Briefing Paper

Building capacity for SIPV primary prevention research and intervention development in Sub-Saharan Africa - Lessons Learned

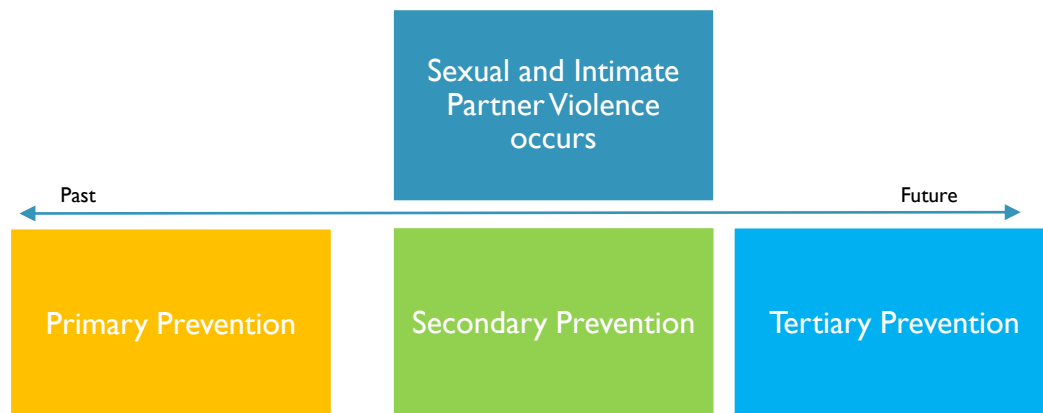## Elizabeth Dartnall[1] and Anik Gevers[2]

Introduction

Violence against women is exists across all cultural and socio-economic contexts. Among the various forms of violence that girls and women suffer, sexual violence is often the least visible and least reported. Throughout the world, boys and men are largely the perpetrators of sexual violence [1, 2], and girls and women the victims [3, 4]. It is increasingly understood that men's use of violence is generally a learned behaviour, rooted in the ways that boys and men are socialized.

Prevention of sexual and intimate partner violence before it occurs in the first place must ultimately be our goal. Prevention is often separated into three phases: Primary prevention, are those interventions and approaches that aim to prevent violence before it occurs; whilst secondary and tertiary prevention, involve approaches that focus on the more immediate responses to violence and the long-term care post violence (Figure 1.)

Figure 1. Different levels of prevention

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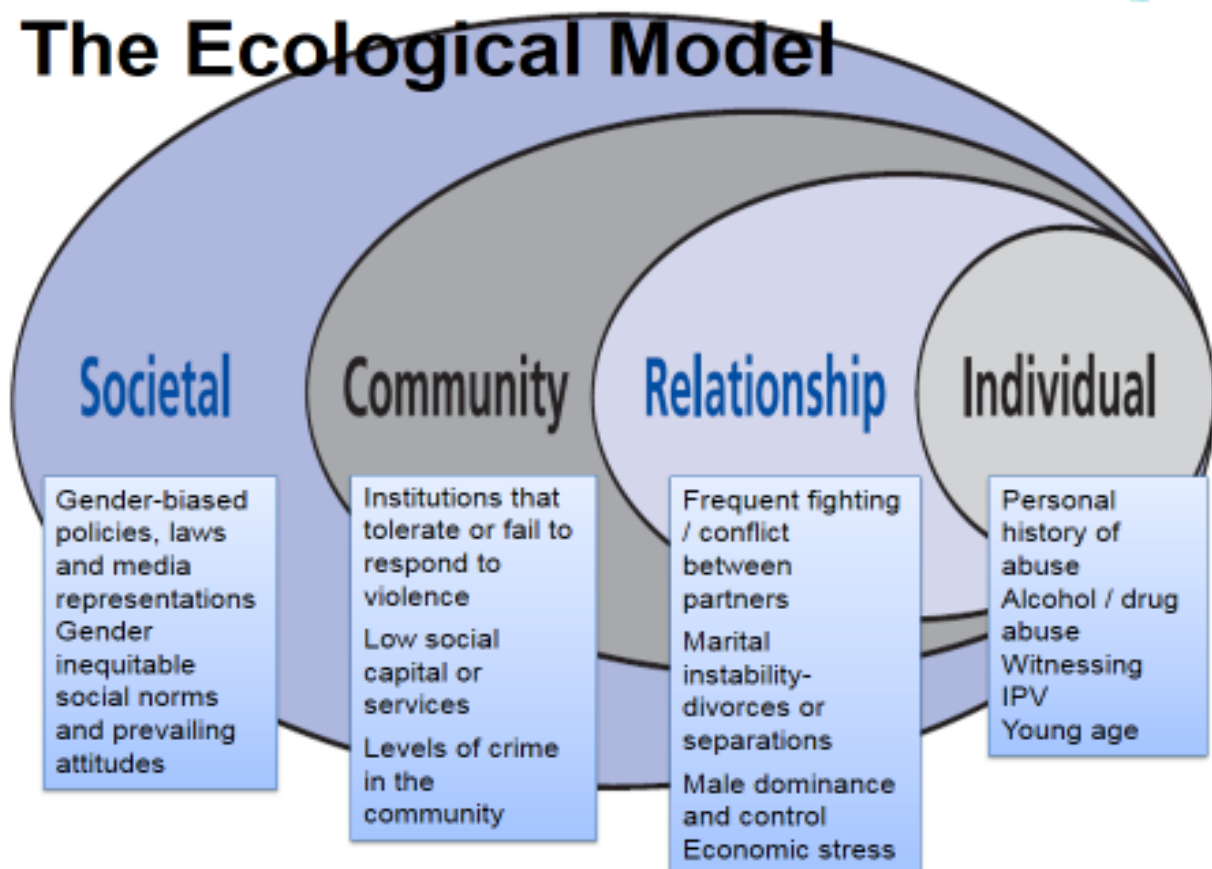
[2] Dr Anik Gevers, Independent Consultant

Risk Factors

Primary prevention interventions for sexual and gender based violence must address root causes or risk factors of this violence including, gender inequality; social norms; social determinants; harmful behaviours and child maltreatment and abuse [5]. Risk factors are often depicted using the ecological model. Causes and solutions to violence unfold across levels of society. The ecological model has four levels of social organization:

- The individual level looks at factors associated with the individual man or woman (e.g. personal history of abuse, abuse of alcohol, education levels, ownership of weapons)
- The relationship level (also sometimes referred to as the family level) explores factors within the intimate partner relationship, or the family (e.g. marital conflict, male dominance in the family, male control of wealth, and isolation of the women in the family)
- The community level looks at the status of women in the community, the tolerance for different forms of violence against women, existence or lack of support services, employment rates, and the levels of crime and male-on-male violence in the community.
- Finally, the social level identifies social-level factors that contribute to perpetration and experiences of violence, such as gender-biased policies, laws and media representations, gender inequitable social norms and prevailing attitudes

The Ecological Model

Societal	Community	Relationship	Individual
Gender-biased policies, laws and media representations Gender inequitable social norms and prevailing attitudes	Institutions that tolerate or fail to respond to violence Low social capital or services Levels of crime in the community	Frequent fighting / conflict between partners Marital instability- divorces or separations Male dominance and control Economic stress	Personal history of abuse Alcohol / drug abuse Witnessing IPV Young age

Primary prevention interventions aim to promote social change, respect, gender equality and prevent perpetration through addressing power imbalances, and childhood adverse experiences and violence. A central task of primary prevention approaches is to empower women and to change dominant constructions of masculinity/femininity into ones which are gender equitable and non-violent.

Interventions by levels of prevention

Forms of primary, secondary and tertiary prevention interventions at the different levels of the ecological model are outlined in Table 2 below.

Table 2. Primary and secondary/tertiary level prevention SIPV interventions

	Individual	Relationship	Community	Societal
Primary Prevention (Before the violence)	Parenting interventions: Promoting parent – child attachment; New parents understanding of development	School based, Life skills interventions - Promoting healthy/safe/respectful/caring interpersonal relationship Microfinance programmes – addressing economic stress	Changing gender social norms through community based interventions	Legislation
Secondary & Tertiary Prevention (at the time of & in the wake of the violence)	Adult and adolescent sex offender treatment programmes Provision of care and support for survivors	Support groups for families of sex offenders	Community engagement programmes (e.g. CoCA - circle of support and accountability)	Public policies directed towards offenders (e.g. offender registers)

What works to prevent sexual and intimate partner violence?

In many countries, interventions to prevent sexual and intimate partner violence are limited and most have not been evaluated. Moreover, since these interventions have been predominantly developed in high income countries their relevance to low resource settings is mostly untested. There is a need for more research to document effectiveness and reliability of different prevention approaches in a range of settings.

Through support from Oak and other funders, the SVRI has been working to build the evidence base and identify best practices in prevention of SIPV. Promising practices based on a clear, evidence-informed theoretical framework, and informed by local practices that drive the violence have been identified and are now available for adaptation and potential scale up in low and middle income countries [6]. These interventions include mother-child, parent-teen, individual and group based interventions. Examples of promising and evidence based programmes:

- Thula Sana: Thula Sana is a home-visiting intervention aimed at promoting mothers' engagement in sensitive, responsive interactions with their infants[7].
- The Sinovuyo Caring Families Programmes: Sinovuyo focuses on reducing the risk of child maltreatment for children from high-risk families among children aged 2-9, and pre-teens and teenagers aged 10-17 years.[i]
- PREPARE: PREPARE is an HIV-prevention programme aimed at reducing sexual risk behaviour and IPV among adolescents. This school-based intervention comprises of 21 lessons focused on developing individuals' motivation and skills.
- Skhokho Supporting Success: Skhokho Supporting Success is a multi-faceted programme that aims to prevent IPV among young teenagers.[ii]

- Stepping Stones: Stepping Stones, a participatory community based intervention for preventing HIV and strengthening relationship skills, has been rigorously evaluated in a RCT in the Eastern Cape Province[8].
- Stepping Stones and Creating Futures: A third adaptation of Stepping Stones[iii] was combined with a locally developed livelihoods strengthening intervention called Creating Futures[9]. This intervention is a peer facilitated group intervention with eleven, three-hour sessions in single-sex groups of about twenty people, and draws from sustainable livelihoods theory and practice[iv].
- IMAGE: The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) was the first to combine a training programme on poverty, gender inequalities, IPV, and HIV/AIDS with group based microfinance.[10]
- SASA! Programme: SASA! engages with communities to change gender social norms.[11]
- Safe Homes and Respect for Everyone (SHARE): SHARE aims to prevent IPV by transforming community attitudes about women's status and the acceptability of violence against women.[12]

To further consolidate these learnings, the SVRI with support from Oak and multiple donors have been working with colleagues to build capacity to develop, adapt and test sexual and or intimate partner violence (SIPV) prevention interventions in East Africa. This paper aims to share lessons learned from building capacity in East Africa for SIPV primary prevention research and intervention development. Click here for more details on this work.

The research teams

Four research teams, four proposals, three countries – Uganda, Tanzania and Kenya

Through this project the SVRI is supporting four research teams in Kenya, Uganda and in Tanzania to develop or adapt promising SIPV primary prevention interventions and to undertake preliminary testing of effectiveness of the interventions.

- Uganda - Parenting for Good Behaviour and Respectability: Developing and piloting an intervention to reduce sexual and gender based violence in Uganda: This team is a research partnership between Child Health and Development Centre, Makerere University and Medical Research Council / UVRI Uganda. The team is co-led by Dr Godfrey Siu and Professor Daniel Wight. They are developing a community based parenting intervention for use with parents/caregivers with children aged 0-17 years.
- Tanzania - Primary prevention of school based gender based violence and parenting intervention in Tanzania: This team is a partnership between Muhimbili University of Health and Allied Science and Women in Law and Development in Africa. This team is adapting and testing a promising whole school intervention in Dar Es Salaam. The aim of which is to reduce sexual and intimate partner violence among school based young adolescents aged 12-14.
- Kenya – Primary prevention of violence in Kajiado primary schools. This consortium is a partnership between LVCT and SOWED. This team is developing and testing a school-based primary prevention intervention. The study population includes primary school students (male and female in class 6, 7 and 8), teachers and parents of the schools, members of the community and county education officers.
- Kenya – Uhusiano Bora – a school based programme for preventing teen dating violence and promoting safe healthy relationships. This project team is a partnership between Child Aid Organisation Kenya; Centre for Gender Equity and Empowerment, Kenyatta University, School of Social Work, University of Hawaii and Coexist Initiative. The team undertook a baseline study in six public primary schools on drivers of sexual violence and youth dating violence in schools. They have used these findings, their theory of change, and a literature

review to inform the adaptation of a promising school – based sexual and dating violence prevention intervention for children aged 12-14 years.

Over the past three years, the SVRI has provided technical advice and guidance to all four teams to develop or adapt and do some preliminary proof of concept testing of SIPV primary prevention interventions. Steps we have taken and lessons we have learned through this process are detailed below.

What we did

The design of this three year project involved three key phases. Each phase was complemented by capacity building and support activities. Project phases:

Phase 1: Project team selection, plan and proposal development
Phase 2: Formative Research and Intervention Development
Phase 3: Proof of Concept Testing

Project phases

CAPACITY BUILDING & SUPPORT

- Phase 1: Project team selection, plan and proposal development
- Phase 2: Formative Research and Intervention Development
- Phase 3: Proof of Concept Testing
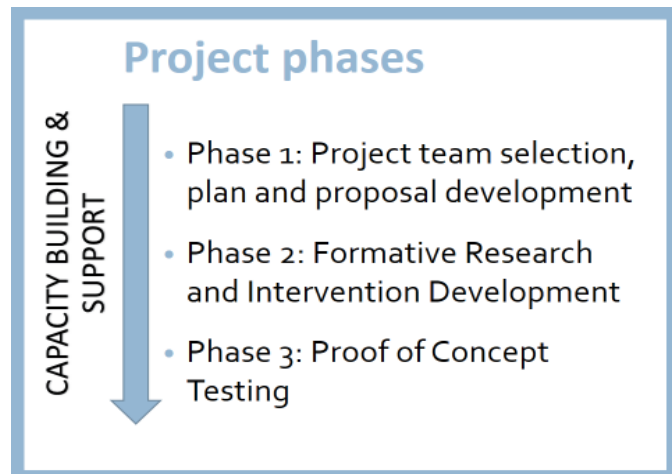
Phase 1: Project team selection, plan and proposal development:

The aim of this phase was first to identify project teams. This was done through an open call for partners in low and middle income countries to express an interest to participate the project. Forty five (45) applications were received. Twenty eight (28) of which were from the three priority countries – Kenya, Uganda and Tanzania. Nine applications were shortlisted and sent out for external review. Clear selection criteria was used to identify the final four teams selected to participate in the project (Box 1).

The four teams were brought together for a week long workshop to give teams an opportunity to get to know each other, meet experts in the field, to develop a shared understanding of primary prevention concepts and a vision for the project and to work with mentors to develop research proposals and plans. More specifically, the aims of the workshop were to:

> **Box. 1.** Selection Criteria - teams must be:
> - Multidisciplinary
> - Led by a locally based institution;
> - A partnership between researchers and practitioners with expertise in: research, intervention development, practice and advocacy;
> - Institutionally able to manage complex projects;
> - Technically able and professionally empowered to adapt and promote the prevention interventions at country level.

- Support the development of multi-disciplinary country teams to adapt, test and implement a school based or parenting GBV prevention intervention
- Review existing primary prevention work currently underway.
- Review existing promising school based or parenting GBV prevention interventions, how they are implemented, theoretical framing, and to what extent they might be applicable to local settings.
- Facilitate the development of country specific adaptation, testing and implementation plans for a particular intervention.
- Develop a communication strategy for the project with project partners.

In total 25 people attended the workshop. Participants included members of the four research team, SVRI and donor representatives, and a selection of technical experts.[3] Technical experts were identified using SVRI extensive networks and experience of the field and reviews of the literature in the field of parenting and primary prevention of GBV. The workshop was structured such that the first two days were spent discussing and debating theory, evidence and research methods, and the last three days were for teams to work together with one of the resource persons to develop and strengthen their proposals.

"This was the best workshop I've attended. The format of plenary and group discussions and their integration, plus time for informal meetings in the evening was invaluable"

"What I liked: relevant topics, mix of researchers, programmers and donors; mix of theory and programmatic content"
(Workshop participants)

All workshop materials and presentations are available online at: http://www.svri.org/primaryworkshop.htm

On return to their respective countries, project teams finalized their research proposals. All teams submitted their full proposals within two months of the workshop being held. The proposals were sent out for peer review. Extensive revision and feedback on the proposals was given to each of the research teams. Feedback focused on need to properly review and reference existing literature, the development of a clear, evidence informed theoretical framework to guide formative research and intervention development, methods and tools for formative research and ethics of doing research on sensitive issues. Once finalised, all teams received ethical approval from locally approved ethics bodies for their formative research.

Phase 2: Formative Research[4] and Intervention Development[5]:

During this phase the SVRI team provided extensive support and guidance to each of the teams to undertake formative research to identify key risk and protective factors in their communities for SIPV. Using this information the SVRI worked with the teams to identify existing tested or promising interventions to adapt to their own setting. Towards the end of this phase, teams developed proposals for the final phase of this project – the testing the feasibility and acceptability, and proof of concept of their interventions.

Key steps activities undertaken by each team during phase 2 include:

- o Review of literature on sexual violence and childhood violence
- o Review of existing intervention materials and adopting or adapting those that best meet the project's learning objectives
- o Formalisation of a theoretical model
- o Creation of, and engagement with a Community Advisory Board
- o Development of research tools, community mobilisation and stakeholder engagement
- o Formative research in communities to identify risk and protective factors for SIPV
- o Development of a programme, content and training manual

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[3] Technical experts who attended the workshop included: Professor Cooper (Reading University); Professor Lynne Murray (Reading University); Rachel Jewkes (MRC and SVRI); Anik Gevers (MRC); Elizabeth Dartnall (SVRI and MRC); Blain Teketel (Oak); and Melissa Adams from IRH, Georgetown University, Washington, DC.

[4] Formative research is the process of gathering key information for intervention development (what to address in the intervention, how to address it, and how to deliver the intervention); and to build a better understanding of the target group and the contexts within which child abuse and sexual and intimate partner violence does or does not occur in their lives (including what makes it more likely and what makes it less likely).

[5] Intervention development, is the use of existing, relevant evidence-based programmes where possible and adapting them to fit the needs/contexts of the target group and addressing the specific risk and protective factors that emerged from the formative research.

- o   Formative research reports
- o   Drafting of phase two pilot proposal

Formative research reports are available online:
- The design and formative evaluation of a parenting programme in Uganda for early prevention of gender based violence. Wight D, Siu G, Zalwango F, Kasule S, Seeley J. SVRI, 2015
- Formative assessment on primary prevention of school based gender based violence (GBV) and parenting interventions in Tanzania. Muhimbili University of Health and Allied Health Sciences & Women in Law and Development in Africa, 2014.
- An exploratory study on the risk factors to child abuse in primary schools in Kajiado County-Kenya: Findings of a formative research. LVCT Health, SOWED Kenya, SVRI and SAMRC, 2015
- Developing/adapting a school-based sexual and dating violence prevention intervention in Nairobi in Kenya. Formative Research Report. Omwenga T, Plummer C and Mwaura P. Child Aid Organization, Kenya, 2014

Phase 3: Testing for feasibility, acceptability and proof of concept:
The final phase of this project is intervention piloting i.e. "trying out" the intervention with a few groups to see whether it is feasible, acceptable, and shows promise of being effective based on objective qualitative and quantitative data collected before and after the programme. Findings from this phase will provide us with preliminary data that can be used as a rationale for an RCT.

Building capacity and support

Capacity building activities and support were offered to all teams throughout each of these phases. The aim of the capacity building strategy was to ensure that at the end of the project, teams have:
- knowledge of the concept of primary prevention of SIPV and how it is distinguished from secondary prevention and responses,
- knowledge of how formative research or operations research can be used to develop and adapt interventions, or strengthen existing interventions,
- skills in developing a Theory of Change for their intervention
- understand about ethical and safety issues in SIPV intervention and research
- have skills and a platform (ie the SVRI) to disseminate their prevention work globally

Based on each teams' needs, a tailored programme of technical support has been delivered, and includes the following:
- **In-country, technical support visits:** Each team has received face to face technical assistance from the SVRI technical advisors. These visits were tailored to the needs of the team and included workshops on intervention development, proposal writing, theory of change, facilitator training. These face to face visits have been supplemented by support by email/ telephone/Skype.
- **Workshops, Wikis and Cross-border Learning Networks:** In addition, the SVRI has brought all the teams together once a year throughout the course of the project to encourage cross-team learning and sharing, and to promote the creation of a peer-to-peer learning network. Teams independently outside these workshops continue to share tools, manuals and experiences. The SVRI has also established a project Wiki where project teams can share their materials, reports and access up to date information on SIPV globally.
- **Learning by doing**: The experience of learning through doing with support from SVRI research experts is an important component of the SVRI capacity building strategy. Project

teams have been supported during all stages of the project from research design to intervention development and evaluation.

- **Communities of practice:** Through this project we are building a community of practice around primary prevention in East Africa. This is supported through our annual meetings, regular Skype contact and Wiki Updates.
- **Training Courses on Specific Issues:** During the course of the project, project team members have been encouraged, and where possible and appropriate supported, to participate in courses relevant to their projects.
- **Monitoring and Evaluation:** Throughout the project, the SVRI has maintained ongoing contact with the teams through email, Skype and the project Wiki. Monthly reports and updates have been encouraged. Clear project milestones and timeframes were agreed with team members.
- **Sharing of tools, measures, guidelines and templates:** Teams have been provided with literature, tools, measures, guidelines and templates for reporting writing, data analysis, presentations to build capacity, help them to meet project milestones and to develop shared measures across all projects.

What we have learnt

We have learnt a number of core lessons through this project around how to support teams in doing formative research, and building or adapting primary prevention interventions, these include:

- **Importance of assessing capacity at the start of a project:** It would be a mistake to assume prior knowledge and skills in primary prevention intervention research and development; therefore, comprehensive capacity assessment is essential to better understand the position and needs of different teams so that a full capacity development and support plan can be formed early on.
- **Specific issues requiring targeting training:** We found that some specific issues needed to be clarified and elaborated on extensively, including: understandings of primary prevention; understandings of ethics and doing sexual violence research with children and adolescents; understanding evidence-informed theoretical models and how these guide the intervention and M&E; using and building on existing research evidence, through literature reviews and especially to inform the risk and protective factors to address in the project which are then used in the theoretical framework for the project.
- **Slow and systematic:** A slow, systematic, and structured approach to capacity building is necessary. This approach may include consistent and on-going, structured mentoring; revisiting and revising core concepts and skills multiple times (spiral type of growth and development repetitive cycles) and from different angles or perspectives; using templates for reports, proposals, intervention adaptation, M&E strategy, etc.
- **Transformation requires time:** Transformation takes time and many teams were in need of development and growth in terms of the principles and values of primary prevention, the types of skills and attitudes consistent with a primary prevention approach, how to adapt and implement a primary prevention programme, and how to evaluate it. It is essential that the project teams embrace primary prevention and the skills and attitudes that are promoted in the programme. It is strongly recommended that teams go through an intervention as participants first in order to understand and integrate the skills, values, and attitudes promoted by the programme.
- **Interventions need to be grounded in theory:** It is essential to have and understand the importance of an a priori, evidence informed theory of change. It is important to demonstrate how this theoretical model is derived from a rigorous evidence-base, guides intervention development and M&E, and must be improved upon using data from on-going studies.

- **Project structure and management:** During the selection and early inception period of the project, a partnership should be set up between SVRI and project teams that positions these two groups within a co-PI model within a grant mechanism with a strong capacity development focus. Such a model is more about partnership and collaboration, than a Technical Assistance only model. The TA model assumes a certain level of capacity and thus focuses on brief inputs, but what is needed is more long-term, intensive involvement through mentorship and input every step of the process and with many of the concepts. Such a partnership requires resources, time and commitment from both partners.
- **Value of meeting face to face to build a community of practice:** Having regular, full regional meetings with multiple project teams and SVRI promotes a community of practice and build links between teams who then begin to support one another and collaborate on primary prevention work. The value of face to face meetings should not be underestimated and must form part of the project plan in order to facilitate learning, pool resources where possible, and make significantly faster and deeper progress on projects. On-going, team-specific meetings through virtual technologies is important to build on and maintain learnings and resolutions formed during the in-person meetings.
- **Value of partnerships and working multiple teams:** Working with multiple teams in multiple settings was helpful to build motivation to continue with this work that is very demanding and often meets with obstacles. Project teams were inspired by one another and learnt a great deal from one another. Further, it provided motivation to persevere knowing that the individual projects were part of a larger group and movement of violence prevention. Partnerships between researchers and practitioners are powerful and can offer both partners exciting opportunities for capacity development; however, such partnerships are not without challenges.
- **Adapt rather than develop:** Teams should be encouraged to adapt existing, evidence-based (or good practice) interventions using formative research rather than developing entirely new primary prevention interventions. Piloting existing intervention approaches to assess acceptability, feasibility, and promise should be essential in primary prevention projects to understand how an existing intervention does or does not work in teams' settings and what and how to change the intervention to be a better fit and to be more effective. Only after successful piloting should teams consider conducting a full, rigorous evaluation.
- **Monitoring and evaluation:** Routine communication including templates and structures for on-going sharing is important.
- **Sustainability and scale-up:** Issues of sustainability and scale up should be integrated from the inception of the project and throughout all phases. This may be done through engaging with community and policy maker stakeholders throughout the project and designing a low-cost intervention. The local project teams should ensure that project implementation strategies are feasible within their settings and the human resource capacity available.
- **Measurement challenges:** There are significant challenges in measurement – definitions, high quality or standardised tools, how to use/implement existing tools, and translation issues all pose a problem to measurement. Understanding how to get good data in order to measure objectives and outcomes of an intervention are a key capacity development area. It is beneficial for the different teams to use some common measures of core concepts and issues to contribute to a larger evidence base.
- **Translation:** Future projects needs to include costs of translating complex concepts into local languages.

Working with these teams to build evidence for primary prevention in East Africa has been an incredible experience. The knowledge generated through this project extends well beyond research findings. This project has built a community of experts in East Africa who will continue to work to preventing violence before it happens in the first place, and ultimately moving toward a safer and vibrant communities for all.

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