCS involves a census, questionnaires, and serological surveys every 12–18 months (Grabowski et al., 2014; Matovu et al., 2007; Wawer et al., 1998). Four RCCS clusters (21 communities) were exposed to SHARE (plus standard of care HIV services) and seven RCCS "control" clusters (29 communities) received standard of care HIV services only (Wagman et al., 2015). The SHARE trial involved a baseline and two follow-up surveys. Eligibility for enrollment included being a Rakai resident, 15–49 years and providing blood for HIV testing at baseline and follow-up (Wagman et al., 2015). The assessment for the current study analyzed data collected during the second SHARE follow-up (2008–2009). A module of 13 questions on awareness of, participation in and opinions about SHARE was administered to RCCS participants living in 10 of the 21 SHARE communities in the four SHARE clusters (N = 2962).

2.4. Quantitative measures and analysis

The RCCS questionnaire includes sociodemographic, behavioral, health, and care-seeking measures (Matovu, Kigozi, Nalugoda, Wabwire-Mangen, & Wabwire-Mangen, 2002). We assessed each participant's age, religion, education level, and marital status from the main RCCS database. The first question asked for the current study was, "Have you heard of the SHARE Project?" All who responded "yes" were asked the questions shown in Table 2.

Sociodemographic characteristics were described overall and by gender. Comparisons between participants who had and had not heard of SHARE were estimated using Pearson's χ^2 and Fisher's exact tests. Among the sub-sample aware of SHARE, we calculated the proportions exposed to SHARE materials, who interacted with SHARE staff/volunteers, and participated in SHARE activities. These estimates were calculated for the entire sample and between men and women, using the same methods described above. All analyses were done using Stata version 12.

2.5. Qualitative participants and procedures

We conducted in-depth qualitative interviews (August through September 2007) with 20 male and female key informants residing in

Table 1
The activities, target population, and intended outcome of each SHARE strategy.

Strategy	Examples of Activities	Target Population	Intended Outcome
Advocacy	Workplace dialogues, local group seminars, dialogues with opinion and local leaders.	Local and religious leaders, local organizations, and government, teachers, health care workers.	Increased awareness of IPV as a public health problem and the right of everyone to live without violence
Capacity Building	Staff development workshops, training of resource persons and volunteers, seminars, community-based workshops on IPV, human rights and women's rights.	Police, probation, and social welfare officers, health care providers, teachers, local and religious leaders, SHARE staff and volunteers, and RHSP counselors and staff.	A developed set of skills for recognizing and preventing IPV.
Community Activism	Work with community volunteers and drama groups, booklet clubs, IPV prevention action groups, door-to-door awareness activities, films.	Women and men, youth, and children within the community.	Active participation in preventing IPV in the community.
Learning Materials	Development and adaptation of booklets, brochures, posters, story cards, and other educational materials.	General public, community members, local organizations, health care providers, and social service officers.	Effective learning through the use of engaging, thought-provoking materials.
Special Events	Local fairs, public marches and campaigns, poster exhibitions, seminars, and collaboration meetings.	Community members, leaders, the general public, and local institutions.	Shared ideas and values for the promotion of IPV reduction.

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