Three Essays Analyzing the Impact of Community and Neighborhood Factors on Intimate Partner Violence against Women in Uganda

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ABSTRACT

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The overall aim of the proposed dissertation is to enhance understanding of the impact of the community and neighborhood in preventing violence against women, and how women who have been displaced from their communities may be at increased risk of violence. This three-paper dissertation utilized secondary data sources from two studies of IPV against women in Uganda: the *SASA!* Study and the Ugandan Demographic and Health Study (UDHS). The first paper used quantitative data from the baseline of the *SASA!* study (a cluster randomized controlled trial of a community-based intervention to prevent violence against women and HIV/AIDS, called *SASA!*), a representative sample of community members in two districts in Kampala. This study hypothesized that women who live in neighborhoods with higher levels of collective efficacy to prevent IPV would be at decreased risk of experiencing male-perpetrated IPV. Using a multi-level logistics model, there was no significant neighborhood effect on intimate partner violence related to collective efficacy or otherwise. However, women with higher levels of self-efficacy to prevent IPV against others were significantly less likely to experience physical IPV themselves. Other fixed effect factors, including younger age, no education, higher number of children, having no electricity, not earning an income, and partner's daily alcohol use significantly predicted women's risk of IPV. Potential research and practice implications will be discussed.

The second paper utilized secondary analyses of the impact of displacement on IPV against women from the Demographic and Health Survey, a representative community sample of women

throughout Uganda. Using propensity score matching, this study attempts to determine the causal effect of displacement on women's experiences of intimate partner violence. Given that assumptions hold, the results indicate that women who are displaced in northern Uganda are *less* likely to experience IPV than if they had not been displaced. Potential explanations for these findings, such as the renegotiation of gender during displacement and the impact of the humanitarian Cluster Approach, will be discussed.

The third paper is an in-depth qualitative study using secondary analysis of focus groups with community leaders in Kampala Uganda, also from the baseline of the *SASA!* study. Key findings using framework analysis of focus group discussions with religious leaders, sengas/traditional aunties, health care workers, police and local council leaders suggest a widely held justification for violence against women based on an underlying cultural belief in men's authority over women and expectations on women. The belief in men's power over women manifests in three, interrelated themes: men's authority, blaming women, and controlling women's sexuality. Few dissenting voices argued against violence against women for reasons related to the impact on the children and the need for women and men to live with peace and happiness in the home. Overall, despite numerous justifications for violence against women, community leaders expressed a strong sense of responsibility in responding to violence against women, particularly in life threatening situations. Suggested strategies for intervening in situations of violence against women in the home included recruiting elders, talking to the men about the violence, calling upon help from local council leaders, and reporting to the police. These suggested strategies were not, however, without underlying sentiments of men's authority and associated risks faced by community leaders. Community leaders also expressed a sense of responsibility in helping organize community members for prevention activities, although they did not see their role as leaders or facilitators of these efforts.

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Acknowledgements and Dedication

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Finally, I would like to dedicate my dissertation to the women and men in Uganda, particularly those from Raising Voices and the Center for Domestic Violence Prevention, who have committed their lives to preventing violence against women and promoting healthy and safe families. Your passion and innovation continues to inspire and motivate me to be a better researcher and human being. I would also like to dedicate this dissertation to the men and

women who participated in the SASA! and DHS studies. To participate in a study on violence requires bravery and commitment to making one's community a better place to live. I hope that this dissertation can make a small contribution to improving the lives of men, women, and families in Uganda.

Introduction to the Dissertation

Violence against women is a human rights violation and global public health concern, affecting an estimated one in three women around the world (DPI, February 2008). The most prevalent form of violence against women is intimate partner violence (C. Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Commonly referred to as domestic violence or abuse, intimate partner violence occurs within intimate or trust relationships and may include "physical aggression, sexual coercion, psychological abuse, or controlling behaviour" (WHO/LSHTM, 2010, p. 11). Though women sometimes perpetrate violence against intimate male partners and violence exists in same sex relationships, the majority of intimate partner violence is perpetrated against a woman by a current or former male intimate partner (Dahlberg & Krug, 2002). In different cultural contexts, intimate partner violence against women (IPV) may be perpetrated by former husbands, a co-habituating partner, boyfriends, or lovers.

Intimate partner violence causes harm that affects multiple aspects of the health and well-being of women and their families. Compared to women who have not experienced abuse, those with a history of IPV are more likely to report mental health disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD). Other health-related effects of IPV include substance abuse, unplanned pregnancy, abortion, miscarriage, and sexually transmitted infections, such as HIV. The most severe health outcomes associated with IPV are homicide, suicide, or premature mortality due to HIV (Dahlberg & Krug, 2002). Violence can affect a woman's ability to work and earn an income, make decisions about her family or children, or participate in her community (Watts, 2005). In addition, children in a family with IPV tend to be at increased risk of child mortality, failure to immunize, and abuse and neglect (Åsling-Monemi, Tabassum Naved, & Persson, 2008; Holt, Buckley, & Whelan, 2008; McGuigan & Pratt, 2001;

Silverman, et al., 2009). Children who are exposed to intimate partner violence may also be more likely to face difficulty with social, emotional, behavioral, cognitive and general health functioning (Kitzmann, Gaylord, Holt, & Kenny, 2003).

The majority of literature on intimate partner violence against women focuses on high income countries. A need exists to expand the knowledge base on IPV against women in low- and middle-income countries, particularly in countries with high prevalence rates, such as Uganda. Furthermore, much of the previous research on IPV against women focuses on the kinds of women who experience violence and to a lesser degree, the kind of men who perpetrate violence. A large gap in the literature exists on the "kinds of places" which either foster or prevent IPV against women (Kubrin & Weitzer, 2003).

Theoretical Framework

Although much research on the community factors of IPV lacks a theoretical framework, studies which do draw upon a framework typically utilize social disorganization and collective efficacy theory. According to social disorganization and collective efficacy theory (Kornhauser, 1978; Shaw & McKay, 1969), structural factors such as poverty, ethnic heterogeneity, community violence, and residential instability contribute to negative health and wellbeing outcomes, including violence (Sampson, 2003). Collective efficacy (a multi-dimensional construct representing social cohesion and informal social control) is proposed to partially mediate the relationship between structural factors and community well-being. For example, communities with concentrated disadvantage are pre-occupied with meeting basic needs and thus unable to develop the social cohesion, or trust, necessary to regulate undesirable behaviors among their neighbors (informal social control). Studies drawing from social disorganization theory as an explanation for intimate partner violence have typically focused on populations in

the United States.

IPV in Uganda

Uganda served as an appropriate country for the focus of this dissertation for several reasons. First, national prevalence rates of intimate partner violence rank Uganda on the higher end of regional and global rates (Claudia Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006; Gass, Stein, Williams, & Seedat, 2011; Rico, Fenn, Abramsky, & Watts, 2011). A population-based survey found that 68 percent of ever-married women in Uganda have experienced at least one kind of violence (physical, sexual or emotional) by an intimate partner (Speizer, 2010). Similar to other countries, the majority of prior IPV studies from Uganda focused on individual and relationship-level factors, with a dearth of research on community-level factors. Furthermore, my previous and ongoing work in the area of violence against women prevention in Uganda allowed for additional insight into the cultural, political, and social context of the country, as well as enormously beneficial connections with colleagues from two Ugandan-based violence prevention agencies (Raising Voices and the Center for Domestic Violence Prevention).

The overall aim of the proposed dissertation is to enhance understanding of the impact of the community and neighborhood in preventing violence against women, and how women who have been displaced from their communities may be at increased risk of violence. This 3-paper dissertation utilized secondary data sources from two studies of IPV against women in Uganda: the *SASA!* Study and the Ugandan Demographic and Health Study (UDHS). The first paper used quantitative data from the baseline of the *SASA!* study (a cluster randomized controlled trial of a community-based intervention to prevent violence against women and HIV/AIDS, called *SASA!*), a representative sample of community members in two districts in Kampala. The second paper utilized secondary analyses of the impact of displacement on IPV against women from the

Demographic and Health Survey, a representative community sample of women throughout Uganda. The third paper is an in-depth qualitative study using secondary analysis of focus groups with community leaders in Kampala Uganda, also from the baseline of the *SASA!* study. Below I present the research questions, aims, and hypotheses for each of the three papers.

Paper 1: Quantitative Data from the *SASA!* Baseline Study

Research questions:

Using a probability sample of 1,582 community members drawn from 8 neighborhoods in Kampala, Uganda, to:

Aim 1: examine the reliability of a newly developed 6-item scale to measure perceived collective efficacy to prevent and respond to IPV.

Aim 2: examine how perceived collective efficacy of efforts to prevent and respond to violence against women at the neighborhood level influences individual women's experiences of IPV.

Hypothesis 1: The aggregated individual social efficacy of efforts to prevent and respond to violence against women is inversely and significantly associated with women's experiences of IPV, all other relevant variables being held constant.

Paper 2: Quantitative Data from the Demographic and Health Survey

Research Questions:

Using a nationally representative sample of 1,749 reproductive-aged women in Uganda, to

Aim 1: determine the causal effect of living in an internally displaced village on women's experiences of IPV.

Hypothesis 1: Women who live in an internally displaced village will be more likely to experience IPV in the last 12 months than if they had never been displaced.

Paper 3: Qualitative Data from the *SASA!* Baseline Study

Research Question:

Using framework analysis of secondary data from focus groups with community leaders in Kampala, Uganda to understand 1) the perspectives of community leaders on the IPV against women in their communities and 2) what, if any, role they see for community leaders in responding to and preventing this issue.

Dissertation Paper 1:

The Effect of Collective Efficacy on

Intimate Partner Violence against Women in Kampala, Uganda

Introduction

Intimate Partner Violence in Uganda

Violence against women in Uganda remains widespread and largely condoned by social norms. For example, studies have found that 73% to 90% of women and 57% to 70% of men in Uganda believe intimate partner violence (IPV) is justified (Koenig, et al., 2003; Speizer, 2010) and there are no national laws protecting women from violence within marriage (Amnesty International, 2010). A population-based survey found that 57% of currently or formerly married women of reproductive age in Uganda report having experienced at least one kind of violence (physical or sexual) by an intimate partner (Speizer, 2010), ranking Uganda on the higher end of both global and regional prevalence rates (Claudia Garcia-Moreno, et al., 2006; Gass, et al., 2011; Rico, et al., 2011). The same population-based survey found that nearly one in four women reported that their first sexual intercourse was forced, the majority by an intimate partner (Uganda Bureau of Statistics (UBOS) and Macro International Inc., 2007). While much of the existing literature on IPV, including that on Uganda, focuses on individual and relationship factors that put women at risk of experiencing IPV, a gap exists on neighborhood or community-level phenomena that may protect women from violence and promote peaceful, healthy relationships. A neighborhood or group-level strength that has garnered increased attention in global public health and IPV literature is collective efficacy.

Collective Efficacy

Collective efficacy is a group-level construct representing a group's shared belief in its ability to accomplish a specific goal. Although the roots of collective efficacy are in social learning theory, the IPV literature most commonly references collective efficacy as a tenet of social disorganization theory. Originally developed by Shaw and McKay (1969) and extended

by Kornhauser (1978), social disorganization theory suggests that crime results from structural factors such as collective disadvantage (poverty), residential instability, community violence, and ethnic heterogeneity. Communities with these structural features are less equipped to regulate crime due to a lack of collective efficacy, a multidimensional construct referring to a group's "linkage of mutual trust and the[ir] willingness to intervene for the common good"(Sampson, Raudenbush, & Earls, 1997, p. 919). The "linkage of mutual trust" is commonly referred to as *social cohesion*, and the "willingness to intervene for the common good" is defined as *informal social control*. Collective efficacy, commonly defined as social cohesion and informal social control, is considered the mechanism through which communities either allow or prevent criminal activity, including violence.

While Sampson, Raudenbush and Earls (1997) are credited in the sociology and criminology literature for coining the term collective efficacy, authors in social psychology typically reference Bandura's social learning theory (1997). Indeed, social disorganization theorists adopted the term collective efficacy from the concept of self-efficacy, a critical component of social learning theory (Albert Bandura, 1977). Self-efficacy, or a person's belief in their ability to achieve a given goal or task, largely predicts an individual's attainment of such goals in a variety of arenas (A. Bandura, 1997). An expansive literature base supports the causal relationship between situated self-efficacy and the performance of a specific task. As a result, self-efficacy is as a key concept in the Transtheoretical Model of behavior change (Prochaska & Velicer, 1997). Bandura (1997) extended the concept of self-efficacy to the group level by defining collective efficacy as "a group's shared belief in its conjoint capabilities to organize and execute the courses of action required to produce given levels of attainment" (p. 477).

Social disorganization theory and social learning theory share important similarities in their understanding of collective efficacy. Both theories conceptualize collective efficacy as a group-level phenomenon that draws upon the interdependent, relational nature of human behavior. Both also agree that collective efficacy – like self-efficacy – is situated toward a specific goal or desired outcomes and not a global or general characteristic of a group. Finally, neither theory refers to collective efficacy in terms of actual behavior, but rather as group characteristics that theoretically precede a specific behavior or action.

In a key, albeit subtle, distinction, social learning theory defines collective efficacy as a group's *belief in its ability* to take collective action while social disorganization theory refers to collective efficacy as the *likelihood* a group will take collective action. The term likelihood is a broader and less specific term than the term ability. Furthermore, social disorganization theory suggests that collective efficacy represents the group's social cohesion or mutual trust in addition to its likelihood of action.

Empirical Evidence on Collective Efficacy and IPV

Literature on the effect of collective efficacy on IPV remains mixed (Wright, 2011), with some authors finding collective efficacy to be a significant protective factor for IPV (Browning, 2002; Wu, 2009), and others finding no relationship (Dekeseredy, Alvi, & Tomaszewski, 2003; Frye, et al., 2008; Wright & Benson, 2011). Browning (2002) found that Chicago neighborhoods with high collective efficacy were less likely to have high rates of either intimate homicide or nonlethal partner violence against women (any IPV that did not result in murder) (Browning, 2002). Examining severe IPV against women (their partner had kicked, bit, or hit them with their fist; hit or tried to hit them with something; beat the up; choked them; threatened them with a knife or gun; had used a knife or fired a gun), Wright and Benson (2011) found that

the relationship between collective efficacy and IPV dissolved when including disadvantage in their model. Both Wright and Benson and Browning used a measure of collective efficacy that combines measures of social cohesion and informal social control. Wu (2009) reported a significant relationship between collective efficacy and female homicide in California, however, using a questionable proxy measure of collective efficacy that comprised of neighborhood structural factors.

Studies examining the effect of social control and social cohesion on IPV as separate constructs also reveal mixed findings. Frye (2008) found no relationship between social cohesion and female homicide, while Caetano and colleagues (2010) reported that social cohesion protected women against IPV. Studies isolating the effect of informal social control on IPV reported insignificant results (Caetano, et al., 2010; Dekeseredy, et al., 2003).

Some evidence suggests that collective efficacy may be modified by the level of social norms or attitudes supportive of IPV. Raghavan and colleagues (2006) found that living in a community with strong social ties or networks may fail to protect women from experiencing IPV or even put them at greater risk if the community has social norms which support IPV. Similarly, Frye (2007) reported that attitudes supportive of IPV decreased the likelihood that an individual would exert informal social control to prevent IPV in his or her neighborhood. The limited number, measurement inconsistencies, and mixed results of studies on collective efficacy and IPV indicate a significant need for additional research in this area. While some studies have considered the effect of social cohesion and informal social control as separate constructs, others aggregate the two constructs to represent collective efficacy. Given the potentially different effects of social cohesion and informal social control on IPV, studies which do not consider collective efficacy as an aggregate of these two concepts may better clarify the

role that a community can have on IPV. Furthermore, most studies, with the exception of Frye (2008), use a general measure of collective efficacy and/or informal social control. As both social disorganization and social learning theory note, collective efficacy is not a global phenomenon and it thus should be measured in its relation to a specific outcome such as IPV prevention. Finally, nearly all studies on the effect of collective efficacy or social control and IPV utilize samples from urban cities in the United States. Given the highly contextualized nature of neighborhoods, additional research examining the relationship between these two variables in different cultural, political, economic, and social environments may contribute to the understanding of collective efficacy and IPV.

Using a probability sample of 1,582 community members drawn from eight neighborhoods in peri-urban Kampala, Uganda, this study aims to examine how collective efficacy to prevent violence against women at the neighborhood level influences women's experiences of physical and sexual IPV in the last 12 months prior to the survey.

Methods

Data Source

The data source for this study comes from peri-urban settlements in Kampala, Uganda. These settlements lie in the outside areas of the city and are categorized as having high population density, concentrated poverty, and small scale agriculture (Kulabako, Nalubega, Wozei, & Thunvik, 2010). Data are from a multistage stratified random sample of 1,532 men and women from the Rubaga and Makindye Administrative Districts in Kampala, Uganda. The data are part of the baseline assessment from the *SASA!* Study, a cluster randomized controlled trial to evaluate the impact of a community-based intervention to prevent violence against women and HIV. All elements of the study protocol were reviewed and approved by the

Institutional Review Boards at both the London School of Hygiene and Tropical Medicine and Makerere University in Kampala, Uganda.

Background on *SASA!*

In the early 2000s, global researchers and policy makers began to call for community-based approaches to preventing violence against women which target social norms accepting violence and men's power over women (Dahlberg & Krug, 2002). Furthermore, a growing body of research began to show the link between HIV and violence against women, resulting in a call for integrated HIV and VAW prevention efforts (Dunkle, et al., 2004). Despite these recommendations, many groups struggled to develop appropriate and effective methods of addressing social norm change through community-based approaches. In addition, a gap in knowledge existed on the practical aspects of an integrated HIV/VAW approach and most prevention efforts which incorporate both tended to focus on the individual or couple and not the community.

In response, Raising Voices—a Ugandan-based violence prevention NGO—developed *SASA!* in 2008 as a community mobilization methodology aimed at preventing violence against women and its linkages to HIV/AIDS (Raising Voices, 2008). The word 'sasa' is a Kiswahili word that means *now.* The *SASA!* model uses an approach that follows the Stages of Change Model (Prochaska & Velicer, 1997) scaled up to the community level, including the promotion of collective efficacy, through the process of four phases: Start, Awareness, Support, and Action. The intervention content focuses on *power*—what it is, who has it, how it is used, how it is abused—and how men and women can achieve balance in their relationships. *SASA!* uses multiple strategies, including local activism with neighbors, media & advocacy campaigns, communication materials such as posters and advertisements, and training of community leaders.

Sampling

The sampling frame for the baseline assessment survey was chosen to reflect the population most likely to have repeated and extensive contact with multiple components of the *SASA!* intervention. For example, a large component of *SASA!* involves the efforts of community activists to engage their neighbors in discussions and activities. The sampling frame therefore comprised households situated in all "Enumeration Areas" in which the community activists in the intervention sites, and passive 'activists' in the control areas were living. The *SASA!* dataset is unique in its inclusion of questions about individual social efficacy to prevent or respond to violence against women in one's own community, the foundational measure of evaluating collective efficacy, and individuals' personal history of intimate partner violence.

Data Collection

Trained, local research assistants conducted face to face interviews from December 2007 to April 2008. Inclusion criteria were: same sex as the community activists, usually lived in the household selected and shared food, aged 18-49 years, and had lived in the community for at least one year. Respondents were limited to one per household for safety and confidentiality. Separate sampling by sex was chosen principally for reasons of safety (to reduce the chance that men in the immediate locality were aware of the nature of the questions that women are being asked and thus the experiences that they may disclose). The target sample size was 200 completed questionnaires per each of the 8 sites. Households were oversampled, to account for potential ineligibility or unwillingness to participate. Household selection procedures were completed in at least 80% of households sampled. Failures to complete this process were largely because there was no household at the mapped location, there was no-one home on repeated visits or language barriers prevented communication. Where the household selection procedure

was completed, the response rates for the community questionnaire were 97% and 98% in the intervention and control arms respectively, and 98% and 97% for males and females, respectively.

Measurements

Intimate partner violence.

The questionnaire contained eight questions, adapted from the Conflict Tactics Scale (Straus, 1990), about specific physical and sexual violent behaviors experienced by women who were in an intimate relationship within the last 12 months. Six questions asked about experiences of physical violence (slapped or thrown something that could hurt; pushed or shoved her or pulled her hair; hit her with a fist or something else that could hurt; kicked her, dragged her or beat her up; choked or burnt her on purpose; threatened to use or actually used a gun, knife or other weapon against her) and two questions assessed sexual violence (threatened or intimidated her into having sexual intercourse even when she did not want to; physically forced her to have sexual intercourse even when she did not want to). Experience of any type of physical or sexual violence at least once during previous 12 months was coded as "1" (no experiences of IPV in the last year were coded as 0).

Collective efficacy.

The measure of collective efficacy was adapted from social learning theory's definition and measurement recommendations (Albert Bandura, 2000). Six questions in the SASA! study asked about participants' individual self-efficacy, or perceived ability to prevent or respond to violence against women in his or her community: "In the last 12 months, to what extent (very able = 3, somewhat able = 2, not very able= 1, not at all able = 0) have you felt able to: a) support a woman experiencing violence to make her own decisions about her safety; b) tell men that using

violence that it is not okay; c) hold men using violence accountable without blaming and shaming them; d) get involved with others who are promoting non-violent relationships between women and men; e) move out of social roles that society expects of you as a man or woman; f) take action to prevent violence against women and girls in your community".

Exploratory factor analysis of all six items resulted in one robust factor or construct with an Eigen value of 3.5, well above the standard cutoff of 1.0. Five out of the six items resulted in sufficient factor loadings of 0.7 or above. The item on respondent's ability to "move out of social roles society expects of you as a man or woman," resulted in a factor loading of .490. Due to this relatively low loading, and the theoretical plausibility of this item as representing a different - albeit related - construct, this item was dropped from the final social efficacy scale used in subsequent analyses. The final iteration of the collective efficacy measurement resulted in a five-item scale ranging from 0 to 15, with higher numbers representing higher levels of collective efficacy to prevent violence against women in one's community. The scale for collective efficacy reported strong internal consistency ($\alpha = .90$). As supported by previous literature(Albert Bandura, 2000), collective efficacy was treated as an aggregate measure, averaged across all individuals living in a given neighborhood.

Additional Women's Variables.

Women's age, number of children and age at sexual debut were all modeled as continuous variables. Dichotomous variables included: currently in an intimate relationship, belonging to the Muganda ethnic tribe, earning money, partner drinks everyday or nearly everyday, self reporting as HIV positive, and partner having more than one wife or woman with whom he lives with as married (polygamous). Education and religious affiliation were measured as categorical variables. Participants were asked the highest level of education attended: no formal education

(reference category), attended or completed primary education, attended or completed secondary education or higher. Religious affiliation categories included: Catholic (reference category), Muslim, Born Again Christian, Protestant, or no religious affiliation.

Six questions asked about the acceptability of physical violence: "In your opinion, does a man have a good reason to hit his partner if: 1) she disobeys him; 2) he suspects that she is unfaithful; 3) he finds out that she has been unfaithful; 4) she spends her time gossiping with neighbors instead of taking care of the children; 5) she does not complete her household work to his satisfaction 6) she refuses to have sexual relations with him." In response to each of these questions "yes"=1 and "no"=0. Eight questions asked about the acceptability of sexual violence: "In your opinion, can a woman refuse to have sex with her partner if: 1) she doesn't want to; 2) he is drunk; 3) she is sick; 4) he mistreats her; 5) she suspects he is unfaithful; 6) she knows that he is unfaithful; 7) she knows/suspects he is HIV positive; 8) he refuses to use a condom." In response to each of these questions "no"=1 and "yes"=0. Each of these items from both sets of questions were added together to create a scale ranging from 0-14, with higher numbers indicating more acceptance of intimate partner violence.

Data Analyses

Descriptive statistics of individual characteristics were conducted by obtaining percentages, means, standard deviations, and range. Bivariate analysis of collective efficacy across neighborhood sites will be assessed using the nonparametric Kruskal-Wallis analysis of variance test. Additionally, bivariate analysis of the variation in neighborhood IPV will be conducted using chi-square tests of association. This study utilized a multilevel logistic regression model that represents the odds that a given woman or man living in a given neighborhood will report having experienced/perpetrated IPV in the last 12 months. This strategy accounts for the

hierarchical structure of the data with 1,569 individuals (level 1) nested within eight neighborhoods (level 2) to differentiate true contextual effects. Individual-level covariates that were theoretically and/or empirically significant in the IPV literature on Uganda were chosen and held in the model, regardless of their significance in bivariate and multivariate analyses. In one exception, the variable for being in a polygamous marriage was dropped from the analysis. Sixteen percent of women (n=116) in the sample reported that they were currently in a relationship with a regular partner but not living together. None of these women were asked whether or not their male partner has more than one partner with whom they live with as married resulting in a large number of missing data and reducing the sample size and power of the model. When included in the model, polygamy was not significantly associated with IPV and was thus dropped from subsequent analyses.

In the equation:

$$\log\left[IPV_{ij}/(1-IPV_{ij})\right] = \beta_{0j} + \beta_{1j}COLLECTIVEEFFICACY_j + \beta_{kij}COVARIATES_{ij} + \zeta_j + \varepsilon_{ij},$$

the i^{th} individual in the j^{th} neighborhood has outcome of the probability of IPV_{ij} *(Intimate partner violence)*, predictor given by $COLLECTIVEEFFICACY_j$, controlling for *k* individual-level characteristics, with random effects at the neighborhood level ζ_j, and residual error ε_{ij}. The specified model was analyzed separately for each dependent variable: women's reports of experiencing physical intimate partner violence and women's reports of experiencing sexual intimate partner violence. Analyses were conducted using STATA 12.0.

Results

Table 1 describes the demographic and risk factors of the sample. As a whole, the sample was 45% female, 36% Catholic, and had a mean age of 28; over 78% had at least attended secondary school. Sixty-eight percent of respondents affiliated with the Muganda tribe and around 12% reported that they or their partner had multiple wives (polygamy). Over half (56%) of the sample claimed to accept IPV against women for at least one reason and the average score on the collective efficacy scale to prevent violence against women was 9.35 (SD = 4.25); possible range = 0-15).

Table 1. Demographic and Risk Factors

Variables	Mean (SD) or %	Range
Female	45.30	0-1
Age	27.77 (7.3)	18-49
In relationship	74.35	0-1
Education		
None	15.73	0-1
Primary	27.86	0-1
Secondary +	78.20	0-1
Religion		
Catholic	35.90	0-1
Muslim	25.28	0-1
Protestant	23.39	0-1
Born again	11.69	0-1
Other/No religion	3.73	0-1

Muganda Tribe	68.04	0-1
Number of children	1.76 (2.23)	0-16
Earns Money	66.69	0-1
Electricity	76.94	
Polygamous	12.17	0-1
Accepts violence	56.76	0-1
HIV positive	6.44	0-1
Male partner drinks everyday	8.91	0-1
Age at sexual debut	17.10 (2.96)	3-36
Polygamous	12.07	0-1
Collective Efficacy	9.35 (4.25)	0-15

Descriptive statistics show relatively homogenous neighborhoods. The only neighborhood characteristic that varies greatly is whether or not participants belong to the Muganda tribe. Site six contains the highest percentage of Mugandans (80%), compared to site two which reported the lowest percentage of Mugandans (53%). Table 2 presents descriptive data on experiencing physical and sexual intimate partner violence across neighborhoods. The neighborhood with the lowest mean score of collective efficacy of 8.50 (SD = 4.1) was site six, while the neighborhood with the highest mean score of 10.39 (SD = 3.6) in Site 2. A nonparametric analysis of variance shows significant differences in the variance of collective efficacy score across the eight neighborhoods (Kruskal-Wallis test = 24.354, p= 0.001). Overall, 22.96% of women reported experiencing physical IPV in the last 12 months. Women's reports of experiencing IPV did not differ significantly across sites. Women's reports of experiencing physical intimate partner

violence range from 16.67 percent to 25.32 percent, while reports of sexual violence by women vary from 5.56 to 6.67 percent.

Table 2. Collective Efficacy and Percentage of Women Experiencing Physical and Sexual IPV, by Neighborhood

	Site 1 (n=163)	Site 2 (n=176)	Site 3 (n=208)	Site 4 (n=214)	Site 5 (n=202)	Site 6 (n=194)	Site 7 (n=220)	Site 8 (n=206)	Total (n=1583)
Collective efficacy[a] (SD)	8.91 (4.63)	10.39 (3.64)	9.52 (4.01)	9.81 (4.20)	9.35 (4.32)	8.50 (4.07)	8.98 (4.40)	9.38 (4.43)	9.35 (4.25)
Physical[b]	23.88 (n=16)	16.67 (n=10)	24.68 (n=19)	24.62 (n=16)	25.32 (n=20)	18.67 (n=14)	24.36 (n=19)	22.22 (n=16)	22.69 (n=130)
Sexual[c]	7.46 (n=5)	16.67 (n=10)	17.95 (n=14)	16.67 (n=11)	11.25 (n=9)	8.00 (n=6)	12.82 (n=10)	5.56 (n=4)	11.98 (n=69)

[a] Kruskal-Wallis test = 24.354, p= 0.001
[b] $\chi^2 = 2.7413$, p = 0.908
[c] $\chi^2 = 10.5945$, p = 0.157

Percentage of women reporting physical and sexual IPV

Two multi-level logistic regression models were used to test the hypothesis that collective efficacy is significantly, inversely related with individual women's experiences of physical or sexual of intimate partner violence in the last 12 months. The results of the multi-level logistic regression models indicated that neighborhood collective efficacy does not significantly predict women's experiences of physical or sexual IPV. In fact, neither of the models detected any variation at the neighborhood level (physical IPV: LR test: $\chi^2 = 0.00$ Prob> chi2 = 1.000; sexual IPV: LR test: $\chi^2 = 2.58$ Prob> chi2 = 0.28). Several fixed effects, however, resulted in significant findings. Women with higher individual self-efficacy to prevent violence against women were less likely to experience physical IPV (AOR = 0.94, p<0.05). Women were also less likely to experience physical IPV if they were older (AOR = 0.94, p<.05). Respondents were more likely to experience physical IPV if they never attended primary school (AOR = 1.67, p<.10) and/or had more children (AOR = 1.21, p<.05). The likelihood of experiencing sexual IPV increased for women who reported currently earning money (AOR = 0.39, p<.01) or held

attitudes accepting IPV (AOR = 1.12; p<.10). Having a partner who drinks every day and living in a home without electricity increased women's likelihood of experiencing both physical IPV (AOR = 5.62; p<.01; AOR = 0.66; p<0.10) and sexual IPV (AOR = 6.52; p<.01; AOR = 0.50, p<.05). Fixed effect factors which did not significantly predict either physical or sexual IPV included being in a current relationship, secondary education (compared to never attended school), religious affiliation, belonging to the Muganda ethnic tribe, HIV status, or age of sexual debut.

Table 3. Demographic factors and Collective Efficacy as predictors of Physical and Sexual Intimate Partner Violence against women in the last 12 months

	Physical		Sexual	
	AOR	95% CI	AOR	95% CI
Fixed Effects				
Individual Self-Efficacy	0.94**	(0.89, 0.99)	0.99	(0.91, 1.07)
Age	0.94**	(0.90, 0.99)	0.99	(0.93, 1.06)
Relationship	1.22	(0.46, 3.19)	0.74	(0.22, 2.46)
Education (ref: no education)				
Primary	1.67*	(0.92, 3.05)	0.81	(0.38, 1.72)
Secondary or more	1.39	(0.70, 2.78)	1.10	(0.47, 2.58)
Religion (ref: Catholic)				
Muslim	1.29	(0.73, 2.30)	1.50	(0.68, 3.30)
Born again	1.48	(0.71, 3.07)	1.90	(0.74, 4.87)
Protestant	1.28	(0.70, 2.33)	1.84	(0.81, 4.18)
Other	2.13	(0.57, 7.91)	2.95	(0.53, 16.56)
Muganda	1.12	(0.70, 1.78)	1.15	(0.62, 2.16)
Number of children	1.21**	(1.01, 1.45)	1.11	(0.87, 1.41)
Earns money	0.82	(0.51, 1.31)	0.39***	(0.20, 0.75)
Has electricity	0.66*	(0.41, 1.07)	0.50**	(0.27, 0.93)
Accepts violence	1.00	(0.91, 1.09)	1.12*	(1.00, 1.26)
HIV positive (self report)	1.55	(0.67, 3.57)	1.47	(0.52, 4.14)
Partner drinks everyday	5.62***	(3.18, 9.94)	6.52***	(3.30, 12.91)
Age at sexual debut	0.95	(0.89, 1.01)	0.97	(0.89, 1.07)
Constant	2.04	(0.34, 12.19)	0.19	(0.02, 2.02)
Random Effects				
Collective Efficacy	0.00	(0, 0)	0.001	(00.0, 0.25)
Intercept	0.00	(0, 0)	0.26	(0.01, 5.75)

*significant at the p=.10 level **significant at the p=.05 level ***significant at the p=.01 level

Discussion

This study is the first to examine the effect of collective efficacy to prevent violence against women on women's experience of IPV in Uganda or any country other than the United States. Using baseline data from the *SASA!* intervention study in Kampala, I found no significant effects at the neighborhood-level from collective efficacy or otherwise. At the individual level, self-efficacy to prevent IPV was negatively associated with women's risk of experiencing physical IPV ($p<.05$). Other significant fixed-effect predictors of women's experiences of physical IPV in this study were being of a younger age, having failed to complete primary school, having more children, not having electricity, and having a partner who drinks alcohol every day. Factors which put women at risk of sexual IPV include: not earning money, not having electricity, accepting violence in intimate relationships, and having a partner who drinks alcohol every day.

Collective Efficacy

This study found no differences in IPV at the neighborhood level. Although numerous studies in other contexts demonstrate that IPV varies at the neighborhood level (Wright, 2011), a recent study from Brazil found no neighborhood variation in IPV (Kiss, et al., 2012). Literature focusing specifically on the impact of neighborhood collective efficacy on IPV reports mixed findings. The null findings of this study in regards to collective efficacy and IPV contradict others which found a significant, negative effect (Browning, 2002; Wu, 2009), but echo others which found no effect (Dekeseredy, et al., 2003; Frye, et al., 2008; Wright & Benson, 2011),

Collective efficacy may have failed to have an impact on IPV in this context for several reasons. First, given that IPV usually occurs in the home, people simply may not know about IPV occurring in their neighborhood. This argument carries less weight when considering the peri-urban context of the neighborhoods surveyed Kampala, particularly in relation to physical

IPV which tends to be more visible than sexual IPV. Households in the districts of Rubaga and Makindye are typically small and very close together, often sharing walls and having open doorways or windows. Neighbors may not always see, hear or find out about IPV occurring; however, it is more likely in these particular districts than in other contexts with more physical barriers and/or space between households.

A more plausible explanation for why collective efficacy may fail to reduce IPV in Kampala may result from social norms considering IPV a private issue. Although the model controlled for attitudes accepting IPV, believing IPV is not acceptable does not necessarily mean believing it is appropriate to intervene with others who are using or experiencing IPV. Qualitative data from focus groups with community leaders the SASA! baseline study suggest that elected local leaders and religious leaders do not intervene in cases related to IPV due to their belief in the issue as a private matter related to the family. Related, community leaders also cited the lack of a law against domestic violence as an indicator that IPV does not warrant outside involvement from others.

This study was the first to use a definition of collective efficacy that specifically focused on the prevention of IPV against women. Previous authors exploring the relationship between collective efficacy and IPV measured collective efficacy as prescribed by social disorganization theory, social cohesion and informal social control, or as separate measures of social cohesion and informal social control. This study used a construct of collective efficacy in line with social learning theory's definition, a group's belief in its *ability* to conduct a particular task. Given the lack of neighborhood variation in the data of this study, I am unable to draw conclusions about the impact of this new definition on furthering the understanding of collective efficacy on IPV. However, the significance of the measure at an individual-level on one's personal experiences

with IPV suggests the construct validity of this new measure. This, coupled with high internal consistency of the collective efficacy measure used herein, suggests the scale may be useful in future studies on collective efficacy to prevent violence against women.

Self-efficacy to prevent IPV

Women who reported higher levels of individual self-efficacy to prevent IPV in their communities were less likely to report experiencing physical IPV themselves (AOR = .94, $p<.05$). In other words, women who felt more able to help other women experiencing violence or intervene with a neighbor who was using violence against his partner were *themselves* less likely to have suffered violence from an intimate partner in the last 12 months. One potential explanation for the relationship between self-efficacy and physical IPV may be that the perceived ability to prevent violence in one's community and support others experiencing violence also contributes to a woman's ability to prevent violence against herself. Violence of any sort is a human rights violation and a person should never be blamed for violence used against himself/herself. Still, seeking help or protection from violence, or avoiding violent relationships all together, is likely easier if a person possesses certain abilities. According to Bandura (1995), the development of health-related efficacy behaviors requires the mastery of the following skills: "how to monitor the behavior they seek to change, how to set attainable subgoals to motivate and direct their efforts, and how to enlist incentives and social supports to sustain the effort needed to succeed" (p. 28). Learning how to enact these skills, such as monitoring IPV in her community, may also make a woman more likely to monitor violence used against herself. Similarly, setting goals or enlisting social supports to prevent violence in one's neighborhood may also aid women in the prevention of violence in their own lives.

Reaching out to others and building social networks, may also aid in women's ability to seek help when they have or are at risk of experiencing violence from their own partners.

Economic Factors

Both economic variables included in the model significantly predicted lower rates of IPV. Those who reported having electricity, a proxy measure for wealth or assets, were less likely to report physical (AOR = 0.66, $p < .10$) or sexual (AOR = 0.50, $p < .05$) intimate partner violence. In fact, household electricity was the only factor, other than partner's daily alcohol use, which protected women from *both* physical and sexual IPV. These findings support the global literature from low and middle-income countries (LMICs) which indicate women's assets are a protective factor against IPV, more so than other economic measures such as income, employment, or educational attainment (Vyas & Watts, 2009b). In Uganda, a mixed method study in rural Uganda found that socioeconomic status, a multifaceted variable that includes asset ownership, was not quantitatively linked to IPV. However, focus groups from the same study reported that poverty led to IPV because men could not provide for the family, resulting in quarrels (Karamagi, Tumwine, Tylleskar, & Heggenhougen, 2006).

Women who reported earning money were two and a half times less likely than those who did not report earning money to experience sexual IPV (AOR = 0.39, $p < .01$). The impact of women's income on IPV has demonstrated mixed results in the global literature on IPV, with most studies from a recent systematic review showing that women's earned income or employment actually increases their risk of experiencing IPV (Vyas & Watts, 2009b). However, most studies in the systematic review examined physical violence or a joint measure of physical and sexual violence, not sexual violence alone. A qualitative study from Uganda supports the finding that a woman's income in peri-urban environments does not put her at increased risk of

IPV, although individuals living in rural areas do believe that a woman's employment could lead to violence in her relationship. When compared to the other literature on women's income and risk of IPV, the findings from this study support the notion that the relationship between these two factors may vary based on context and type of violence.

The significance of both economic variables supports two economic explanations of IPV: marital dependency theory and financial stress theory. Marital dependency theory argues that women who are financially dependent on men are forced to stay in violent relationships as result of limited economic options (Gelles, 1976). Another potential explanation, financial stress theory claims that families living in poverty face increased household conflict and stress (Straus, Gelles, & Steinmetz, 1980). In reality, the economic factors contributing to IPV around the world, and in Kampala, are complex and most likely involve multiple causal pathways that vary by context and circumstance.

Partner's Alcohol Use

Alcohol use by women's partners was the strongest predictor of both physical and sexual IPV in this study. If a woman's male partner drinks alcohol everyday she is five times more likely to experience physical IPV (AOR = 5.62, $p < .01$) and over six times more likely to experience sexual IPV (AOR = 6.52, $p < .01$). These odds ratios are comparable to a recent study using national data which found that women in Uganda are six times more likely to experience IPV if their male partners often get drunk (N. Tumwesigye, Kyomuhendo, Greenfield, & Wanyenze, 2012). The impact of men's alcohol use on women's experiences of IPV in Uganda is higher than in other countries (Gil-Gonzales, Vives-Cases, Alvarez-Dardet, & Latour-Perez, 2006), perhaps due to the widespread consumption of alcohol. In 2004, Uganda had the highest per

capita alcohol consumption in the world (WHO, 2004) and, as of 2011, Uganda ranked second in alcohol consumption in Africa (WHO, 2011).

The link between alcohol and IPV is suggested to occur in a variety of ways. One proposed mechanism is that alcohol compromises a man's tolerance of negative emotions, such as frustration or disappointment, causing him to be more likely to overreact toward the source of their discomfort (Murphy & O'Farrell, 1996). Other explanations suggest that alcohol reduces men's inhibitions, causing them to behave in ways that they would not in an unaltered state (Collins, 1982). Conner and Ackerley (1994) propose that the combination of alcohol related factors contribute to the association between men's alcohol use and violence, mainly the physiological and cognitive effects of alcohol, the interaction of frustration and alcohol, and the tendency of men who drink to seek personal power. Gender interactionalists propose that both violence and alcohol consumption are behaviors through which men demonstrate or perform masculinity in accordance with social norms defining what it means to 'be a man' (Courtney, 2000). For example, men's alcohol use in Uganda is linked to respect and virility (N. M. Tumwesigye & Kasirye, 2006). Given the widespread use of alcohol in Uganda, more research is needed on the relationship between IPV and alcohol use and how the relationship is moderated by other factors such as economic stressors and gender.

Demographic Characteristics

Women in the study experienced less physical IPV if they were older, had attended or completed primary school (as compared to never attending school), and had fewer children. Although new to the literature on IPV in Uganda, these protective factors are found in the literature on IPV from other low and middle-income countries (WHO/LSHTM, 2010). Older women may be at less risk than younger women due to the fact that their male partners are

probably older. As men age, they are less likely to use any type of violence, other than self-inflicted violence such as suicide (WHO, 2002). The impact of having more children on women's risk of IPV may result from the increased stress on the family from having more children. Also, men who use violence against their intimate partners may also use having children and/or pregnancy as another form of exerting power and control. The significance of primary school contributes to a mixed body of research reporting that women's primary education is sometimes a protective factor from IPV and sometimes a risk factor (when compared to no education) (Vyas & Watts, 2009b). Although women's completion of secondary education has been found to be a protective factor in Uganda (Karamagi, et al., 2006; Speizer, 2010) and other LMICs (Vyas & Watts, 2009b), this study measured education as having attended or completed secondary school and found no protective impact on IPV.

Limitations

Results should be considered in light of study limitations. The lack of differences at the neighborhood level may be due to the nature of the sample. Participants came from two out of five administrative divisions in Kampala. These two, adjacent administrative districts are both outside the central commercial and business districts and were selected as part of a cluster randomized controlled trial. Thus, researchers intentionally selected similar neighborhoods in terms of demographic and predictive characteristics for use in the cluster randomized trial. Indeed, the descriptive analysis conducted as part of this study demonstrates the neighborhoods' similar characteristics in terms of nearly all demographic and predictive characteristics. The only characteristic upon which the neighborhoods differed was the percentage of individuals belonging to the Muganda tribe, which was not a significant predictor of IPV in the logistic model. Additionally, the small number of neighborhoods in the sample may have also resulted

in limited variability of neighborhood characteristics. The study maintains merit given the early stage of the literature on neighborhood characteristics and IPV, particularly in Uganda or Africa.

Although the binomial nature of the dependent variable may have also limited the variability, a bivariate analysis using chi-squared test of association of the frequency of violence (never, one time, a few times, many times) and neighborhood rates of social efficacy also resulted in non-significant findings.

The absence of certain measures in the dataset, such as men's current income or women's alcohol consumption, may result in the potential for over estimation of given variables in the model. Similarly, another potential limitation contributing to the null findings for collective efficacy may have resulted from inadequate measures.

One plausible explanation for these findings involves the potential for reverse causality when using cross sectional data. Violence against women by a male partner often occurs in combination with controlling behavior, such as limiting a woman's activities and interaction with others (Antai, 2011; Krantz, et al., 2009). Thus, women experiencing physical IPV may have less freedom or ability to prevent violence in their community, help other women experiencing violence, or other forms of community engagement.

Implications for Future Research and Practice

This study furthers the knowledge-base on IPV in Uganda, as well as the global literature on collective efficacy and self-efficacy to prevent IPV against women. Future research should examine the role of collective efficacy as a protective factor for IPV using a larger and more diverse sample of neighborhoods in Uganda and other countries in Africa. The field would also be furthered by research considering the potential interaction effect between collective efficacy and other significant factors such as socioeconomic status or age. Additional research testing the validity and reliability of the collective efficacy measure used in this is also recommended.

Findings from this study support the need to test the efficacy of interventions, such as *SASA!*, that aim to prevent violence against women through enhancing self-efficacy, and ultimately collective efficacy, to prevent IPV.

Given the significant relationship between daily alcohol use and IPV, additional research is needed to understand this relationship and test potential interventions which incorporate the reduction of alcohol use. Approaches such as *SASA!* that aim to engage community members on rethinking the roles that society places on men and women may consider incorporating discussions of masculinity and alcohol use or the negative impact of harmful alcohol use on one's family. Given Uganda's absence of a clear policy on alcohol (N. M. Tumwesigye & Kasirye, 2006), structural solutions such as laws limiting the density of alcohol establishments or number of hours in which alcohol establishments are able to remain open may also result in reductions in IPV.

Given the protective nature of electricity and women's income found in this study, research testing the potential impact of economic interventions such as microfinance or cash transfer programs on preventing IPV should be considered. Evidence supporting the protective nature of economic empowerment interventions suggests that only those approaches which also incorporate social norm change around VAW and women's equality tend to result in reduced IPV. Thus, one potential approach may be incorporating savings and loans groups in the same neighborhoods as those using social norm change approaches such as *SASA!*. Alternatively, microfinance or enterprise interventions may prove more beneficial at reducing IPV if they also incorporate consciousness raising and/or skill building activities on gender equality or shared decision making in relationships between men and women. Finally, given the widespread production and sale of homemade alcoholic drinks, the promotion of alternative income

generating activities may have the combined benefit of women's economic empowerment and a reduction in the availability of alcohol. Lastly, additional research is needed to understand the relationship of women's alcohol use on their experiences of IPV.

Conclusion

This study furthers the knowledge-base on IPV in Uganda, as well as the global literature on collective efficacy and self-efficacy to prevent IPV against women. Non-significant variation at the neighborhood-level supports other recent findings from at least one LMIC, but may also have resulted from the purpose of the sample as a baseline in a cluster randomized controlled trial. Women with higher self-efficacy to prevent IPV in their community were less likely to report experiencing IPV themselves, suggesting the potential effectiveness of interventions aimed encouraging women to take action in their community to prevent IPV. The significance of other risk (young age, accepting IPV, partner's alcohol use, many children) and protective (primary education, women's income, electricity) factors also contribute to the understanding of IPV against women in Uganda and better inform ongoing or future prevention interventions. Finally, this study contributed to the advancement of social disorganization theory by testing a non-global collective efficacy measure on the prevention of IPV in one's community.

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Dissertation Paper 2:

The Effect of Displacement on Intimate Partner Violence against Displaced Women in Northern Uganda

Introduction

For over twenty years, conflict between guerrilla rebels of the Lord's Resistance Army and the government of Uganda plagued the northern part of the country. The conflict displaced over 2 million people, forcing an estimated 85% of internally displaced persons (IDPs) to live in government-created camps called protectorate villages (Roberts, Ocaka, Browne, Oyok, & Sondorp, 2008). The protectorate villages have been characterized by over-crowding, poverty, health and mental health risks, and gender-based violence (Dolan, 2009; MoH/WHO/UNICEF/IRC, 2005; Roberts, et al., 2008). While many internally displaced persons in northern Uganda are now returning to their place of origin, many other persons remain displaced in the region and around the world. According to UNHCR, an estimated 36.5 million people around the world are displaced due to conflict (UNHCR, October 2010).

Global attention and research on gender-based violence in displacement (commonly referred to as humanitarian) settings has largely focused on sexual violence perpetrated by rebels or military forces (Annan & Brier, 2010; Henttonen, Watts, Roberts, Kaducu, & Borchert, 2008; Hynes & Cardozo, 2000; Orach, et al., 2009; L. Stark & Wessells, 2012). However, a systematic review of gender-based violence in humanitarian settings found that women are most likely to experience intimate partner violence (IPV) than any other form of violence (Lindsay Stark & Ager, 2011). Yet, little evidence exists to suggest whether women who have been displaced are at increased risk of experiencing IPV as a result of the displacement. Researchers and practitioners regularly highlight the link between displacement and IPV (McGinn, 2000; Rothkegel, et al., October 2008; Szczepanikova, 2005; Ward & Vann, 2002) and some even specifically suggest a causal relationship (Okello & Hovil, 2007). Despite these claims, few

studies exist empirically testing either an association or a causal relationship between displacement and IPV.

The majority of literature directly linking displacement and women's risk of IPV in Uganda and elsewhere focuses on the interaction of relationship and societal-level factors, particularly relationship stress and the renegotiation of gender which occurs during displacement (Annan & Brier, 2010; Horn, 2010; Okello & Hovil, 2007). Claiming a "causal relationship between [men's] humiliation and domestic violence," Dolan (2009) argues that men's abuse of women, other family members, and themselves results from the masculinity crises experienced by men in northern Uganda (p. 210). This masculinity crisis, according to Dolan's ethnographic research, manifested from men's sense of powerlessness in a domestic or political arena due to the conflict and living in displacement villages. Men's accessibility to agricultural land decreased when forced to live in displacement camps, simultaneously decreasing their ability to earn a livelihood and increasing women's importance as breadwinners for the family (El-Bushra, El-Karib, & Hadjipateras, 2002). Similarly, a qualitative study in a displacement setting in Kenya, found that IPV increased during displacement due to limited economic opportunities and increased dependence on humanitarian aid that led to changes in traditionally held roles and responsibilities for men and women (2010). Specifically, men's inability to fulfill traditional responsibility as economic provider for the family was believed to decrease men's perceived masculinity, leading to stress and an increased use of IPV to reinstate a sense of power.

Although not specifically referenced in the burgeoning literature on IPV and displacement, these arguments align with a gender interactionalist explanation of IPV. According to an interactionalist perspective, gender does not originate from innate or biological characteristics, but is rather demonstrated through a relational performance with others (West & Zimmerman,

1987). As an explanation for IPV, men use violence against women as a means of performing masculinity—particularly when they are unable to demonstrate masculinity through other socially prescribed means (such as physical protection or economic support).

A review of the broader literature on forced displacement indicates that displacement is associated with numerous other individual, relationship, community, and societal conditions which are known risks factors for IPV in other contexts in low and middle income countries (WHO/LSHTM, 2010). At an individual-level, displaced persons are at an increased risk of substance abuse, compromised mental health, disrupted educational attainment, and unemployment (Aguilar & Retamal, 2008; Porter & Haslam, 2005; Weaver & Roberts, 2010). Forced displacement may also increase relationship stress or changes in educational or income disparity between spouses, also associated with increased risk of IPV in other contexts (Horn, 2010). At the community-level, forced displacement is thought to affect social networks and trust (Ward & Vann, 2002), other potential contributors to IPV. Finally, women may be put at additional risk of IPV during conflict and displacement due to societal-level changes or reinforcement of social norms around gender, power, and violence or a breakdown in the rule of law (L. Stark & Wessells, 2012; Ward & Vann, 2002).

Evidence on violence against women in northern Uganda, particularly by an intimate partner, while limited, is likely more extensive than many other humanitarian contexts. Most studies that do exist use qualitative methods to examine programming and to address gender-based violence (GBV) more broadly (Henttonen, et al., 2008; Landegger, et al., 2011; Okello & Hovil, 2007). The term gender-based violence (GBV) refers to any "harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females" (IASC, 2005, p. 7). In a study on GBV using a systematic random sample across four

camps in northern Uganda, Stark and colleagues found that 51.7% of women reported experiencing physical IPV and 41.0% reported experiencing sexual IPV (marital rape) in the last year.

In the larger population, Uganda ranks at the higher end of regional and global IPV prevalence rates (Claudia Garcia-Moreno, et al., 2006; Gass, et al., 2011; Rico, et al., 2011). A population-based survey found that 57% of currently or formerly married women of reproductive age in Uganda report having experienced at least one kind of violence (physical or sexual) by an intimate partner (Speizer, 2010). The same population-based survey found that nearly one in four women reported that their first sexual intercourse was forced, the majority by an intimate partner (Uganda Bureau of Statistics (UBOS) and Macro International Inc., 2007). Studies on social norms around IPV in Uganda report that the majority of men and women condone or justify IPV. For example, studies have found that 73% to 90% of women and 57% to 70% of men in Uganda believe intimate partner violence (IPV) is justified (Koenig, et al., 2003; Speizer, 2010). Furthermore, there are no national laws protecting women from violence within marriage (Amnesty International, 2010).

Given the dearth of evidence on the causal relationship of displacement on IPV, the purpose of this study was to determine whether women who have displaced in northern Uganda are at increased risk of experiencing IPV than if they had not been displaced.

Methods

Sampling

The proposed study used data from a nationally representative survey, the 2006 Uganda Demographic and Health Survey (UDHS). Conducted between May and October 2006, the full survey includes a sample of 8,531 women aged 15 to 49 years. The survey employed a multistage sampling strategy. Researchers first selected a random sample of enumeration areas,

then systematically selected a random sample of households in each enumeration area. All eligible women in each household were approached and asked to participate in the general interview on women's health. One out of every three households was selected to receive the interview module on domestic violence (IPV). Within each household selected to receive the domestic violence module, researchers invited one ever-married or partnered woman to respond to questions on domestic violence. The total sample size of ever-married women selected to complete domestic violence question module was 2,169. Fifty-eight women (two from IDP camps) were selected, but did not complete the domestic violence module due to an inability to find privacy. An additional 24 women (one from an IDP camp) did not complete the survey for other reasons, not provided by DHS. The sub-sample selected to complete the domestic violence module almost identically represents the larger UDHS sample of women on age, marital status, residential, regional, educational, and wealth index distributions (Uganda Bureau of Statistics (UBOS) and Macro International Inc., 2007). The UDHS dataset is unique in that it is the only country-wide representative survey that includes questions about IPV and is one of the few large data sets collecting information on both displaced and non-displaced populations. The UDHS was conducted again in 2011, but given the return of many displaced persons to their villages, the survey did not gather information on displacement.

Measurements

Internally displaced (treatment variable). Women who were currently living in an internally displaced village were coded as "1" (all other women were coded as "0").

Intimate partner violence (outcome variable). The questionnaire contained nine questions adapted from the Conflict Tactics Scale (Straus, 1990) about specific physical and sexual violent behaviors experienced by women who were in an intimate relationship within the last 12 months.

Seven questions asked about experiences of physical violence (push, shake or throw something; slap; twist her armor pull her hair; punch her with his fist or with something that could hurt; kick her, drag her or beat her up; try to choke her or burn her on purpose; threaten or attack her with a knife, gun, or any other weapon) and two questions assessed sexual violence (physically force her to have sexual intercourse with him even when she did not want to and force her to perform any sexual acts she did not want to). Experience of any type of physical or sexual violence at least once during previous 12 months was coded as "1" (no experiences of IPV in the last year were coded as 0).

Matching variables. Eight pre-treatment variables were available or created to match displaced and non-displaced women. For displaced women, calculations were conducted on several of the matching variables using the number of years in current residence (displacement village) to create a 'pre-treatment' measure. Women's age at time of displacement was modeled as continuous variables and, for displaced women, calculated by subtracting number of years lived in current residence (displacement village) from her age at time of survey. Women's number of children at displacement, also modeled as a continuous variable, was calculated for displaced women using the ages of her children at the time of survey and the number of years since displacement. Women's education level was modeled as a categorical variable including no formal education, primary, secondary, and higher. For displaced women, education level was calculated by subtracting her number of years in current residence (displacement village) from number of years of education at time of survey and her age at time of survey. The resulting number of years of education was transformed into the appropriate category. Religion was modeled as a categorical variable for Protestant, Catholic, Pentecostal, and other. A dummy variable for polygamous was assessed using the question, 'Does your husband live with more

than one wife or woman as if married?'. In the northern region of Uganda, polygamy is equally common for all people, regardless of displacement status (Uganda Bureau of Statistics (UBOS) and Macro International Inc., 2007). Thus, it is unlikely that displacement affected polygamy status, justifying it as a pre-treatment variable. IPV in the family of origin was included as a dummy variable and determined by asking women if their father beat their mother. Age of sexual debut was modeled as a continuous variable and, for displaced women, dropped or coded as not yet having sexual intercourse if sexual debut occurred before displacement. Forced first sexual debut, a dummy variable, indicates whether women's first sexual intercourse was forced or wanted. This variable was also only calculated for displaced women whose sexual debut occurred before displacement and was otherwise dropped.

Data Analysis

When studying the causal effect of forced displacement on any given outcome, the gold-standard randomized experiment is neither ethical nor feasible. To approximate random assignment to displacement and a control non-displacement groups, this study uses propensity score matching. Propensity score matching is based on Rubin's (1974) Causal Model. The procedure aims to ascertain the counterfactual by matching cases who have received the treatment (been displaced) with cases who have not received the treatment (not been displaced). Matching is achieved by determining one confounding variable that is a combined score of multiple confounding variables (the propensity score). Matching with replacement will be used to reduce bias, meaning that a person not in the treatment group may be matched more than once to a person in the treatment group if they have similar propensity scores.

In this study, the outcome of interest is whether or not women experienced any sexual or physical violence from an intimate partner in the last 12 months. The first step of the analysis

involved bivariate comparisons of the outcome variable of interest, intimate partner violence, and matching variables. In the second step of the analysis, a pre-match comparison analysis was conducted to test for overlap in treatment groups. The third step involved obtaining balance based on the following identified confounding covariates: age, education, religion, IPV in family of origin, age of sexual debut, forced first sexual debut, number of children, polygamous marriage. Sufficient balance was assessed based on closeness to the following criteria: 1) the difference in means for each continuous variable to be less than or equal to .05 treatment group standard deviations, 2) the ratio of standard deviations for each continuous variable to be between .91 and 1.1, and 3) the difference in percentages across groups for each binary variable to be less than or equal to .025 (Gelman & Hill, 2007). Next, a post-match comparison was conducted by again plotting histograms and bar graphs for the propensity scores in each group separately. Finally, the estimate of the treatment effect of displacement on IPV was determined through a regression-adjusted matched estimate using weights. Weights, necessary due to the use of matching with replacement, equal the number of times each observation was used in the analysis. Thus, each observation in the treatment group gets a weight of "1" and each control gets a weight equal to the number of times it was used as a match. Analysis was conducted using STATA 12.

Results

In bivariate analyses, compared to non-displaced women, displaced women were less likely to experience sexual violence from a partner in the last 12 months ($\chi^2 = 11.3082$, p=0.001) and more likely to experience severe physical violence ($\chi^2 = 11.8997$, p=0.001) (See Table 1). There was no difference in displaced women's experiences of less severe physical violence ($\chi^2 = 0.9651$, p=0.326). A larger, though not statistically significant, percentage of non-displaced

women reported experiencing at least one form of physical or sexual IPV in the last 12 months ($\chi^2 = 0.5697$, p=0.450).

Table 4. Women's experiences of violence from an intimate partner in the last 12 months, in percentages

Variable	Displaced	Non-displaced	Test statistic (t test or χ^2)	P value
Sexual violence	14.11	26.09	11.3082	0.001
Less Severe Physical Violence	34.81	31.00	0.9651	0.326
Severe Physical Violence	31.41	6.23	11.8997	0.001
Any Physical or Sexual Violence	40.76	43.90	0.5697	0.450

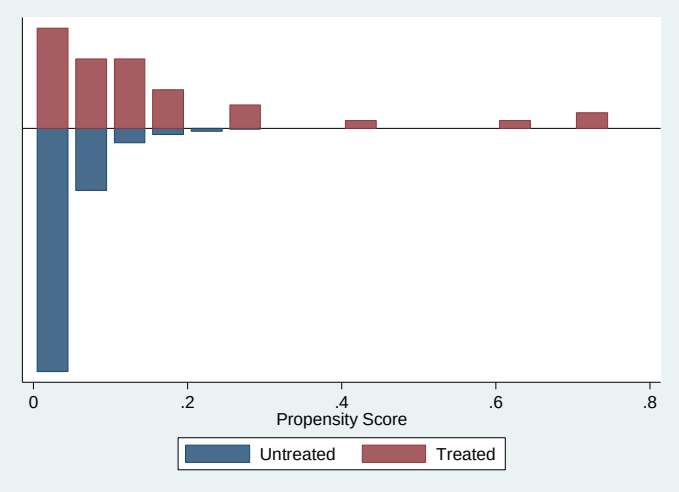
Displaced women differed from non-displaced women on many pretreatment covariates (See Table 2). Descriptive statistics of the treatment and control groups show that displaced women tend to be younger, have fewer living children, completed fewer years of education, and had a father who beat their mother. Displaced and non-displaced women also vary significantly by religious affiliation, with two thirds of the former identifying as Catholic.

Table 5. Covariates

Variable	Displaced (mean or %)	Non-displaced (mean or %)	Test statistic (t test or χ^2)	P value
Age	27.01	28.77	2.61	0.009
Education in years	3.2	4.79	5.41	0.000
Number of living children	2.8	3.20	2.066	0.0389
Polygamous marriage	34.72	29.09	5.570	0.135
Religion: Catholic	66.84	43.05	52.2724	0.000
Protestant	22.63	33.25		
Pentecostal	7.89	7.83		
Muslim	0.53	11.57		
SD Adventist	0.00	2.32		
Other	2.11	1.92		
Father beat mother	55.61	44.42	22.246	0.000
Age of sexual debut	18.12	16.75	1.18	0.2371
First sexual intercourse was forced	20.11	24.35	1.55	0.213

In the second step of the analysis, the presence of sufficient overlap between displaced women and non-displaced women was conducted by examining the overlaid graphs of each group's propensity scores. Figure 1 shows the original two-way histogram of propensity scores for the treated (displaced women) and untreated (non-displaced women).

Figure 2. Overlap of propensity scores of treated (displaced) and untreated (non-displaced)



While sufficient overlap appears on the left side of the graph, the red bars on the right side of the graph represent four individuals in the treatment group who do not have sufficient overlap with those in the untreated group. Given that there is not sufficient overlap for these individuals, and that they are few in number, they were dropped from the final analyses. The table below provides a summary of those four individuals.

Table 6. Description of displaced women for whom insufficient overlap exists

	Woman 1	Woman 2	Woman 3	Woman 4
Experienced any IPV in last 12 months	No	No	No	Yes
P-score	.4445	.6132	.7247	.7457
Age	16	16	18	15
Number of children	1	1	1	1
Religion	Protestant	Pentecostal	Catholic	Catholic
Father Beat Mother	Yes	No	No	Yes
Education	Primary	Primary	Primary	Primary
Relationship is Polygamous	No	No	Yes	No
Forced Sexual Debut	Forced	Wanted	Wanted	Wanted
Age of Sexual Debut	17	19	At marriage	At marriage

Upon determining sufficient overlap for the vast majority of the treatment group, the third step involved making modifications to the model in attempt to achieve better balance. Sufficient balance was achieved for the majority of covariates, including the two most important theoretical variables among all confounding pre-treatment variables (i.e., whether or not a woman's father beat her mother and attending secondary education) (World Health Organization/London School of Hygiene and Tropical Medicine, 2010). Ideal balance was not achievable on some variables: age, age of sexual debut, polygamous, no education, and protestant (See Table 3).

Table 7. Balance of key confounding covariates

	Treated	Control	Absolute difference in percentage	Absolute difference in means/SD of treatment	Ratio of SD
Age	27.047	28.907		0.074[a]	0.91
Children	2.465	2.558		0.024	0.94
Age of Sexual Debut	14.116	14.953		0.202[a]	2.15[b]
Polygamous	0.442	0.140	0.302[c]		
No Education	0.372	0.326	0.046[c]		
Primary Education	0.605	0.651	0.026		
Secondary Education	0.000	0.000	0.000		
Higher Education	0.023	0.023	0.000		
Catholic	0.744	0.767	0.023		
Protestant	0.186	0.209	0.091[c]		
Pentecostal	0.070	0.023	0.047		
Other Religion	0.000	0.000	0.000		
Father Beat Mother	0.628	0.605	0.023		
Forced Sexual Debut	1.140	1.163	0.023		

a Does not meet balance based on the cut-off value of less than .05.
b Does not meet balance based on the cut-off value of greater than .91 and less than 1.1.
c Does not meet balance based on the cut-off value of less than .025.

In the final step of analysis, the estimand of the treatment effect of displacement on IPV was determined through a regression-adjusted matched estimate using weights to force the sample to represent matched pairs. As shown in Table 4, women who are displaced were less likely to have experienced intimate partner violence during the last 12 months than they would have been had they not been displaced (OR=.21, p=.014), given that assumptions hold. In other words, women who have been displaced are 4.59 times less likely to experience intimate partner violence than if they had not been displaced.

Table 8. Final logistic regression including propensity score weights

	Odds Ratio	Robust Standard Errors	P value	95% Confidence Interval
Displacement	0.218	0.136	0.014	0.065, 0.737
Age	0.821	0.057	0.004	0.717, 0.940
Number of children	1.905	0.495	0.013	1.145, 3.171
Age at sexual debut	1.093	0.091	0.286	0.928, 1.287
In polygamous marriage	7.150	5.463	0.010	1.599, 31.965
Primary Education (Ref: No Education)	1.064	0.663	0.921	0.314, 3.608
Secondary Education	1	omitted		
Higher Education	0.999	3.645	1.000	0.001, 1271.821
Protestant	0.954	0.665	0.946	0.243, 3.742
Pentecostal	.357	0.512	0.473	0.021, 5.952
Other Religion	1	Omitted		
Father beat mother	1.688	.975	0.365	0.544, 5.238
First sexual debut was forced	4.488	1.909	0.138	0.720, 10.687

Discussion

Contradictory to the study hypothesis, these results suggest that women who are displaced in Uganda are less likely to experience intimate partner violence than if they had not been displaced. Forced displacement due to conflict is a flagrant violation of human rights and should never be considered as an advisable policy. However, what may prove useful is the examination of conditions and resources in displacement camps that could be replicated elsewhere to continue protecting displaced women and better protect other women from IPV. Potential explanations of these findings include increased attention and programming related to gender-based violence and

a redistribution of opportunities and resources between men and women. Recommendations for future research and implications for programming will be discussed.

Findings from this study call into question the commonly cited gender interactionalist explanation of IPV claiming that men use violence against their intimate partner at higher rates due to increased stress and challenged masculinities. While men's struggle with humiliation and masculinity in conflict settings proves a real and important phenomenon, its relevance in the prevention of IPV for displaced women may be superseded by the presence of other protective factors. These findings are particularly germane given the intensified focus on men and masculinities in global GBV prevention efforts.

Displaced women's increased economic power relative to their husbands may help explain their reduced risk of IPV. According to Marital Dependency Theory, women enter into or stay in abusive relationships due to financial dependence on their partners. If women are able to obtain increased financial power they will be able to leave or avoid violent relationships. Although the relationship between women's income and IPV is mixed in the global literature (Vyas & Watts, 2009b), increased income among a sample of women in Kampala served as a protective factor from IPV (Carlson et al., in preparation). Descriptive data from the UDHS show that, compared to non-displaced women, displaced women are more likely to earn more than or equal amounts as their husbands. Around 55 percent of displaced women report earning less than their partners, compared to 80 percent of non-displaced women ($\chi^2 = 31.2205$, $p<.000$). Furthermore, displaced women (21.53%) are more likely that non-displaced women (13.80%) to have the final say on large household purchases ($\chi^2= 6.38$, $p= 0.041$).

Another potential explanation for women's experiences of IPV may be reduced use of alcohol by male partners among refugee populations, compared to the larger population in

Uganda. Indeed, cross sectional studies elsewhere in Uganda have found that men's alcohol use is a highly predictive risk factor for IPV (Carlson et al., in preparation). In a qualitative study with displaced women in northern Uganda, Annan and Brier (2010) reported that nearly all incidences of IPV were precipitated by alcohol use by their partner. However, Roberts and colleagues (2011) found alcohol use rates to be lower amongst displaced populations in northern Uganda, as compared to studies from the larger population. Analysis of data from the UDHS found no statistically significant difference in the frequency with which a woman's partner gets drunk between refugee populations and non-refugee populations. Thus, less alcohol use among displaced men may serve as one reason for women's lower risk of experiencing IPV after displacement.

Results from this study may also provide evidence in support of humanitarian GBV programming and coordination among agencies in place in northern Uganda at the time of the survey. In 2006, Northern Uganda was chosen as one of four global settings to pilot the Cluster Approach to humanitarian response. The Cluster Approach mandates the coordination of all humanitarian efforts, includes a gender-based violence sub-cluster, and assigns key agencies in charge of coordinating gender-based violence prevention and response programming. A case study of the Cluster Approach in Uganda found that while not all sectors benefited, the approach greatly improved gender-based violence programming.

Representatives from international, national, and governmental agencies working in Gender-based violence prevention and response in northern Uganda reported that the Cluster Approach helped to delineate roles and responsibilities, establish common training and funding opportunities, improve coordination of referrals, and build capacity of government actors (Landegger, et al., 2011). In fact, the Inter-Agency Standing Committee (the global coordinating

body for humanitarian response) chose Uganda as the site for a "GBV Good Practices Mission Report"(IASC, 2008). Furthermore, the IASC Guidelines for GBV Coordination in humanitarian settings recommend gender parity in camp employment and leadership positions, thus potentially creating an environment more sensitive to women's protection and empowerment (IASC, 2005). Hence, the institutional acknowledgement of GBV as a real and important issue and well-coordinated, albeit imperfect (Henttonen, et al., 2008), GBV programming may have resulted in displacement women's protection from IPV.

Study findings must be considered in light of limitations. Requisite assumptions for this causal effect include SUTVA, ignorability, sufficient overlap, and balance. The nature of secondary data analysis limits the ability to include all relevant variables, thus potentially threatening the assumption of ignorability. For example, no pre-treatment variable existed in the dataset on socioeconomic status *prior* to displacement. Thus the analysis did not include a matching variable on pre-displacement socioeconomic status.

Another assumption for causality is sufficient overlap of treatment and non-treatment groups. As previously discussed, four women from the treatment group did not have sufficient overlap with women in the untreated group and were dropped from the model. Finally, ideal balance was not achievable on some potentially important matching covariates. Chief among these variables theoretically, is polygamy. In Uganda and in the global literature on intimate partner violence, women in polygamous marriages are at increased risk of experiencing IPV. However, better balance could not be attained for polygamous relationships without sacrificing balance for other variables of greater theoretical importance. Although lack of formal education was not fully balanced, the effect of education is shown in a systematic review to reduce women's experiences of IPV only after the attainment of secondary school or above (Vyas & Watts, 2009a).

Future studies should examine the causal relationship between displacement and IPV in other humanitarian contexts, as well as the potential mediating roles of humanitarian programming, women's income, and men's alcohol use. Since most research on men's threatened masculinity on IPV in displacement is qualitative, a need exists for additional research that uses knowledge from qualitative studies to inform quantitative inquires. Furthermore, continued research is needed to monitor the impact of the handover of GBV programming to government actors on women's experiences of IPV in northern Uganda, particularly given concerns around government capacity to implement GBV prevention and response programming (Henttonen, et al., 2008; Landegger, et al., 2011).

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Dissertation Paper 3:

Community Leaders' Understanding of Intimate Partner Violence against Women in Kampala, Uganda and their Role in Responding to and Preventing Violence

Introduction

Uganda is a landlocked country in eastern, sub-Saharan Africa with a population of 33.6 million persons (CIA, 2012). More than 80% of Ugandans live in rural areas, and the majority of urban residents live in the nation's capital, Kampala (Speizer, 2010). Ninety-seven percent majority of Ugandans identify as Catholic (42%), Protestant (42%), or Muslim (13%). A strong women's movement in Uganda contributed to the establishment of the Ministry of Gender, Labor and Social Development in 1986. The guarantee of non-discrimination on the basis of sex included the revised 1995 Constitution, and the proliferation of civil society organizations supporting women's rights. Despite these developments, Ugandan women have not shared the same rights as men under the law or within society. Traditions such as polygamy, widow inheritance, and bride price are considered to contribute to women's subordinate status and risk of experiencing violence. For example, when men and women get married in Uganda, it is common in many districts for the husband and his family to pay a bride price to the wife's family of origin. In exchange for this payment, the wife is commonly considered property of the husband and may not share equal decision making power about the children, finances, and other aspects of the family. Furthermore, a bride price may contribute to an expectation that a wife must consent to sex at any time (Amnesty International, 2010). Polygamy is also common in Uganda, a known risk factor for IPV. Furthermore, if a woman's husband dies she often becomes the property of his brother or family, perpetuating gender inequalities. After years of advocacy and numerous failed attempts, the Domestic Violence Act was passed in 2010 outlawing physical, sexual, emotional, and economic abuse within marriage.

Present day gender relations and expectations for women in Uganda stem from a long history of both African and British colonial influence. In what they identify as the 'Domestic Virtue

Model,' Kyomuhendo and McIntosh (2006) outline a set of expectations of women originating from both African and British values at the turn of the 20th century that have maintained significant influence on modern day Ugandan society. Core elements of the Domestic Virtue Model include expectations for women to marry and bear children; assume operation of the household; remain submissive to men; leave decision making to men; and use resources, but not own them. Women's adherence to these interrelated expectations results in whether they are perceived as a good woman and respected by her community. According to the Domestic Virtue Model, men's use of violence against women results from violations of these established expectations on women's responsibilities and place in society.

National prevalence rates of intimate partner violence rank Uganda on the higher end of regional and global rates (Claudia Garcia-Moreno, et al., 2006; Gass, et al., 2011; Rico, et al., 2011). A population-based survey found that 68 percent of ever-married women in Uganda have experienced at least one kind of violence (physical, sexual or emotional) by an intimate partner (Speizer, 2010). The same study found that 55% of ever-married women reported experiencing at least one kind of violence in the last 12 months.

A 2003 study in Rakai, a rural district in central Uganda, reported that the most common reason for physical assault against women by a male partner was a woman neglecting the household chores. Women reported other reasons for experiencing violence such as disobeying their husband or elders, refusing sex, arguments over money, or suspected infidelity of the woman (Uthman, Lawoko, & Moradi, 2010). Compared to women with no education, women with a secondary education were less likely to experience violence. Also, women with many children were less likely to experience violence. Other factors associated with risk of violence were not being formally or legally married to a partner and being in a relationship for less than

10 years. Alcohol use before sex, especially by male partners, was found to be a predictor of a woman's risk of experiencing violence. If a woman thought it was very likely that her husband was HIV positive, she was almost four times more likely to experience violence (Uthman, et al., 2010).

Both quantitative and qualitative studies from Uganda have found widespread social norms which condone or justify violence against women from a male partner. Studies have found that 57% to 70% of men and 73% to 90% of women justified violence against an intimate partner for at least one reason (Koenig, et al., 2003; Speizer, 2010). Reasons for justifying male violence against a female partner include: a woman refusing to have sex with her partner, a woman using contraception without her partner's permission, a woman neglecting the household or children, a woman disobeying family expectations, arguing with the husband, going out without informing the husband, burning the food, and a woman's infidelity (Koenig, et al., 2003; Speizer, 2010). Ugandans tend to have attitudes which condone violence against women if they are of younger age, reside in a rural area or urban area outside of Kampala, have four or fewer children, do not identify with a religious affiliation, and saw their father beat their mother during childhood. In contrast to other studies in sub-Saharan Africa, educational attainment and wealth/income status has been shown to have no significant association with attitudes condoning violence in Uganda (Uthman, et al., 2010; World Health Organization, 2002).

Community Leaders

Although previous studies have considered attitudes on violence against women among the larger population in Uganda, very few studies have explored the views of community leaders. Community leaders and service providers can have a large impact on attenuating the negative effects of IPV on a victim and preventing future incidences by refusing to provide sanctions for

perpetrators (Counts, Brown, & Campbell, 1992). Conversely, Campbell (2002) claimed that a survivor's experience engaging with service providers who reinforce stigma or self-blame is so traumatic that such an event could be called 'the second rape'. However, the way in which community leaders and service providers work with survivors or work to prevent violence in their community is influenced by their attitudes toward violence and accepted gender roles. A review article found that community members with attitudes that condone or justify violence against women "respond with less empathy and support to victims, are more likely to attribute blame to the victim, are less likely to report the incident to the police, and are more likely to recommend lenient or no penalties for the offender" (Flood & Pease, 2009). In addition, for institutional actors, such as police officers, judges, religious leaders, social workers, and health care practitioners, supporting or justifying violence influenced their response to survivors.

In Uganda, formal reporting of domestic violence cases most often occurs through the local council system, a hierarchical system of councils and committees that provide a forum for people to interact with authorities. According to one study, 8.5% of all intimate partner violence cases were reported to the local council mechanism, as opposed to 2% reported to the police and 0.2% reported to the formal justice system (ICRW/UNFPA, 2009, p. 8). The lowest level of the council system comprises elected representatives, including men, women, and youth. The local councils do not necessarily have legally mandated authority, but are seen as authorities in the community. Cases which are prosecuted in an official court of law are typically the most severe situations and, prior to the Domestic Violence Act, done so through general assault charges (ICRW/UNFPA, 2009). Police officials tend to be the last resort in intervening in situations of domestic violence. However, police officials in Uganda reported widely held attitudes that

blame women for the violence used against them and believe that preserving the family is more important than supporting women's rights and safety (Amnesty International, 2010).

Throughout Uganda, the most common sources from which women seek support are from their own family or in-laws, followed by friends or neighbours and social service organizations. A traditional institution, sengas or traditional aunties, tend to be a more common source of informal support and intervention in relationships between men and women. The traditional role of a senga is to counsel young women on preparing for marriage, including aspects of sexual behaviour (Muyinda, Nakuya, Pool, & Whitworth, 2003). Although little is known about sengas understanding and role in responding to intimate partner violence, they serve as a one of the first sources called upon when couple's experience conflict. Given the high percentage of Ugandans who identify with a religious affiliation, religious leaders prove another important source of influence and assistance in the prevention and response to violence against women. Medical providers serve as another source of support for survivors and leaders in the community. In a nationally representative survey of health care providers in Uganda, 68% said that they treated at least one woman per week for injuries resulting from intimate partner violence (Kaye, Mirembe, & Bantebya, 2005). These providers, each seeing on average 52 women who have been abused by a partner per year, have an opportunity to help women at a critical time. Though most women in Uganda do not seek institutional support, an Amnesty International report claimed that those who do seek services tend not to receive adequate support from shelters, legal aid centers, health facilities, or law enforcement. The current study sought to understand how community leaders[1] (police, religious leaders, sengas, local council leaders and health care providers) in Kampala,

[1] The term 'community leaders' was selected as a result of a discussion between the author and a group of local staff from Ugandan civil society organizations working to prevent domestic violence (Raising Voices and the Center for Domestic Violence Prevention). Although research from some cultural contexts may refer to health care workers, for instance, as service providers, Ugandan colleagues agreed that the overall prominence persons in these positions hold in the community make them more accurately described as community leaders.

Uganda understand violence against women in intimate relationships and their role in responding to or preventing violence.

Methods

This study used secondary data analysis of focus groups conducted July through September 2008 with police, religious leaders, sengas (traditional aunties), council leaders and health care providers in Kampala, Uganda. Data were collected as part of a cluster randomized control trial testing the efficacy of SASA!, a community-mobilization intervention to prevent intimate partner violence and HIV. The SASA! intervention aims to change norms that consider men as more powerful and valuable than women and seeks to raise awareness about the health benefits for everyone when men and women share power in the home and community (Raising Voices, 2008).

Data Collection

Participants were recruiting differently, depending on the group. To recruit the local leaders and sengas, a formal request letter was sent to the chairperson of each parish. The chairperson then recruited local leaders from their parish in addition to sengas from their respective community. A formal letter of participation request was also sent to the police, health care providers, and the respected religious leaders. The letters specified the eligibility criteria for participants. For example, a request was made to the police for purposeful sampling of members from multiple units, including the front desk, criminal unit, and the family and child protection unit.

Eight focus groups were conducted with different types of community leaders: local council leaders, health care workers (two separate groups comprised of different health care workers), religious leaders, Muslim religious leaders, police, and sengas (two separate groups comprised of

different sengas). Focus groups were conducted in English and Lugandan, one of the most common native languages spoken in south and central Uganda. Each group contained unique participants, except for the two groups of religious leaders. The first focus group with religious leaders included religious leaders from multiple faiths, including Christian and Muslim. However, upon completion of this group, the Muslim leaders requested that a second focus group be conducted with only Muslims. The number of participants in each group ranged from 7 to 11, with the exceptions of one health care worker group that had 4 participants and the police group which had 17 participants. The focus groups with religious leaders and Muslim leaders contained only men while the focus groups with sengas and one of the health care workers contained only women. Discussions with one health care worker group, local leaders, and police comprised both men and women. Some transcripts of the focus group recorded the sex of the participants speaking throughout. However, others did not. Whenever possible, the sex of the speaker will be indicated (except for sengas who are all female and religious leaders who were all male).

Focus groups were led by two local facilitators, one female staff of an organization for the prevention of violence against women and a female local research staff. Both completed a comprehensive 7-week research training course. Informed consent was obtained from all focus group members prior to participation. Approval to conduct research with human subjects was granted to the Principal Investigators of the parent study by the London School of Hygiene and Tropical Medicine, the Makerere University Medical School, and the Uganda National Council for Science and Technology. Given the secondary analysis of this study, human subjects exemption was received from Columbia University.

Data Analysis

This study used the 'framework analysis' approach outlined by Krueger (1994) and Ritchie and Spencer (1994). Framework analysis is recommended for focus group analysis (Rabiee, 2004) and involves five, interconnected steps to data analysis of qualitative data: familiarization, identifying a thematic framework; indexing; charting; mapping and interpretation. In addition to clearly delineated steps of analysis, framework analysis allows for themes to develop both from the research question and from qualitative narratives found in the data. The focus groups which were conducted in Lugandan were translated by one of the focus group facilitators using tape recordings of each discussion. Data analysis of all focus groups was conducted in English. The first stage of data analysis, familiarization, involved numerous readings of each of the focus group transcripts in full and observational notes taken during the focus groups. Given the secondary nature of this analysis, a longer amount of time was spent in the familiarization stage to obtain an overall sense of each of the focus group discussions. Furthermore, during familiarization, I engaged in conversations with the primary focus group facilitator to understand the overall ease of discussion and engagement of participants. This activity resulted in better understanding challenges that arose during and after the focus group facilitation that were not identifiable in the text. For example, by engaging in discussion with the primary facilitator, the researcher discovered that the discussion with religious leaders from multiple faiths proved contentious and the Muslim participants subsequently requested their own focus group because they did not feel the previous discussion adequately reflected their views.

During the next stage, identifying a thematic framework, I wrote memos and codes in the margin of the transcripts attached to ideas or concepts that arose from the text. For example, one idea which arose from the text across all of the focus groups was the concept that women want to

be beaten by their partners. Thus, the following short phrase, "women want beating" was attached to quotations such as the following from the focus group with police officers:

> And some women culturally believe that whoever is called a woman has to be beaten by a man. There are some women who say that if a man does not beat me, how will I know that he loves me?

The third and fourth stages, indexing and charting, occurred in close proximity of one another and first required the highlighting of individual quotations and making comparisons within and across cases in each focus group. Next, charting further contributed to data reduction by extracting quotations from their original context and arranging them under relevant themes. For example, one theme which emerged from the data was a fear that intervening in situations may put oneself at risk. Table 1 presents examples of quotations that were extracted from their original context and pasted together related to this theme.

Table 9. Example quotations for the theme, "Intervening is dangerous"

"Find out, if intervening, the tools being used. Because it could be a knife or machete, then it lands on you." (Local Leader)
"It depends on the family. Some men are bad. They can even turn on you and start beating you when you go to separate them." (Senga)
"Some men are bad. The tempers will be up and so he will just leave the wife and start beating you saying that it has always been you in love with my wife." (Christian Religious Leader)

The final stage in framework analysis, mapping and interpreting, involved analyzing individual quotations and connecting them throughout the data. To aid in this stage, the researcher considered the following criteria recommended by Kruger (1994): interpreting coded data; words; context; internal consistency; frequency and extensiveness of comments; specificity of comments; intensity of comments; and big ideas. While each of these criteria proved useful in

mapping and interpreting the data, one illustration of their use was in regards to *words* or considering the actual words used and their meaning. For example, at this phase of analysis, I examined the common use of the word "discipline" in relation or exchange with "wife beating". Such analysis aided in the understanding of participant's view of violence against women from male partners as a means of controlling or punishing women. The software programs ATLAS.ti and Microsoft Word were used to facilitate data management and analysis.

Table 2 presents the interview protocol for each focus group. By and large, the facilitators adhered to the wording and order of this protocol, asking clarifying or probing questions when relevant. Given the use of secondary data analysis, questions could not be changed based on initial findings from data analysis. Initial review of the interview protocol elicited recommendations on question wording of future studies. Certain questions, such as "What are the consequences of all these things on women, men and children?" assume that participants, in fact, believe that there are consequences on women, men and children. Instead, I would recommend asking a previous question to first inquire *if* participants believe there are consequences. Similarly, the question, "What practical suggestions would you give a man to avoid beating?" assumes that a participant would in fact give practical suggestions and that he, in fact, opposes wife beating. First asking a previous question asking if a participant would give advice or suggestions might prove less leading. Another question, "In our communities do women and men keep quiet about these challenges that women experience at home?" might have been better worded if asked about men and women separately. In regards to question ordering, question thirteen and fourteen might have been better asked toward the beginning of the focus group. In response to these questions in some of the focus groups, participants said that they had already discussed these issues.

Table 10. Interview Protocol for Focus Groups with Community Leaders

1. In our communities, it is normal or expected for a man to make all the decisions in the family to be the head of the household? Why or why not?
2. Are families stronger when men discipline their wives?
3. What does it mean for a man and a woman to balance power in a relationship?
4. In any relationship there are challenges. Sometimes women experience difficult things from their partners. For example, some women are beaten by their partners. What types of other things like this do women experience in our community?
5. Are there times when a man has a good reason to hit his partner? If yes, please describe these situations?
6. What are the consequences of all these things on women, men and children?
7. In our communities do women and men keep quiet about these challenges that women experience at home?
8. What effect does this have on women? On their HIV status?
9. If you saw a man beating his wife, how might you handle this situation?
10. What practical suggestions would you give a man to avoid beating?
11. How could you support others in the community who are speaking out against violence?
12. Have you spoken out against violence in your family? Your social or work group? Your community? How?
13. Can you tell us one experience in the last one year when you did something that is different than what community expects of you as a man or a woman?
14. Do you think it is important to balance power in a relationship?
15. Do you feel there is social pressure on men to avoid using violence?

An initial analysis of the data may suggest that some questions were problematic by participants' responses challenging the questions. While participants' concerns with question wording proves valid, their responses also uncover beliefs regarding gender relations and violence against women. In two instances, a local council leader and a Muslim leader argued that these questions were biased against men.

> This questionnaire assumes that it is only the woman who experiences violence...There is no question that talks about violence against men. Yet, men also go through violence. (local council leader)

Similarly, a Muslim leader suggested the alteration of the questions.

> There is a need to adjust these questions. All the questions from the beginning to the last are bent on bringing men down. Can't we rephrase them? All are protecting women.

Considering these responses, future studies may wish to consider including more neutral questions and inquiring about violence against both men and women. Although the focus of this study is on violence against women, inquiring about violence against men may also serve to reveal underlying challenges in relationships and serve as a point of comparison for violence experienced by women. However, these responses prove valuable in demonstrating a belief that men's experiences of violence are equally important or concerning or perhaps suggesting an underlying lack of concern for violence against women.

Also in the focus group with Muslim leaders, a participant challenged the question on balancing power between men and women.

> I think you need to change this whole thing of power. It is very well known that power belongs to men. So there is nothing to teach people about or to change in communities.

In this instance, a Muslim leader objected to the wording of question while simultaneously revealing beliefs about relationships between men and women. Furthermore, a senga suggested that the term 'power' was not the appropriate word and that a discussion of 'responsibilities' would be better. While future studies may wish to alter questions with the word power or regarding violence against men, such objections in and of themselves proved useful sources of data and do not necessarily undermine the findings.

Results

Community Leaders Understanding of Violence against Women

Community leaders understanding of men's violence against women is intrinsically connected to beliefs in men's power and superiority over women. This theme arose in participants' understanding of violence against women through three interrelated ideas: men's authority, women are to blame for the violence used against them by men, controlling women's

sexuality. By and large, dependent upon belief in men's power over women, participants from each focus group justified men's use of violence against women or other forms of disciplining women. However, a small group of dissenting voices arose against violence against women, especially among health care workers and Christian religious leaders, suggesting the negative impact of violence against women and the need for men and women to live peacefully.

Men's authority.

During focus group conversations on violence against women, participants emphasized the importance for women to remain submissive to men's authority. Violence against women was widely discussed as an action taken when women do not abide by men's wishes or as a means for men to teach women what men want. Some participants defended the use of violence against women while others disapproved. However, most of those who disapproved of violence against women did not discount—and even reinforced— need for women to learn and abide by men's authority. Community leaders highlighted specific examples of the types of mistakes women may make that would warrant violence from their partners, such as neglecting the children or other domestic responsibilities.

Community leaders commonly viewed women challenging men's decisions as an attempt by women to achieve equal status with their partners, an act which participants believed would result in violence against women.

> But what I see is that as a woman, our men like humble people, so we should not seek to be equal with them. If the man is high, you as a woman you should be low, if your views differ him, he will use his status to harass you. (senga)

Furthermore, by neglecting the men's wishes or making their own decisions, some community leaders implied that women are acting like men and thus shaming or disrespecting their husbands and thus, deserve to be beaten.

Related to the theme of violence against women as a form of reprimanding women for defying men's authority, community leaders often used the term *discipline* as an alternative word to violence or beating. Muslim leaders, local leaders, and sengas argued that disciplining women makes the home stronger by teaching women, and subsequently their children, what the man of the house wants. For example, one senga suggested that disciplining women in the home would help women "learn how to be responsible and cater to their husbands."

Some community leaders who disapproved of violence against women, recommended finding "alternative ways of disciplining" (female health care worker). Health care workers and police officers, in particular, argued against violence as a form of disciplining because it can sometimes go too far. Sengas and Muslim leaders offered alternative ways that women can be disciplined, besides what they considered to be "beating" or "battering". According to one Muslim leader, "you can punish her differently, for example, refuse to eat her food, deny her sex, use a small cloth to beat her or beat with a stick, but not battering."

Muslim leaders were inconsistent in their views on whether or not their religion condones violence against women, although the discussion continued to uphold the view that the use of men's violence is to correct women for their mistakes. One Muslim leader was very clear that Islam does not condone wife beating:

> In Islam, there is no single time allowed to beat your wife. If she makes a mistake, call family members from all sides and you discuss. According to the teaching of the Prophet, there is no time when you should hit a woman.

However, another Shiek disagreed,

> For a woman in Islam to be beaten, she must have made a mistake forty times. So, there is no need to discipline [one's] wife. In Islam it teaches that if a woman makes a mistake, use a cloth, then a stick, later. The home will be stronger, but it depends on how the man handles it (Muslim leader).

Some community leaders disapproved of violence against women because of its ineffectiveness at getting women to do what men want. In fact, some leaders suggested that women may get use to the violence from their partners or the violence may reinforce women's wrongful misconduct.

> It is bad to discipline [women]. The home will be weak. [The couple] just needs to discuss [their problems]. Otherwise, this will make the women get use to being beaten or abused, so she does not change, but just continues doing what the men do not want" (senga).

The risk of making women "bigheaded" was suggested by sengas and local leaders to explain why men should not use violence. Bigheaded women are considered to be rebellious and not submissive to her partner's wishes. Discussion around men's authority sometimes indicated women as objects under the control or ownership of men. The quotation which most severely exemplifies men's control over women as objects came from a male local leader who likening being married to a woman to driving a car:

> It is good to beat women. In any marriage we are like in a car where the driver has to engage gears; you have to know that you are climbing a hill so you engage the appropriate gears. So in marriage, in most cases, women do not understand and do not follow instructions. So they need to be beaten to be awakened up to do what is right.

> Sometimes you tell the women to cook boiled rice but they cook fried rice. (male local leader)

Blaming women.

Reinforcing the notion that violence is women's faults was the view that women want or invite men's violence. In fact, the most commonly cited explanation for wife beating was that woman want or ask to be beaten. Both male and female participants from every focus group raised this idea. Some participants suggested that women want to be beaten to know they are loved by their partners. One police officer even claimed that being beaten by one's husband is a way of knowing or demonstrating one's womanhood.

> And some women culturally believe that whoever is called a woman has to be beaten by a man. There are some women who say that if a man does not beat me, how will I know that he loves me? (police officer)

In other references to this idea, participants—mainly women—implied that women ask to be beaten as a means of defiance against their husbands. According to one senga, "...the genesis of the problem is that sometimes as women we develop that thing of fight me and see what will happen, and we fail to realize that we have to be below the men at all times."

The focus on violence against women as a result of being a woman's fault, either because she disobeyed her husband or asked to be beaten, was intensified by the minimal reference to other explanations for men's use of violence against women. The only groups which identified other potential causes were the two health care worker discussion groups. One health care worker linked violence to men's alcohol use and men's control of decision making in the household. In the other discussion group with health care workers, a participant drew a connection between men's unemployment and violence against women.

> Even poverty itself can also cause a woman to be beaten. For example, if the man fails to get the money. He gets all the anger to the woman and he starts beating or abusing the woman because he failed to get the money. That is just an idea…[laughter]. (health care worker)

The laughter which such an idea evoked, in addition to general absence of linking men's unemployment to their use of violence throughout any of the focus group discussions, perhaps suggests the overall uncommon presence of this idea amongst community leaders.

Controlling women's sexuality.

Violence against women often included a discussion around women's sexuality or men's failure to control women's sexuality. One of the most common justifications for violence against women was in cases of women's infidelity. This idea came up by men and women and in nearly every focus group, except the discussion with Muslim leaders. In fact, one police officer suggested that the law upholds men's right to beat a woman if she is caught being unfaithful, given that he paid a dowry for her. While community leaders highly disapproved women's infidelity, men were expected to be unfaithful.

Some community leaders expressed the view denying men sex was justification for violence and that men even own women's sexual organs.

> If a woman denies a man sex she can be in trouble, because 'the things' belong to a man and women just keep them for men. So, if they refuse to give to the men these things then they should be beaten. (Muslim leader)

Dissenting voices.

Despite the common justification of men's violence against women, several participants discussed the disapproval of violence they held, as well disapproval within the community at

large. A small, but noteworthy group of participants discussed the negative effect of violence on a relationship and a family. Some community leaders, mainly health care workers, argued against violence against women in the home due to the long-term consequences on the children.

Participants from each discussion group, except Christian or Muslim leaders, offered views that the community does not approve of men's violence against women. These community leaders evidenced the view that the community disapproves of violence by referencing the frequency of articles written about violence against women in local newspapers and the interference made in situations of domestic violence by local leaders and neighbors. Furthermore, community leaders argued that people do not like fighting and that "nobody would like to see his sister, mother or any relative going through violence in a home" (male police officer).

Some community leaders disagreed with the need for women to obey men's authority and be disciplined for their mistakes. Christian leaders, sengas, and local council leaders expressed views that disciplining a woman results in less peace and happiness in the home and the general breakdown in strength of the home.

> It is not good to discipline a woman. There can be no peace. God put women and man together not to fight, but to live together happily. Of course we know the home cannot be well [all the time]. There may be some arguments. But, as religious leaders we are saying there should be forgiveness in the home because God is love. (Christian leader)

Others found that sharing responsibility and decision making was a way to avoid violence, as opposed to a cause of violence common amongst many community leaders. The following quotation from a police officer represents a less common idea from the focus groups that women and men should maintain mutual responsibility and presence in the family.

> Because a family is made of two people, a female and a male…So, I understand that in order for things to go well both must take part in discussion. They must all take responsibilities in decisions. The two will have responsibilities for buying of other things and upbringing of the children in the home, because there are two people that bring up a child and each of the two has a responsibility over the children. Everything should be guarded and protected by both people so that we overcome some of the domestic violence in a home and community. (Police officer)

However, even participants who disagreed with violence against women acknowledged the challenges in overcoming men's authority and helping men to stop using violence. Health care workers provided a more nuanced view when asked whether or not there is social pressure on men to not use violence: "whatever a man does, there is no option, but to get use to it" (female health care worker). This idea suggests that even though people may not approve of or like violence, that men's authority surpasses any possibility of stopping the phenomenon.

Related, health care workers thought that, although rhetoric opposing violence against women was present, such messages lacked impact: "there is social pressure, but it is weak, it is there in words." The following excerpt from a discussion amongst female health care workers further exemplifies their more nuanced perspective on social pressure on men to avoid using violence:

> Health care worker 1: They don't reject [violence against women]. That is what I was telling you that they know that the role of a man is to beat a woman. They know that men have to beat their wives they have to superior.
>
> Health care worker 2: Even culture…
>
> Health care worker 1: …but culture is dynamic.

> Health care worker 3: All that has been said either culturally, socially, morally whatever; men are at crossroads, they don't know what to do and they need support.

Although the first health care worker from this excerpt claims that the community accepts violence against women as the 'role of a man', she also suggests that culture is not stagnant. The third health care worker from this excerpt implies that, given this potential for change in culture, men might be at a place they are ready to change, if provided support. The only other view from any other focus groups which suggest that men may need support in changing came from a Christian leader who suggested that men need to be "sat down and taught how they can relate with their wives without violence, but social pressure in the community is not enough" (Christian leader).

Community Leader's Role in Responding to and Preventing Violence against Women

Community Leaders expressed a strong sense of responsibility in responding to violence against women in their communities, describing multiple ways in which they have or would intervene in situations of violence against women. While potential lethal violence was considered most deserving of intervention, the most common means of intervening or preventing violence included separating the couple, talking to the man and talking to the woman, recruiting assistance from other community elders, local leaders, or family and friends, and lastly reporting to the police. Community leaders discussed potential challenges of engaging in these strategies, as was ways in which community members would support prevention activities.

A common theme among proposed strategies was the greater acceptability or need to intervene in situations in which a woman, or her unborn child, was in grave danger. For example, one senga recommended only intervening if you have a reason, such as the violence seems severe or if the woman is pregnant.

> [If a man is beating his wife] you first give them time, unless if you see that there will be bloodshed or if the woman is pregnant. If you are a neighbor you can come in and you should have a reason for interfering in that problem. (senga)

Although most strategies discussed by community leaders included what they would do, examples of situations in which they have intervened in the past nearly always involved a near death level of violence–often with a weapon. Participants from the police, sengas, Muslim leaders, and local council leaders discussed having actually taken this course of action in the past.

The most common strategy suggested by community leaders who discussed what they would do if encountering a situation of domestic violence was first to separate the couple and then talk to the man. When talking to a man community leaders, particularly health care workers, emphasized the need to educate men about the negative physical effects of violence against women to women and their potential unborn child.

While risk of death to a woman or her unborn child was a common theme, other negative outcomes of violence tended to focus on risks to the man. Religious leaders (both Christian and Muslim), health care workers, and a police officer, suggested talking to men about the potential legal punishment and financial consequences of using violence against their wives.

> Health care worker 1: So, you [tell him] the implications and you show him the costs he will incur when he beats her so if he is an understanding person he will not continue beating her.
>
> Health care worker 2: You emphasize the issue if the costs and show him that he is the one who will pay for all these things if he beats the woman. You tell him that [if] you

> beat her, they will take you to police, and you will be punished and after being punished you will pay all the involved costs.

Although most community members referenced talking with men who were using violence, some also recommended talking to women who were experiencing violence as a potential way in which they could intervene. Not surprisingly, most community leaders who proposed this tactic were women, including sengas, health care workers, and local leaders. One of the commonly recommended strategies in talking to women was to advise them to better obey, and not provoke, their husbands.

> You may also talk to the woman. For example, [tell her to] respect yourself such that she keeps quiet, because if she continues quarreling, the fight will continue. Talk about the respect that comes when a woman respects herself. At times you may have tell her about how to react to such a scenario because at times they are beaten because of how they have responded to situations but you tell her to respond to him respectfully. (senga)

Participants from each focus group recommended engaging others in the response and preventing of violence against women, including elders, police, local leaders, neighbors, a friend of the man's, and the woman's family. Elders, such as sengas, and local leaders were most commonly recommended from each of the focus groups as the first persons form whom to seek help. Sengas supported reaching out to sengas or kojas (traditional uncles), not local leaders as the first point of contact to help with situations of domestic violence. However, sengas also described challenges that women may face when seeking help from other sengas, namely a lack of confidentiality and lack of sympathy.

> Women keep quiet, even when you get a problem. For example you may get a problem and see an elderly person and you go to tell him about it expecting advice. But she will

> tell you that, that is a very small thing and tell you about her experience of how they have seen greater things than what you are referring to. Immediately after you leave she will tell other people. So you keep quiet with your problem and others think that you have a better family, but this makes women keep silent because you may find your problem in the whole village…let me die with my things. (senga)

Community leaders commonly suggested resolving violent conflicts between a man and a woman by engaging family members or friends. In some discussions, participants recommended calling family members from both the man and woman's side and in other discussions they recommended calling family members or friends of the man. In particular, one police suggested involving "other family members who may be more experienced in marriage."

Reporting to the police was another commonly suggested solution in responding to and preventing future violence given by participants. Although, some disagreement existed between community leaders as to whether cases were commonly reported to the police. Most agreed, however, that cases typically went through local leaders or elders, and the particularly 'complicated cases' would be referred to the police (police officer). One health care worker indicated that cases should be reported to the police given the presence of Community Liaison Officers within the police who are designated to handle situations of domestic violence. However, another health care worker expressed her view that they are also expected to serve as police in the community when it comes to situations of domestic violence.

> The truth is that as medics in the community we are instructed in most cases to work as the police. You will find that of the two people fighting, or both of them, maybe a woman may come first because she is usually the immediate victim and the man may follow because he thinks that a woman has come for a letter to take to police. While there, I

> counsel [them]. You let them sit before you and you listen to their issues. You may tell the woman to forgive the man and maybe counsel them. (male health care worker)

Police officers discussed potential issues or challenges in reporting to police. Some police offers acknowledged that some women may not want to prosecute their husbands or may want them released from jail. One police officer discussed a situation in which a woman who was abused by her husband came to ask for his release and was nearly assaulted by a police officer in the process.

> This is an example of such a thing. I have had such a couple fight. This was a very giant person working with revenue. The man was beating his wife as I stood on the way, I intended to look but the man was so annoyed, not until I got to the police post I told my boss the OC and got the man power I needed and went and found that he was seriously beating the lady. I said let me try to save this lady. The man fought us until we over powered him and took him to the police office. We wanted to cool down the gentleman till tomorrow so that they can settle their problems through counseling in the concerned department. By then it was around 9:00pm. At 3:00am the man was already in the cell. The woman had disappeared and we didn't know where she went. At 3:00am she came and my fellow officer said, 'Who is that one?'. The power had gone off then I said, 'Madam, what is wrong with you?' She said, 'I want my husband.' Then I said, 'Your husband is still annoyed.' Then I said, 'Cool down until tomorrow.' She could not even respond and she eventually asked whether the man had beaten us or her. Then my fellow officer came and even wanted to slap her until I said to him not to do so, and the other officer sent away the lady. So, as [the other respondent] has said, those ladies also need a lot of counseling or even the entire family.

Corruption within the police and the court system as an impediment to properly prosecuting cases of domestic violence was another idea, albeit uncommon, which arose in focus groups. According to sengas, when police or courts are given money, the man will be released from custody, regardless of his crime or sentence. Finally, some police officers do not believe that women are aware of the services available to them within the police force.

While women experiencing violence may be unsure about services available to them within the police or legal system, community leaders reported contradictory views on the legal status of

violence against women in Uganda. While some believed that the law forbade violence against women, others thought that the law supported violence against women. For example, a Christian religious leader said that, "according to the laws in Uganda, you don't interfere, you just walk away and leave them to fight to injury or death. (David)." In fact, the focus group discussion with police broke out into shouting regarding differences of opinions in what the law says regarding wife beating. Unfortunately, the shouting resulted led to an unclear transcript of the dialogue and it does not appear whether or not a conclusion or agreement was reached. However, one respondent suggested bringing the law in for review.

Challenges in intervening.

Community leader discussed additional challenges in intervening in situations of violence, including the need for men to intervene, physical risk, and potential allegations of infidelity. Both men and women mentioned the potential physical risk of intervening in situations of violence. However, women expressed an overall challenge in intervening, as men are commonly considered to have more authority to do so.

According to one health care worker,

> I would personally first look around for any man, and ask that man to separate them, because I may not manage them. But when a man is beating his wife it is a hard thing so it would not be good to interfere though I would personally even hate seeing it. But, as we said according to the community you would simply look for the man around to separate them. (female health care worker)

A commonly held fear among particularly community leaders, particularly women, was the risk of danger to oneself when directly intervening. According to one local leader, "find out, if intervening, the tools being used because it could be a knife or machete, then it lands on you."

Perceived infidelity was also discussed as a potential difficulty or risk of intervening in situations of violence against women by sengas and religious leaders. According to a male religious leader, "Some men are bad. The tempers will be up so he will just leave the wife and start on beating you saying that it has always been you in love with my wife." Most of the ideas regarding infidelity were hypothetical scenarios, but one senga described a situation where this actually happened to her when she was trying to help a woman experiencing in her home.

> One time I called [the woman] and I tried to counsel her and to explain, but she believed that I was in love with her husband. Because I knew their problems and had been counseling her about what women do, but at this event she thought I wanted to take her husband, but she disclosed it at the end. And I told her I wanted to save her life because saying if you come in I will cut your intestines out the wife had a knife and she had wanted to kill the husband, I talked to her about the consequences of killing the husband. But you have to be very careful when handling such cases as it is very hard to stop people that are fighting. You can't just go as a Senga of the village. She may ask you if you are the one who gave her to the man. It calls for a lot of wisdom when you are intervening. (senga)

Although local leaders expressed that other community members remain quiet about violence against women, most felt that they had a unique responsibility to speak out or intervene. An additional responsibility to lead by example in their own lives was so discussed.

> If you are a local leader, but you have a problem related to violence in your home, how would people look at you. That is why as a leader you have to be a role model. (male local leader)

Overall, only a few community leaders indicated a belief that violence against women is a private matter that only involves the man and the wife. These ideas were generally expressed as views held by others in the community, including women themselves, not necessarily views held by the leaders themselves. The idea that violence against women is a private issue between

husband and wife was also discussed in regards to why others may not intervene, but tended not to influence community leader's attitudes on intervening.

Another reluctance that community leaders expressed when discussing their role in preventing and responding to violence against women was the belief that some people cannot be changed or helped. Some community leaders, particularly health care workers, local leaders, and religious leaders, seemed resigned to the belief that some people will be violent, no matter what actions they take to intervene. A local leader acknowledged, however, that this resignation could put people at risk.

> Sometimes some people you see them fight today and the next day they are happy together. So others just ignore them saying that those ones are like that, but this means they are at danger (male local leader).

In addition to expressing a unique responsibility to respond to violence against women, community leaders discussed ways in which they could use their well-known status in the community to mobilize prevention activities. For the most part, however, community leaders saw their role as one of recruitment for activities conducted by outside NGOs or the Catholic Church. In a notable exception, one senga described prevention work with men she has facilitated:

> I have been [talking with men] in …. most of the time because I do voluntary work [there]. I get my free time and talk to them where they are working. And if you walk around you will find a group of about 20 men and they have bought sodas. So, if we get some time and get them at their places of work and invite them for a seminar and tell them about home affairs…because I have personally got a lot out of the men through this approach. For example, in garages, you can talk to them about home issues. They also have problems, for example that their women have no lubrication [for sexual intercourse]. But after talking to them, they learn how to handle their wives, how to approach them. They appreciate it. Eventually he will tell you that what you told him worked. So if we can reach and talk to them, maybe they will change. The other thing we have to tell the men is to talk to their wives humbly to know what they want. (senga)

In addition to being one of few persons describing ongoing involvement in prevention work, this was also one of the only references to the need for men to be humble and find out what women want.

Discussion

Findings from this study present previously unexplored views in the literature on community leaders' understanding of violence against women and their role in responding to and preventing violence against women in Kampala, Uganda. Primary findings using framework analysis of focus group discussions with sengas, police officers, health care workers, religious leaders, and local council leaders suggest a widely held justification for violence against women based on an underlying belief in men's authority over women and expectations on women. The belief in men's power over women manifest in three, interrelated themes: men's authority, blaming women, and controlling women's sexuality. Few dissenting voices argued against violence against women for reasons related to the impact on the children and the need for women and men to live with peace and happiness. Overall, despite numerous justifications for violence against women, community leaders expressed a strong sense of responsibility in responding to violence against women, particularly in life threatening situations. Suggested strategies for intervening in situations of violence against women in the home included recruiting elders, talking to the men about the violence, calling upon help from local council leaders, and reporting to the police. These suggested strategies were not, however, without underlying sentiments of men's superiority and associated risks faced by community leaders.

This study found an overarching belief in violence against women as a manifestation of men's right to use their authority over women. This theme arose in both community members' understanding of violence against women and in their suggested strategies to intervene. Most

community members believed in women's need to remain submissive to men's authority, and either supported the use of violence or other forms of disciplining to ensuring submissiveness or disregarded the use of violence due to its ineffectiveness at ensuring submissiveness. Even community leaders who suggest talking to women who have experienced violence recommend telling women how to better respect her partner's wishes to avoid violence in the future. Women's efforts to gain equal status as men was seen by many as a risk of experiencing violence from men. In a study of gender in Kampala, Wyrod (2008) also found a view that gender equality would lead to a backlash against women, such as increased violence against women.

The need for women to remain submissive to men's authority and the right of men to use violence if women do not remain submissive exemplifies key tenants of the Domestic Virtue model (Kyomuhendo & McIntosh, 2006). According to Kyomuhendo and McIntosh, the influence of the Domestic Virtue model resulted in present day hostility against women who do not abide by these expectations, as well as domestic violence. Also connected to the Domestic Virtue model were the findings that women who neglect household responsibilities or care for children deserve violence from their partners. These beliefs originate from long standing beliefs in women's duties as caretakers of the home and children (Kyomuhendo & McIntosh, 2006).

Another common theme found through discussion groups with community leaders was the tendency for violence against women to be considered the result of women's actions or inactions, not necessarily from the behaviours of their partners or another outside factor. While highly connected to expectations about women's responsibilities and remaining submissive to men, blaming women for the violence used against them arose in both participants' understanding of violence and ideas in how to intervene. In addition to violence resulting from women making mistakes, the most commonly cited cause of violence was that women ask for or want violence.

However, the context of how or why women ask to be beaten was different amongst the different groups. Men who mentioned this theme seemed to accept the desire for women to want violence to know they are loved at face value, as a legitimate explanation or justification for violence. In certain cases, community leaders argued that women want to be beaten to define their womanhood. Women community leaders, particularly health care workers and sengas, indicated that women who ask to be beaten are actually doing so in a manner of defiance. To my knowledge, no other sources on violence against women in Uganda found the common belief that women want to be beaten. However, the larger theme of blaming women for the violence used against them is present in other studies in Kampala (Wyrod, 2008).

Women's infidelity was the second most commonly cited reason for men's use of violence against women. Some participants also cited women's refusal of sex to their husbands as another cause of domestic violence. Such findings are consistent with other studies (Kaye, Mirembe, Mia Ekstrom, Bantebya, & Johansson, 2005) and indicate the pervasive ideology of women's duty to provide sex to their husbands and men's threatened security when they perceive women's sexuality as uncontrollable (Kyomuhendo & McIntosh, 2006). Women engaging in sexual behaviour outside of marriage also conflicts with expectations regarding child bearing, as it suggests sex may serve another purpose than reproduction.

The only focus group which did not discuss this idea of women's infidelity as deserving of violence was with Muslim leaders. However, this could be that violence against women was, in general, more widely accepted by Muslim leaders and thus, women's infidelity, might have been a given, not necessary for discussion. In other groups, infidelity was sometimes discussed as an exception for why women should be beaten, after the conversation established that, in general, beating was not acceptable. Contrarily, men's infidelity was expected. Structural explanation of

gender suggests that men are more promiscuous because they have more power to do so in society (Connell, 1987).

In general, the focus group discussions emphasized women's misbehaviour as the cause of violence in the home. In limited examples, primarily from health care workers, participants linked women's violence to men's alcohol use and men's lack of employment. These findings contrast quantitative studies which suggest that the economic status of men and men's alcohol use are associated with women's risk of intimate partner violence from their male partners (Carlson, et al., in preparation; Karamagi, et al., 2006). However, the brief reference of men's alcohol use and unemployment contributing to violence against women, but overall lack of discussion on the topic, mirrors qualitative studies with community members in Kampala (Wyrod, 2008). Additionally, across all of the focus groups, only one mention arose on women's employment as a potential cause of violence against women. However, women's attempt to gain status in other ways—such as making decisions or communicating with their male partners—was discussed as a reason leading to violence against women.

The general lack of discussion on women's economic status or control of income as a threat to men and cause of violence also contrasts other studies (Carlson, et al., in preparation; Kaye, Mirembe, Mia Ekstrom, et al., 2005; Kyomuhendo & McIntosh, 2006). The lack of discussion on this topic may result from both the location of the study in Kampala and the type of participants. Studies in Kampala have found that women's income is actually a protective factor against intimate partner violence, not a factor contributing to her risk of violence (Carlson, et al., in preparation). Additionally, this study focused on community leaders and service providers. Women community leaders may themselves earn money and not find their financial status to be

a threat to their relationship. Similarly, male community leaders may be more use to working with employed women and not find them to be a threat deserving of violence.

Some community leaders, although few, provided dissenting views which disapproved of violence and supported equality in relationships between men and women. Those most supportive of love and peace in relationships were Christian religious leaders and health care workers, while one police officer also emphasized mutual responsibility of the home and children and shared decision making. Health care workers, in particular, emphasized the negative health impact of violence on women and unborn children, as well as long-term consequences of children exposed to violence. Furthermore, health care workers and police officers both disapproved of violence due to its potential for men to "go too far". However discussion of the negative impact of violence on women and children contracted the more commonly mentioned negative effects of violence against women on men, such as going to jail or paying a fine, despite the plethora of research on the negative outcomes of violence against women on women's health and the overall well-being of the family (Dahlberg & Krug, 2002; WHO/LSHTM, 2010).

These dissenting views most likely derive from these community leaders' unique education and position. Health care workers and police have likely witnessed the most severe physical effects of violence against women and thus more cognizant of these negative impacts. Christian leaders explained their views on love and peace in relationships in connect with teaching from the Bible and their understanding of God, also further explaining why some demonstrated a unique perspective on violence against women.

Although community members demonstrated an overall justification of violence against women, they did not necessarily *like* violence. Health care workers made the keen observation that although some people in the community do not necessarily want violence, they have to accept it as tenant of men's power and authority. Still, some new messaging and activity emerging in Uganda against violence against women and promoting women's rights indicate that public thought around violence against women may be slowly changing (Wyrod, 2008). During 2008, the year these focus groups were conducted, Ugandan was experiencing an increase in public discourse on violence against women. A search of two of the most prominent national Ugandan newspapers, The New Vision and the Daily Monitor, saw an increase in the number of articles published referencing "domestic violence" from 30 in 2003 to 71 in 2008. During 2012, the number of articles referencing "domestic violence" increased further to 122.

Community Leader's role in responding to and preventing violence against women

Despite overarching messages justifying violence against women and the need for women to remain submissive, community leaders demonstrated a strong sense of responsibility in responding to violence against women. This sense of responsibility particularly came through when discussing severe incidences of violence that involved weapons or were potentially lethal. The acceptability of violence, so long as it is not lethal or extreme violence, dates back to colonial Uganda. In 1927, the Colonial Office in London, in response to reports that women in Gulu District were beginning to "misconduct themselves with comparative impunity" and failing to respect their husbands authority, recommended that such women be given to their husbands "for chastisement, [but] she be presented to the village chief afterwards as an assurance that the beating would not be excessive" (Kyomuhendo & McIntosh, 2006, p. 79). These sentiments remain present in modern day Uganda, as further evidenced in a study from Wakiso district that

reported that only women with severe injury from domestic violence seek help from health clinics (Kaye, Mirembe, Mia Ekstrom, et al., 2005).

Community leaders also discussed perceived risks associated with intervening in situations of domestic violence. These risks often highlighted a paradox, particularly for women, between their perceived responsibility to intervene and limited authority as women. According to the Domestic Virtue model, women are expected to remain submissive to their male partners, as well as other men in the community. Even police women expressed challenges in breaking up fights as a woman, claiming that they would try to recruit male community members to assist them. Worries about risk of injury also proved common amongst community leaders, which particularly makes sense given the higher acceptability of intervening in situations of severe violence. Finally, risk of being accused of infidelity was another commonly made challenge in community leaders efforts to intervening in situations of domestic violence. Although both men and women expressed these concerns, longstanding social fears around women's uncontrollable sexuality prove relevant (Kyomuhendo & McIntosh, 2006). Given that men's infidelity is much more acceptable, and even expected, amongst community members, community perceptions of infidelity assumes blame on women. As previously mentioned, a structural explanation of gender suggests that unequal views on men and women's infidelity arises from larger gender power imbalances (Connell, 1987). Given this assumption, women community leaders face competing expectations to become involved in and assist in community problems yet remain submissive to men or risk accusations of infidelity.

This study found that police are engaged, but typically in the most complicated or serious cases, and often after seeking help from informal sources and local council leaders. Kaye and colleagues (2005) found similar results, "only when injuries were serious were the police

involved, and then as a last resort" (p. 629). Community leaders, however, expressed confusion over the legal stance on domestic violence, which reflect findings from elsewhere in Uganda (Kaye, Mirembe, Mia Ekstrom, et al., 2005). Uncertainties about domestic violence laws particularly make sense given the time period the focus groups were conducted (during 2008). At this time, bills outlawing domestic violence at the national level had been put forth, but not yet passed. However, the Penal Code was amended in 2007 and included assault, which some domestic violence cases had been prosecuted with, and the Divorce Act stipulated cruelty as grounds for divorce or separation (Amnesty International, 2010). Confusion among community leaders, including elected leaders and police, on the legal status of domestic violence likely reflected a broader confusion or ignorance on the ability to prosecute cases in the court of law. The subsequent passage of the national Domestic Violence Act has hopefully begun to clarify among community leaders and members the illegal status of violence against women, even if the law lacks full implementation (Nalugo, December 1, 2012).

Contrary to other studies (Kaye, Mirembe, Mia Ekstrom, et al., 2005; Kyomuhendo & McIntosh, 2006), community leaders only made limited references to the idea of violence against women as a private issue. Although participants did acknowledge this phenomenon, related discussion was limited and tended to be a way of describing beliefs amongst others in the community. In other words, community leaders did not express the same belief that domestic violence is between a man and woman and thus, they should not intervene. Given that each of the types of community leaders have a legal or culturally mandated responsibility to help families and couples in the community, the absence of such views on privacy makes sense. These findings suggest that beliefs about the private nature of violence against women and the

need to remain respectful of such boundaries are not shared equally by all members of the community and may depend on one's status and position.

Participants made virtually no references of sexual violence in marriage. However, prevalence rates of intimate partner violence in Uganda indicate that 35.5% of women in Uganda have experienced sexual violence from an intimate partner during their lifetime, and 24.8% in the last year. The disconnect between discussion of sexual violence in marriage and statistics from prevalence data may suggest a lack of social acceptability in discussing sexual violence in marriage. Another possibility could be that community leaders do not view sexual violence as a form of violence, as others have suggested that "the prevailing perception [is] that a married woman cannot be raped by her spouse" (Kaye, Mirembe, Mia Ekstrom, et al., 2005, p. 629). These assumptions also align with the Domestic Virtue model expectations on women to remain sexually available to their partners at anytime (Kyomuhendo & McIntosh, 2006).

Limitations and Future Research

Findings must be considered in light of limitations and efforts made to increase trustworthiness. Limitations of this study primarily resulted from the use of secondary data analysis. First, the use of pre-existing focus group transcripts limited the researcher's ability to analyze data concurrently with data collection, a recommended process in framework analysis of focus groups (Rabiee, 2004). Related, the use of secondary analysis prohibited the revision or alteration of question wording and order. Another limitation, of "not being there" impeded the researcher's ability to interpret subtle nuances of body language, facial expressions, or unspoken interactions and communication. To overcome these limitations, the researcher extended the familiarization stage of data analysis and conducted frequent consultation with primary researchers. Finally, the researcher's positionality as a white, U.S.-resident conducting research

on a sample from a different culture and continent served as another, unavoidable limitation. Attempts to lessen the affect of outsider positionality included recognizing, considering, and disclosing this status and by consulting with Ugandan colleagues on findings and interpretations. For example, an in-person presentation on preliminary findings to Ugandan colleagues, including the lead focus group facilitator, allowed for further nuanced analysis and interpretation of findings. Finally, efforts to overcome potential limitations in language translation of some of the focus groups included ongoing consultation with native speakers on the meaning and interpretation of key words and phrases.

Future research should consider exploring the perspectives of both male and female community members who have engaged with these community leaders in their response and prevention of violence against women. Conducting similar research elsewhere in Uganda, such as rural areas, would allow for additional comparisons based on context and location. Other studies may seek to use quantitative methods to obtain a representative sample of community leaders and examine the association between beliefs regarding violence against women and actions in the prevention or response. Finally, future research and practice may consider ways to build the skills and efficacy of community leaders in the prevention and response of violence against women, and the subsequent impact on preventing and responding to violence against women.

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Dissertation Conclusion

This dissertation presents one of the first set of studies examining the impact of community and neighbourhood factors in the prevention of intimate partner violence in Uganda. Utilizing a random sample of 1,582 community members drawn from neighborhoods in Kampala, Uganda, my first paper tested the hypothesis that women who live in neighborhoods with high levels of collective efficacy would experience lower rates of IPV than women who live in neighborhoods with low levels of collective efficacy. Results of a multi-level logistic regression model showed no significant variation in neighborhood IPV, due to collective efficacy or otherwise. However, individual self-efficacy to prevent IPV significantly predicted women's risk of physical IPV, as did other significant individual-level, fixed effects.

In my second paper, I used a nationally representative sample of 1,749 reproductive-aged women in Uganda to examine the effect of displacement on women's experiences of IPV in Uganda. Utilizing propensity score matching, I found that displaced women were less likely to experience IPV than if they had never been displaced. In the paper I explored potential explanations for these findings contradicting my hypothesis. For example, women may receive protection from IPV as a result of a potential reorganization of the gender structure whereby women receive more authority and opportunities during displacement, particularly since displaced camps in northern Uganda received an influx of humanitarian aid and gender-based violence programming.

The third paper reports on a framework analysis of secondary focus group data with community leaders in Kampala, Uganda. The purpose of the study was to analyze community leaders' understanding of violence against women and their role in responding to and preventing IPV in the community. Findings emphasize the influence of social norms upholding men's

authority in the practice of violence against women and how community leaders respond to or prevent IPV. While community leaders expressed a strong sense of responsibility in responding to IPV, these norms affect their perceived ability to intervene, particularly for female leaders.

Overall, findings from these three papers indicate that community and neighbourhood are important areas of study in the prevention of IPV in Uganda. However, given the limited scope of theory and research on the area, the manner in which one's community and neighbourhood become important in the prevention of IPV may not necessarily occur as originally predicted. For example, contrary to commonly held assumptions, living in a displacement camp reduced women's risk of experiencing IPV. Furthermore, efficacy to prevent violence against women in one's community protected women from experiencing IPV, but at an individual-level as opposed to the neighbourhood-level. Also, community leaders maintain a stronger sense of responsibility in response to IPV than in prevention efforts, although particularly in situations of severe or life-threatening physical violence. Given the burgeoning state of the literature base on IPV and community in Uganda and other low and middle-income countries, these findings support the need for continued research and further development and testing of theories.

Findings from my dissertation studies indicate the need for social disorganization theorists to consider gender as an additional structural factor organizing communities. As a social structure in Uganda, gender organizes social institutions (i.e. marriage) and interactions between men and women based on an unequal hierarchy. My analysis of focus groups with community leaders indicated that social norms which simultaneously manifest and uphold men's power over women support the use of violence against women and inhibit women leaders from taking action against violence. And, as proposed in the study on IPV and displacement, in situations where women can overcome gender inequality and earn more money and control over earnings than men, they

are at lowered risk of experiencing IPV. The study on collective efficacy and IPV also found that women who are less likely to accept the use of men's violence over women are at reduced risk of experiencing sexual violence. Thus, as suggested by a recent review article on community-level factors and IPV, community-level analysis of IPV tend to ignore a gendered analysis (Vanderende, Yount, Dynes, & Sibley, 2012). Further, I argue that as a theory, social disorganization ignores the analysis of gender and should adopt gender inequality as a structural characteristic (in addition to poverty, residential instability, etc.) affecting a community's ability to regulate and prevent violence.

Findings from these dissertation studies also support the need for continued research and programmatic consideration of men's alcohol use and women's economic empowerment. Evidence from both the collective efficacy and displacement studies indicated that men's alcohol use is a potential factor putting women at risk of increased IPV. However, in focus groups on IPV community leaders rarely mentioned men's alcohol use (along with a general absence of factors causing violence outside of women's shortcomings). Despite strong empirical support for men's alcohol use on women's experiences of IPV in both Uganda and the global literature, men's alcohol use and IPV is sometimes sensitive subject among practitioners. Feminist, domestic violence advocates often claim that men who do not drink also use violence and not all men who drink use violence. While this statement is fully accurate, research indicates that women whose partners drink are at a higher risk of experiencing IPV compared to women whose partners do not drink. Based on findings from my dissertation which support the global literature evidence on men's alcohol use and IPV, I argue one way to help bridge the disconnect between practice and research is to use thoughtful, careful language in discussions. Research does not show, for example, that alcohol use is the *cause* of IPV, but a *contributing* factor. As a

community of practitioners, advocates, and researchers dedicated the prevention of IPV, we can discuss how to address the contributing factor of alcohol use as one part of a multipronged prevention strategy.

Findings from these studies also indicate the importance of women's economic empowerment as a potential addition to a multipronged prevention strategy. Although community leaders rarely mentioned the role of income or economic empowerment, findings from the two quantitative studies indicate the potential importance of women's economic empowerment as a protective factor from IPV. Social disorganization theory recognizes poverty as a factor limiting a community's ability to intervene and protect women from violence. However, few studies have tested the relationship between these factors, nor the moderating effect of social norms regarding women's empowerment and ability to control family finances. A growing call from researchers indicates the need for additional research on understanding women's economic empowerment as contextualized by the gendered norms in which she lives (Heise, 2011).

These studies also highlight a need for future research on community-level research on IPV to differentiate the study of sexual, physical, and severe physical violence. My paper on collective efficacy found a different set of factors predicting sexual versus physical violence. For example, young age and failing to attend formal education predicted women's risk of physical violence, but not sexual violence. On the other hand, women's acceptance of IPV predicted their risk of experiencing sexual violence, but not physical violence. The focus group study with community leaders also revealed a distinction between different types of violence. While discussion of sexual violence was largely avoided, community leaders reported increased acceptability of intervening in cases of severe, or life threatening, physical violence. In addition

to the need for differentiated research, these findings indicate that prevention and response programming should consider tailoring efforts to address different types of violence.

Findings from these papers also indicate a need for improved communication and collaboration between violence prevention practitioners and researchers working in international humanitarian aid and international development. Often working in silos, humanitarian and development violence against women prevention advocates have much to gain from one another in both research and practice. Findings on the reduced risk of experiencing IPV after displacement among women in northern Uganda indicate a potential learning opportunity for other displaced and non-displaced contexts to adopt potential effective programming and policy efforts which occurred in the displaced villages. These findings, however, also call into concern the process of turning over efforts to local actors and the need to monitoring the potential risk of women's risk of IPV increasing as humanitarian funding and resources for women in northern Uganda decreases. Related, findings from this dissertation on the important role of community leaders in violence against women intervention suggest their role as an important source for building capacity at multiples stages of humanitarian emergencies, particularly for long-term sustainability of efforts after conflict has subsided.

These three studies open the door for a great deal of additional research. Future research should utilize larger samples from different contexts in Uganda and other low and middle-income countries, including those with displaced populations, to test the effect of group-level collective efficacy on women's experiences of IPV. To further advance social disorganization theory and the inclusion of gender inequality as a structural characteristic, studies on collective efficacy and IPV should include a test of the moderating effect of social norms supportive of violence against women and gender inequality. Future research should also examine the effect

of displacement on women's experiences of IPV in other displacement contexts, and also test for mediating effects of men's alcohol use and women's economic empowerment. Given the importance of economic factors in both of the quantitative studies in this dissertation, future research should continue analyzing the effect of women's economic empowerment on their risk of IPV. The continued use of qualitative research remains essential in this area of study, as it both provides deeper understanding of concepts, direction for quantitative studies, and illuminates complex mechanisms of change. Ultimately, a better understanding of the complexities, strengths, and challenges of communities in the prevention of IPV will contribute to the development of more effective intervention and programming.