

**Title/ running head:** Preventing intimate partner violence: Towards a framework for supporting effective community mobilisation

**Authors:** Jenevieve Mannell<sup>a</sup>, Anna Dadswell<sup>b</sup>

a) Institute for Global Health  
University College London  
30 Guilford Street, London  
United Kingdom  
Email: [j.mannell@ucl.ac.uk](mailto:j.mannell@ucl.ac.uk)  
Phone: 020 7905 2626

b) Faculty of Health, Social Care and Education  
Anglia Ruskin University  
Bishop Hall Lane  
Chelmsford  
CM1 1SQ  
Email: [anna.dadswell@anglia.ac.uk](mailto:anna.dadswell@anglia.ac.uk)  
Phone: 0845 196 3531

**Acknowledgements:**

Funding for data collection was provided by the London School of Economics (seed grant, no grant number allocated).

**Title**

Preventing intimate partner violence: Towards a framework for supporting effective community mobilisation

**Abstract**

Community mobilisation is a promising new strategy for preventing intimate partner violence (IPV) against women in low-income settings. However, little is known about the contextual factors (e.g. socio-economic, cultural, historical and political conditions) that enable the effective mobilisation of communities for IPV prevention. This paper draws from theoretical work of Campbell and Cornish (2010) on the relationship between context and community action in addressing HIV/AIDS to propose a framework for situating community mobilisation for IPV prevention in its surrounding symbolic, material and relational contexts. The framework is refined using empirical data from a case study of a gender-based violence (GBV) prevention intervention in Rwanda, including interviews with members of government-mandated GBV Committees and focus group discussions with members of two village communities (n=35). A thematic analysis identifies various contextual factors needed to support community mobilisation for IPV prevention, including: broad symbolic understandings of what constitutes IPV; capacity to economically support women who choose to leave violent relationships; mechanisms for addressing the silence that often surrounds IPV; support from policy and government authorities; and opportunities to effectively challenge inequitable policy and legal frameworks. This framework is useful for policy-makers and programme planners interested in IPV prevention in and by communities.

## **Introduction**

Intimate partner violence (IPV) is a major global health concern with one third of women experiencing physical or sexual violence in their lifetime (World Health Organisation, London School of Hygiene and Tropical Medicine, & South African Medical Research Council, 2013). IPV is a form of gender-based violence (GBV) that encompasses physical aggression, sexual coercion, psychological abuse, and controlling behaviours including economic violence (e.g. controlling another person's economic resources) (Butchart, Garcia-Moreno & Mikton 2010; Buzawa & Buzawa, 2013). While men also experience IPV, women are more likely to experience severe injuries, coercive behaviours, or be killed by violence from male partners (World Health Organisation, 2013). Contexts with established norms of gender inequality, where violence against women is seen as a normal part of intimate relationships, have the highest risk of IPV (Jewkes, 2002). Increasingly, IPV prevention efforts in these contexts have used participatory approaches that mobilise communities to challenge the social and cultural norms perpetuating IPV (Gibbs, Willan, Jama-Shai, Washington, & Jewkes, 2015). We argue that these interventions, while important, often lack key consideration of the contextual factors that contribute to successful community mobilisation efforts. This paper draws on insights from community health psychology about the influence of socio-economic, cultural, historical and political contexts on community action to develop a framework for the contextual factors that contribute to effective IPV prevention in and by communities.

Community mobilisation is used in this paper to refer to the process through which community members use their knowledge of social inequalities and vulnerability to build a collective response to a health problem, thereby enabling greater self-reliance for the community while improving health outcomes (AVAHAN, 2008; Campbell & Cornish, 2010). In IPV prevention, community mobilisation interventions have often relied on external change

agents (Maton, 2008) – typically non-governmental organisations (NGOs) or academic partners – to train local facilitators to engage communities in conversations about violence. These community conversations highlight the role of power in people’s everyday lives (Author, forthcoming) to raise awareness of the underlying factors that shape health-related behaviours (Gibbs et al., 2015). The intended outcome is a change in social and cultural norms that reduces violence in intimate relationships and/or the prevalence of sexually transmitted infections such as HIV. In a recent review of the literature, Ellsberg and colleagues (2015) indicate promising results from community mobilisation interventions to prevent IPV in low-income settings. For example, *SASA!* and *SHARE* in Uganda reported changes in social norms that are perceived to perpetuate IPV and decreases in continued physical and sexual abuse (Abramsky, Devries, Michau, Nakuti, Musuya, Kyegombe, et al., 2016; Kyegombe et al., 2014; Wagman et al., 2012). In the case of *SHARE*, the intervention also achieved a significant increase in HIV disclosure and a reduction in HIV incidence among both men and women (Wagman et al., 2012).

Socio-economic, cultural, historical and political contexts, or ‘social contexts’, are critical in determining the effectiveness and long-term sustainability of public health interventions (Sommer & Parker, 2013). While social contextual factors are well recognised in relation to the underlying causes of IPV (Heise, 1998; Jewkes, 2002), there has been little consideration of the influence of social contexts on the effectiveness and sustainability of community efforts to prevent IPV. This is not entirely surprising given that community mobilisation is a relatively recent form of intervention for IPV and that primary prevention research in IPV is in its infancy (Jewkes, 2014). In addition, most of the published literature on community mobilisation for IPV prevention presents interventions that have been implemented and evaluated using randomised control trials (Abramsky, Devries, Michau, Nakuti, Musuya, Kyegombe, et al., 2016; Jewkes et al., 2008; Kyegombe et al., 2014), which necessarily focus

on community level variables to assess the impact of the intervention and control for (rather than investigate) social contexts. However, improved conceptual understandings of the social contextual factors that enable effective and sustainable community mobilisation for IPV prevention are urgently needed in order to adequately support communities.

While little is known about this in relation to IPV prevention, scholars working in HIV/AIDS have pointed to the ways in which contextual factors can undermine community mobilisation interventions – we take this as our starting point. For instance, pressure from global donors to deliver HIV/AIDS outcomes in short time frames is often misaligned with the long-term requirements of sustainable community mobilisation (Cornish, Priego-Hernandez, Campbell, Mburu, & McLean, 2014; Kelly & Birdsall, 2010). Furthermore, existing governance structures do not always support communities to prevent HIV or care for those living with AIDS; for example traditional leaders may resist mobilisation efforts as part of a general opposition to change in their community (Campbell, 2010). More positively, communities who mobilise to challenge inequalities in the broader social context, and not just change the behaviour of individual community members, often have the best outcomes (Campbell & Cornish, 2012).

Similar considerations about the influence of social context on community mobilisation for IPV prevention have not yet been explored. Our aim is to address this gap by proposing a framework for understanding and assessing the interface between social contexts and community mobilisation for IPV prevention. The framework is adapted from Campbell and Cornish's (2010, 2012) theoretical work on supportive social contexts for community mobilisation, and refined using interviews and focus group discussions from a case study of a community mobilisation intervention for IPV prevention in Rwanda.

### **Conceptual Framework**

Campbell and Cornish (2010) argue that 'supportive social environments' are a crucial

aspect of community mobilisation, the presence or absence of which can facilitate or inhibit health-enabling behaviours and thus influence health outcomes. They argue that the success or failure of interventions is contingent on symbolic, material and relational dimensions of the social environment. The symbolic dimension is epitomized by the cultural meanings, ideologies and understandings through which people make sense of themselves and the world around them. We use the symbolic context to refer to social norms and cultural meanings associated with IPV prevention activities, including how community members feel they should respond to IPV and the pathways they see for its prevention. The material context refers to the extent to which individuals have access to the resources they need to live healthy lives free from IPV, including money, food, and paid work. This helps interrogate whether an intervention is able to mitigate the material barriers to IPV prevention (e.g. women's financial dependence on their husbands) as well as material constraints on the sustainability of community activities (e.g. compensation for time and effort). The relational dimension refers to the connections that exist within communities (e.g. personal relationships, relationships between community members) and connections between communities and more powerful allies (e.g. relationships with higher levels of government). This draws attention to the role these connections play in effective and sustainable IPV prevention activities (e.g. providing access to resources, legal procedures, and supportive policies). These dimensions are understood to overlap and interact with each other to form the wider social environment shaping the success or failure of community mobilisation interventions (Skovdal, Campbell, Nhongo, Nyamukapa, & Gregson, 2011).

### **Case Study: Gender-Based Violence Committees in Rwanda**

This paper draws on a case study of a community mobilisation intervention implemented by the Government of Rwanda to address GBV by establishing GBV Committees at village level. The GBV Committees offer a unique opportunity for developing better

understandings of how social environments can support community mobilisation for IPV prevention. Firstly, the Committees are composed of locally elected members from within the community, which provides the communities with direct ownership over the design and implementation of their activities. The Rwandan government's guidelines on the GBV Committees ask members of the Committees to sensitise and raise awareness about GBV, refer and assist victims, advocate for services, report perpetrators, carry out home visits and report to the government (Ministry of Gender and Family Promotion, 2011). Secondly, the challenges facing Rwandan communities in tackling IPV are substantial given the widespread acceptance of violence as a normal part of intimate relationships. In a 2015 population health survey, Rwandan women agreed that a husband beating his wife was acceptable under particular circumstances: if she argues with him (20%), neglects the children (29%), goes out without telling him (22%), or refuses to have sexual intercourse with him (24%) (National Institute of Statistics Rwanda, 2016). This makes Rwanda a particularly challenging context for preventing IPV (Mannell, Jackson, & Umutoni, 2016) with potential lessons for the effectiveness of community mobilisation in settings where experiences of poverty interact with patriarchal social norms to produce particularly poor health outcomes for women (Campbell & Mannell, 2016).

## **Methods**

### *Research design and ethics*

The research question guiding the Rwandan case study was: *How does the social environment enable or inhibit the mobilisation of communities to prevent GBV?* The research involved interviews with GBV Committee members and focus group discussions (FGDs) with male and female community members respectively across two sites in Kigali. In total, twelve interviews and four FGDs were conducted, transcribed and translated, and analysed using

thematic analysis (Fereday & Muir-Cochrane, 2006). Ethical approval for the research was granted by the London School of Economics (06/08/2013) and data was collected in 2014.

### *Sampling*

The two villages were purposively selected for ease of access based on existing relationships between the research team, consisting of a locally-based researcher and two skilled interpreters, and the village leaders who gave initial approval for the research. Both communities, referred to as 'Community A' and 'Community B' to protect confidentiality, represented typical *umudugudu* (small administrative areas corresponding to local villages) in Kigali, composed of 100-150 households. The interpreters were both members of the local communities which helped in recruiting participants and establishing rapport. Semi-structured interviews were held with all members of the GBV Committee in both communities (n=12). Snowball techniques were used to recruit men and women in each community to participate in gender-specific FGDs (n=23).



Table 1: Research participants

Location	Data collected	Role in GBV Committee	Gender	N
<b>Community A</b>	Interview 1	<i>Umudugudu</i> chief	Man	1
	Interview 2	Head of GBV Committee	Woman	1
	Interview 3	Leader of cell	Man	1
	Interview 4	Head of social affairs	Woman	1
	Interview 5	Health worker	Woman	1
	Interview 6	Head of children's affairs	Woman	1
	FGD 1	N/A (community residents)	Women	6
	FGD 2	N/A (community residents)	Men	6
<b>Community B</b>	Interview 7	<i>Umudugudu</i> chief	Man	1
	Interview 8	Head of social affairs	Woman	1
	Interview 9	Health worker	Woman	1
	Interview 10	Head of children's affairs	Woman	1
	Interview 11	VP of GBV committee	Woman	1
	Interview 12	Coordinator of GBV committee	Man	1
	FGD 3	N/A (community residents)	Women	5
	FGD 4	N/A (community residents)	Men	6
<b>TOTAL participants</b>				<b>35</b>

#### Data collection

Before each interview and FGD, the research team explained and discussed with participants the project's aims, the nature of the research and their right to withdraw at any time. Participants were also given an information sheet and asked to sign a consent form. The research team entered into a dialogue with participants to ensure informed consent was obtained and to alleviate any concerns around recording and/or reporting details of specific cases of GBV. Participants were given a small incentive of 5,000 RWF (~US\$6.50). All interviews and FGDs were held in Kinyarwanda, facilitated by the lead researcher (first author, English-speaking) and one interpreter. During FGDs the second interpreter translated the conversation from Kinyarwanda into English for the researcher in order to facilitate the flow of the conversation. Data were recorded, and later transcribed and translated from Kinyarwanda into English.

In interviews with GBV Committee members, participants were asked about their role in the Committee, their understanding of the Committee's goals and structure, and what actions they had taken to prevent GBV in their community, as well as what they do when a case of GBV comes to their attention. Participants in FGDs were asked more broadly about any community activities happening to prevent or respond to GBV (including the work of GBV Committees) and what participants saw as the role of the community in addressing GBV. A short vignette was developed in order to elicit shared understandings within the group about community responses to a specific case without having to ask about actual cases that may be too sensitive for group discussion (Hughes, 1998). The vignette was about a neighbour named Claudine, who was married and being beaten by her husband. Participants were asked what they thought the community should do and how they thought they could prevent cases such as this from happening.

### *Analysis*

Thematic analysis of the data was conducted by the second author through a hybrid process of deductive and inductive thematic analysis in order to combine both theory-driven and data-driven interpretations of the qualitative data (Fereday & Muir-Cochrane, 2006). The coding process followed Attride-Stirling's (2001) steps for thematic analysis. Initial codes were developed using participant's own language to ensure that the findings stayed true to their intended meaning. After coding half the data with a total of 98 codes, a thematic framework was defined by collating codes under basic themes according to commonalities and connections, then establishing organizing themes within the theory-driven global themes of symbolic, material and relational contexts. The rest of the data was then coded using this thematic framework, which was refined as necessary to create a comprehensive coding frame shown in Table 2.

Table 2: Influences of the social context on GBV prevention in and by communities (thematic analysis)

Global theme	Organising themes	Basic themes
<b>Symbolic</b>	Representations of GBV	GBV includes economic, physical, sexual, emotional forms of partner violence
		GBV includes child abuse and women abusing men, and not only GBV against one's wife/ unmarried partner
		GBV is caused by alcohol, infidelity, cultural norms, disagreements, and poverty
	Patriarchy in society	Men/husbands are the head of the household
		Women/wives are the primary caregivers of children
		Rising gender equality is creating conflict in households
	Culture of silence	Women are silent about their experiences of GBV
		Women deny instances of GBV even when approached by community members
	<b>Material</b>	Funding for GBV survivors needed in situations of...
Providing for the family		
Divorce, leaving an abusive partner		
Economic dependency of women		
Limited funding for GBV Committees		Training needs not met
		Burden of voluntary positions
<b>Relational</b> (community relationships)	Private/ interpersonal	Support from family and friends
		Involvement of neighbours
		Involvement of respected elders
	Public	Discussions during <i>umugoroba w'ababyeyi</i> (parents' evenings)
		Discussions during <i>umuganda</i> (monthly community meetings)
		Activities of the GBV Committees
<b>Relational</b> (community-government relationships)	Legal court system	Legal consequences for perpetrators
		Legal rights for women
	GBV committee at other levels of government	Referrals
		Visits and presence in community
	Police	Referrals to police by GBV Committees
		Men are concerned about the police

## Findings

Within each of the symbolic, material and relational dimensions outlined by Campbell and Cornish (2010), our findings describe how the social environment has influenced the potential effectiveness and sustainability of community mobilisation for IPV prevention in

Rwanda. While the original focus of the study was on GBV more broadly, the findings focus specifically on partner violence as this is how community and GBV Committee members primarily used the term ‘GBV’.

### *Symbolic*

The symbolic context refers to the social norms, cultural meanings and understandings associated with IPV and IPV prevention. Participants identified a wide range of factors that they felt contributed to IPV including alcohol use, infidelity, disagreements, cultural norms and poverty. Explanations of these factors were frequently framed by gender inequalities that help to construct violence as an accepted social norm. For instance, a male participant described the relationship between alcohol and IPV as women not fulfilling ‘appropriate’ gender roles:

*Participant: Yes, we have different views on this; a long time ago, it used to be that a woman could not go to a bar, at least without her husband. Women could not get drunk; but today...*

*Interviewer: But could women drink then?*

*Participant: Yes they drank. But, they still knew their duties and responsibilities and were not side tracked. They would go home to their families. But today, wives leave their families late in the night and go to bars. Today, you find that in some homes the husbands get home before the wives. (Male participant, FGD Community A)*

This provides an example of how gender norms that blame women for the violence they experience persist despite the activities of the GBV Committees.

Significant barriers to IPV prevention were also identified, for instance participants described how women experiencing IPV often remain silent for various reasons including ignorance, fear, shame and dependency:

*The saddest thing was that the woman refused to talk even though she was being beaten up. She refused to talk, and the couple denied everything. They said they were not fighting and that the commotion people heard was not from them... (Male Participant, FGD Community A)*

In response to these social norms of silence and denial, Committee members developed particular strategies, including spreading awareness about forms of violence that may not be recognised by the community and supporting women in discussing IPV experiences in public:

*I think what my colleague said is true, many women do not know that verbal abuse is also violence, they don't know that denial of child support is also violence, that rape is also violence... The GBV Committee encourages women [experiencing violence to speak out during public meetings] because hiding some of those things makes GBV increase. (Female participant, FGD Community B)*

In this way, the GBV Committees at village level are attempting to shape community understandings of the symbolic meaning of IPV-related behaviours and the role of communities in IPV prevention. Indeed, many community members held broad understandings of what constitutes IPV, frequently referring to economic forms of violence as well as physical, verbal and sexual abuse.

However, there was little discussion by GBV Committee members about the need to tackle persistent inequalities - including economic disparities - between women and men, or address the gender norms that continue to perpetuate women's silences and blame women for the violence.

### *Material*

The material factors that influence community action to prevent IPV are extremely prominent in Rwanda as a low-income country with high levels of extreme poverty.

Participants highlighted the challenges of this context and the need to facilitate women's participation in the job market as part of IPV prevention strategies:

*We have a cultural mind-set of dependent women. When you are having problems in your relationship, you are thinking about a lot of things even if you are not married: your kids, where to go if you separate, financial means, no job, and it becomes overwhelming. So the Rwandan culture of dependence and poverty holds you in an unhappy relationship because you are trying to survive. This means of course that, an independent woman who has a job, it is much easier for her. She separates, her salary comes in and life continues. (Female Participant, FGD Community B)*

In some cases, the GBV Committees act to support women experiencing IPV financially. For example, one GBV Committee member explained how they had lobbied on behalf of a woman who had separated from her husband because of IPV:

*Participant: The authorities finally decided to separate them because they were afraid for the woman's life, the man could kill her...*

*Interviewer: Have you done a follow up for this woman?*

*Participant: Yes we did, she now has health insurance for her children and the possibility for her children to go to school. We advocated for her in the 'ubudehe'.<sup>1</sup>*

*Interviewer: So the committee provided money for the school fees?*

*Participant: No we report to the umudugudu that reports to the cell and then the cell to the sector, it is the sector who provided money. It is government support. (GBV Committee Member, Community A)*

GBV Committee members recognised the ways in which economic realities both contribute to acts of violence within relationships and inhibit women's options. This is consistent with evidence that financial support for women experiencing violence is a critical component of effective IPV prevention interventions (Buzawa & Buzawa, 2013).

However, the ability of communities to challenge the material realities in which IPV occurs is constrained by the broader economic context. Providing training and establishing cooperatives for women to engage in income generation was considered an important strategy; yet these kinds of approaches require substantial investment to set up and sustain. In reality, GBV Committee members and community members both reported a lack of funding and training as one of the biggest challenges facing IPV prevention activities:

*We do all this in order to serve people; we don't earn anything from it, but if we could get an allowance... Also when they give us training, they could also give us materials to help us teach people. If we could have books and modules it would be good. (Committee Member, Community A)*

This indicates pervasive problems in carrying out community mobilisation activities within a low-income setting, where GBV Committees are granted no funding for their activities or for the Committee members themselves.

#### *Relational – community relationships*

The relational factors that constitute and influence community action to prevent IPV was the most prevalent theme coming from the data. Relational factors refer to connections that

---

<sup>1</sup> A forum involving members of the community that places people into economic categories for the implementation of social protection programmes.

are made within communities, and between communities and more powerful stakeholders (e.g. those embedded in political and legal systems).

Communities challenged IPV by bringing it up at public community meetings called *umuganda* – mandatory monthly events instated by government. Community members discussed how they report cases of IPV during *umuganda* meetings and take decisions on the best way to respond:

*When they become so difficult we bring them to the general assembly of all the population and we make them stand up in public and there we blame them, telling them that it is not good the way they are behaving... There used to be a man, he was always drunk... and used to beat his wife. We decided to bring him in front of umuganda. The people showed him how he was mistaken and also they showed him another man who used to be in the same situation and had changed. The man hasn't totally changed but there is a difference since that time. (Committee Member, Community B)*

In this way, IPV becomes a community concern. In relation to these public discussions of IPV, one participant claimed: *'everyone has a role in the community and it has to be teamwork'*.

Another instrumental source of community support is found in the *umugoroba w'ababyeyi* or meetings for parents. These are usually attended by women only, as women are considered to be the primary caregiver for children, and are conceptualized by participants as a place to share problems and advice on marital life and child nutrition. Issues of IPV are often discussed, and plans are made on how to take appropriate action:

*In the umugoroba w'ababyeyi for instance, a woman may stand up and share her story with others that her husband has been beating her regularly... The woman feels that it has become too much and so she suddenly breaks out and shares with other women as a way of seeking help. This is because in the umugoroba w'ababyeyi the women get to know each other so closely, form friendships and hence feel comfortable to share their stories. (GBV Committee Member, Community B)*

These parents' evenings provide a safe space for women to share and make sense of their experiences of IPV, which is critical to bringing about transformative social change (Campbell & Cornish, 2010). The persistence of IPV as a private domestic issue has long undermined efforts to address it, and efforts by GBV committees to bring the issue into public spaces for

open discussion have the potential to increase IPV reporting by women and change perceptions of IPV's acceptability.

*Relational – community/government relationships*

Participants mentioned a number of links with government officials that helped with IPV prevention, including by providing access to the court system, accessing the administrative power of GBV Committees at other levels of government (cell, sector, district), and involving the police.

The potential of involving higher levels of authority was often raised as a form of IPV prevention by acting as a deterrent for IPV-related behaviours. For example, participants discussed the role that changes in punishments for IPV have had on prevention:

*Interviewer: Does he still beat his wife?*

*Participant: He used to do so before but now he doesn't because today there is punishment for someone who beats his wife. (GBV Committee Member, Community B)*

It was noted that this punishment could extend to neighbours who do not take action against violence, which helps to construct IPV as a community concern requiring a collective response:

*Yes I would tell them what I know. Because if someone's blood is being spilled you need to talk. If somebody dies their neighbours can also be charged with negligence. (Female Participant, FGD Community A)*

By framing IPV as a community rather than a personal issue, bonds and solidarity around the need to prevent IPV are established which has the potential to reshape symbolic ideas of IPV as a private issue in ways that further undermine the culture of silence.

If cases of IPV cannot be resolved by the community or in the *umudugudu* meetings, participants explained that a married couple would be referred to a higher level of government. In the most severe circumstances, the case was taken to the police and/or engaged the court system as a mechanism for assisting with divorce rulings.

*When they are married, we analyse the level of violence we bring it in the umugoroba w'ababyeyi and there we made a report because it is beyond of our capacity. We make a report for the cell and the cell reports to the sector, which sends the case to the district. We are not able to handle such case, when they are legally married, and*



*divorce is possible. In terms of preventing violence, when we are scared about a murder or any kind of violence, we quickly investigate in order to know if the conflict is serious or not. If it is serious we contact the police to be involved in the issue.*  
(Committee Member, Community B)

Rwanda's decentralised government structure with GBV representatives at all levels, each with unique responsibilities, gives community members a new set of possible actions in responding to IPV. This can also act as a form of secondary prevention by ensuring that IPV cases that cannot be handled by community members will be dealt with by broader institutions, thus reaffirming the idea that IPV is a social problem with real consequences for perpetrators (Song, Wenzel, Kim, & Nam, 2015).

However, the excerpt above also highlights some of the limitations current legal protections have for unmarried women. Unmarried women who experience IPV are rarely reported to higher levels of government because divorce proceedings are not relevant in these cases and IPV is otherwise not perceived as a legal issue. In fact, GBV Committees often advise unmarried women who are experiencing IPV to marry their abusive partner. This is a strategic solution that participants claimed increased stability in the relationship, and gives women legal protections that limited future instances of abuse:

*Interviewer: Do you think that the abuse disappeared after their marriage?*  
*Participant: No not really. But because they are now married, we show them that the law is over them, so they do not do it as often as before. The violence is reduced considerably.* (Committee Member, FGD Community A)

Encouraging women to marry their abuser does provide an option for unmarried women who have no other institutional pathway to follow after experiencing IPV. However, community members rarely mentioned the potential risks associated with this approach, including subjecting women to life with an abusive partner. Within this context, this becomes a logical approach to IPV prevention from the perspective of GBV Committees and may in fact prove to be effective in circumstances where symbolic and material factors inhibit other responses. In this way, GBV Committees are navigating complex pathways through the restrictive aspects of

symbolic/material contexts and community/government relations. Nonetheless, unmarried women remain extremely vulnerable to IPV through this approach.

## **Discussion and Conclusions**

Our findings highlight several factors that enable effective and sustainable community mobilisation for IPV prevention within the three dimensions of symbolic, material and relational contexts. This helps establish a framework that can be used to identify social contextual factors that support effective IPV prevention efforts in and by communities. Symbolically, addressing the culture of silence and facilitating a broad community understanding of violence helps to ensure that communities are able to intervene in a wide variety of cases. However, the exclusive focus on IPV as only one form of GBV also narrows this potential by masking the necessity of addressing gender inequalities as a root cause of men's violence against women (Fleming et al., 2015). Materially, infrastructure or networks that can provide financial support to women experiencing violence are critically important for effective IPV prevention particularly in low-income settings. Economic support for activists or 'change agents' (such as GBV Committee members) within communities may also be needed to ensure the long-term sustainability of IPV prevention activities. Within the relational context, establishing links within communities can facilitate efforts to bring IPV into public discussions and undermine the culture of silence that often surrounds violence against women (Fox et al., 2007). Links between communities and powerful stakeholders, such as the police, government authorities and legal structures, helps to ensure effective community activities that hold perpetrators accountable for violence and provide support for women experiencing violence.

However, our findings also point to an additional dimension that is needed to effectively assess community mobilisation for IPV prevention in the Rwandan context: gender inequalities embedded in social and political institutions. While gender norms can be

considered part of the symbolic context, a focus on the presence of unequal gender norms within communities obscures the way gender inequalities are reinforced by formal institutional structures, such as government policy and law. Adding an analysis of these institutionalised gender inequalities to our framework ensures that community IPV prevention activities are assessed for their capacity to disrupt institutional frameworks that uphold women’s inferior position vis-à-vis men beyond the community level. For instance, in the Rwandan case study Committee members were unable to challenge the broader structural inequalities formalised by legal frameworks that protect married but not unmarried women. An analysis of institutionalised inequalities highlights this as a limitation of the surrounding social context in Rwanda and its lack of support for IPV prevention. *Table 2* summarises our proposed framework.

*Table 3: Contextual factors needed to support effective community mobilisation for IPV prevention*

<b>Symbolic</b>	<b>Material</b>	<b>Relational</b>		<b>Institutional</b>
		<i>Within communities</i>	<i>Between communities and powerful allies</i>	
<b>Definition:</b>				
- Social norms and cultural meanings associated with IPV and prevention activities	- Economic resources for health outcomes - Economic resources for health interventions	- Relationships between community members	- Relationships between community members and powerful allies	- Gender relations that have been institutionalised in government policy, law, education, health services, etc.
<b>Examples for IPV prevention:</b>				
- Broad definitions of IPV that establish a wide space for potential intervention by community members	- Financial resources available for IPV survivors - Compensation for community tasks/ responsibilities related to IPV prevention	- Supportive community relationships that effectively address the silences surrounding IPV	- Relationships with police and government authorities that deter IPV-related behaviours	- Legal structures that support gender equality - Gender policies that support GBV survivors (widely defined to include men/ boys and LGBT populations)

The importance of the policy and legal environment to the success of gender interventions is not new. Policy plays an essential role in supporting gender equal norms, women's empowerment and agency (King & Mason, 2001), and ensuring the success of public health interventions more broadly (Blankenship, Bray, & Merson, 2000; Gibbs, Mushinga, Crone, Willan, & Mannell, 2012). Heise's (2011) ecological framework, which has been widely adopted for IPV prevention interventions as a conceptual framework, locates policies and legal frameworks within the broader gender order that influences violent behaviours. However, interventions that address policy are often separated from those that address the community level with different intervention models being utilised for different purposes (see Ellsberg et al., 2015). By adding the institutional dimension into considerations for community mobilisation interventions, we are calling for: (1) a clearer recognition of how institutionalised inequalities influence the potential of community mobilisation for IPV prevention; and (2) an acknowledgement of the need for community members to challenge broader structural inequalities in order to ensure the success of IPV prevention at the community level.

The proposed framework for the social contexts that support community mobilisation for IPV prevention helps identify the contextual supports needed for social change to occur. It does this by assessing community activities to prevent IPV according to whether the necessary supports are in place to support broader engagement by communities. Drawing from the Rwandan case study as an example, the framework sheds light on how community activities such as advising unmarried women to marry their abusers are situated within a symbolic context where wives have greater value than unmarried partners; a material context where women are often dependent on income provided by men and community interventions are unfunded; a relational context where community members publically discuss IPV and may reinforce marriage as a suitable solution; and an institutional context where the law protects a married women's rights and sanctions acts of violence committed by the husband, but leaves

unmarried women at risk. Using the framework not only helps point to the logic behind the activities of GBV Committee members and how these are rationalized to prevent IPV, but also quite importantly points to the marginalisation of unmarried women experiencing IPV in this context and how intersecting dimensions of the social environment perpetuate this marginalisation in Rwanda.

The framework also points to the importance of thinking of community mobilisation as a socially embedded process in and of itself, and not simply a mechanism for challenging IPV-related social and cultural norms within communities. Communities are perceived within the framework as participants involved in challenging the structural and institutional barriers to IPV prevention in their communities and not just the locus of social norms that perpetuate IPV-related practices. This supports a definition of community mobilisation as a process whereby communities draw on their experience of inequalities and vulnerability to tackle the barriers they see to the health of their community (AVAHAN, 2008), which stands in contrast to interventions such as *SASA!* and *SHARE* that frame mobilisation primarily as a community-based activity (Abramsky, Devries, Michau, Nakuti, Musuya, Kiss, et al., 2016; Wagman et al., 2016). Our argument is that mobilisation should ideally be a process whereby communities challenge the broader social and institutional structures that undermine their collective efforts to prevent IPV rather than only a means of changing social norms.

IPV prevention is a process bound up in the complexities of social contexts. By adapting work on supportive social environments (Campbell & Cornish, 2010) and adding an analysis of institutionalised gender inequalities, this paper has developed a framework for understanding and interrogating the social contextual factors that influence community mobilisation for IPV prevention. The case study of GBV Committees in Rwanda demonstrates the value of this framework in identifying and challenging aspects of the social context that inhibit effective community mobilisation for IPV prevention. The framework is therefore

useful for navigating symbolic, material and relational dimensions of the social context – as well as institutionalised gender inequalities - in order to better facilitate IPV prevention in and by communities. More broadly we hope this paper inspires greater consideration of the social and structural context, including its gendered dynamics, in community mobilisation interventions.

## References

- Abramsky, T., Devries, K. M., Michau, L., Nakuti, J., Musuya, T., Kiss, L., ... Watts, C. (2016). Ecological pathways to prevention: How does the SASA! community mobilisation model work to prevent physical intimate partner violence against women? *BMC Public Health, 16*, 339. <https://doi.org/10.1186/s12889-016-3018-9>
- Abramsky, T., Devries, K. M., Michau, L., Nakuti, J., Musuya, T., Kyegombe, N., & Watts, C. (2016). The impact of SASA!, a community mobilisation intervention, on women's experiences of intimate partner violence: secondary findings from a cluster randomised trial in Kampala, Uganda. *Journal of Epidemiology and Community Health, jech-2015-206665*. <https://doi.org/10.1136/jech-2015-206665>
- Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research, 1*(3), 385–405.
- AVAHAN. (2008). *Avahan—The India AIDS Initiative: The Business of HIV Prevention at Scale* (p. 40). New Delhi: Bill & Melinda Gates Foundation. Retrieved from [https://docs.gatesfoundation.org/documents/avahan\\_hivprevention.pdf](https://docs.gatesfoundation.org/documents/avahan_hivprevention.pdf)
- Blankenship, K., Bray, S., & Merson, M. H. (2000). Structural interventions in public health : AIDS. *AIDS, 14*, S11–S21.
- Butchart, A., Garcia-Moreno, C., Mikton, C., World Health Organization, & London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women global trends and determinants of prevalence, safety, and acceptability*. Geneva: World Health Organization. Retrieved from [http://whqlibdoc.who.int/publications/2010/9789241564007\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf)
- Buzawa, E. S., & Buzawa, C. G. (2013). What does Research Suggest are the Primary Risk and Protective Factors for Intimate Partner Violence (IPV) and What is the Role of

- Economic Factors? *Journal of Policy Analysis and Management*, 32(1), 128–137.  
<https://doi.org/10.1002/pam.21668>
- Campbell, C. (2010). Political will, traditional leaders and the fight against HIV/AIDS: a South African case study. *AIDS Care*, 22(sup2), 1637–1643.  
<https://doi.org/10.1080/09540121.2010.516343>
- Campbell, C., & Cornish, F. (2010). Towards a fourth generation of approaches to HIV/AIDS management: creating contexts for effective community mobilisation. *AIDS Care*, 22(1), 1569–1579.
- Campbell, C., & Cornish, F. (2012). How can community health programmes build enabling environments for transformative communication? Experiences from India and South Africa. *AIDS and Behavior*, 16(4), 847–857.
- Campbell, C., & Mannell, J. (2016). Conceptualising the agency of highly marginalised women: Intimate partner violence in extreme settings. *Global Public Health*, 11(1–2), 1–16. <https://doi.org/10.1080/17441692.2015.1109694>
- Connell, R. (2012). Gender, health and theory: Conceptualizing the issue, in local and world perspective. *Social Science & Medicine*, 74(11), 1675–1683.  
<https://doi.org/10.1016/j.socscimed.2011.06.006>
- Cornish, F., Priego-Hernandez, J., Campbell, C., Mburu, G., & McLean, S. (2014). The impact of community mobilisation on HIV prevention in middle and low income countries: a systematic review and critique. *AIDS and Behavior*, 18(11), 2110–2134.  
<https://doi.org/10.1007/s10461-014-0748-5>
- Ellsberg, M., Arango, D. J., Morton, M., Gennari, F., Kiplesund, S., Contreras, M., & Watts, C. (2015). Prevention of violence against women and girls: what does the evidence say? *The Lancet*, 385(9977), 1555–1566.



- Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods*, 5(1), 80–92.  
<https://doi.org/10.1177/160940690600500107>
- Fleming, P. J., Gruskin, S., Rojo, F., & Dworkin, S. L. (2015). Men’s violence against women and men are inter-related: Recommendations for simultaneous intervention. *Social Science & Medicine*, 146, 249–256. <https://doi.org/10.1016/j.socscimed.2015.10.021>
- Fox, A. M., Jackson, S. S., Hansen, N. B., Gasa, N., Crewe, M., & Sikkema, K. J. (2007). In Their Own Voices A Qualitative Study of Women’s Risk for Intimate Partner Violence and HIV in South Africa. *Violence Against Women*, 13(6), 583–602.  
<https://doi.org/10.1177/1077801207299209>
- Gibbs, A., Mushinga, M., Crone, E. T., Willan, S., & Mannell, J. (2012). How Do National Strategic Plans for Hiv and Aids in Southern and Eastern Africa Address Gender-Based Violence? A Women’s Rights Perspective. *Health & Human Rights: An International Journal*, 14(2), 10–20.
- Gibbs, A., Willan, S., Jama-Shai, N., Washington, L., & Jewkes, R. (2015). ‘Eh! I felt I was sabotaged!’: facilitators’ understandings of success in a participatory HIV and IPV prevention intervention in urban South Africa. *Health Education Research*, 30(6), 985–995. <https://doi.org/10.1093/her/cyv059>
- Heise, L. (2011). *What Works to Prevent Partner Violence? An Evidence Overview | STRIVE* (p. 126). London: STRIVE Research Consortium. Retrieved from <http://strive.lshtm.ac.uk/resources/what-works-prevent-partner-violence-evidence-overview>
- Heise, L. L. (1998). Violence against women: an integrated, ecological framework. *Violence Against Women*, 4(3), 262–290.

- Hughes, R. (1998). Considering the Vignette Technique and its Application to a Study of Drug Injecting and HIV Risk and Safer Behaviour. *Sociology of Health & Illness*, 20(3), 381–400. <https://doi.org/10.1111/1467-9566.00107>
- Jewkes, R. (2002). Intimate partner violence: causes and prevention. *The Lancet*, 359(9315), 1423–1429.
- Jewkes, R. (2014). *What Works in Preventing Violence Against Women and Girls: Evidence review of the effectiveness of response mechanisms in preventing violence against women and girls* (p. 41). London: Department for International Development (DFID). Retrieved from <https://www.gov.uk/government/publications/what-works-in-preventing-violence-against-women-and-girls-review-of-the-evidence-from-the-programme>
- Jewkes, R., Flood, M., & Lang, J. (2015). From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls. *The Lancet*, 385(9977), 1580–1589. [https://doi.org/10.1016/S0140-6736\(14\)61683-4](https://doi.org/10.1016/S0140-6736(14)61683-4)
- Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Puren, A., & Duvvury, N. (2008). Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. *BMJ: British Medical Journal*, 337. <https://doi.org/10.1136/bmj.a506>
- Kelly, K. J., & Birdsall, K. (2010). The effects of national and international HIV/AIDS funding and governance mechanisms on the development of civil-society responses to HIV/AIDS in East and Southern Africa. *AIDS Care*, 22(sup2), 1580–1587. <https://doi.org/10.1080/09540121.2010.524191>

- King, E., & Mason, A. D. (2001). *Engendering development through gender equality in rights resources and voice* (World Bank Policy Research Report) (p. 32). Washington, D.C.: World Bank.
- Kyegombe, N., Abramsky, T., Devries, K. M., Starmann, E., Michau, L., Nakuti, J., ... Watts, C. (2014). The impact of SASA!, a community mobilization intervention, on reported HIV-related risk behaviours and relationship dynamics in Kampala, Uganda. *Journal of the International AIDS Society*, *17*(1). <https://doi.org/10.7448/IAS.17.1.19232>
- Mannell, J., Jackson, S., & Umutoni, A. (2016). Women's responses to intimate partner violence in Rwanda: Rethinking agency in constrained social contexts. *Global Public Health*, *11*(1–2), 65–81. <https://doi.org/10.1080/17441692.2015.1013050>
- Maton, K. I. (2008). Empowering Community Settings: Agents of Individual Development, Community Betterment, and Positive Social Change. *American Journal of Community Psychology*, *41*(1–2), 4–21. <https://doi.org/10.1007/s10464-007-9148-6>
- Ministry of Gender and Family Promotion. (2011, July). National Policy Against Gender-Based Violence. Republic of Rwanda. Retrieved from [http://www.migeprof.gov.rw/IMG/pdf/GBV\\_Policy-2\\_1\\_.pdf](http://www.migeprof.gov.rw/IMG/pdf/GBV_Policy-2_1_.pdf)
- National Institute of Statistics Rwanda. (2012). *Demographic and Health Survey 2010 - Final Report*. Kigali, Rwanda: Ministry of Finance and Economic Planning. Retrieved from <http://www.statistics.gov.rw/publications/demographic-and-health-survey-2010-final-report>
- National Institute of Statistics Rwanda. (2016). *Demographic and Health Survey 2014/2015 - Key findings*. Kigali, Rwanda: Ministry of Finance and Economic Planning. Retrieved from <http://www.statistics.gov.rw/publication/demographic-and-health-survey-dhs-20142015-key-findings>

- Skovdal, M., Campbell, C., Nhongo, K., Nyamukapa, C., & Gregson, S. (2011). Contextual and psychosocial influences on antiretroviral therapy adherence in rural Zimbabwe: towards a systematic framework for programme planners. *The International Journal of Health Planning and Management*, 26(3), 296–318. <https://doi.org/10.1002/hpm.1082>
- Sommer, M., & Parker, R. (2013). *Structural Approaches in Public Health*. Abingdon: Routledge.
- Song, A., Wenzel, S. L., Kim, J. Y., & Nam, B. (2015). Experience of Domestic Violence During Childhood, Intimate Partner Violence, and the Deterrent Effect of Awareness of Legal Consequences. *Journal of Interpersonal Violence*, 886260515586359. <https://doi.org/10.1177/0886260515586359>
- Wagman, J. A., King, E. J., Namatovu, F., Kiwanuka, D., Kairania, R., Semanda, J. B., ... Brahmbhatt, H. (2016). Combined Intimate Partner Violence and HIV/AIDS Prevention in Rural Uganda: Design of the SHARE Intervention Strategy. *Health Care for Women International*, 37(3), 364–387. <https://doi.org/10.1080/07399332.2015.1061526>
- Wagman, J. A., Namatovu, F., Nalugoda, F., Kiwanuka, D., Nakigozi, G., Gray, R., ... Serwadda, D. (2012). A Public Health Approach to Intimate Partner Violence Prevention in Uganda The SHARE Project. *Violence Against Women*, 18(12), 1390–1412. <https://doi.org/10.1177/1077801212474874>
- World Health Organisation. (2013). *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines*. Geneva: World Health Organization.
- World Health Organisation, London School of Hygiene and Tropical Medicine, & South African Medical Research Council. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence* (No. 9789241564625) (p. 51). Geneva, Switzerland: World

Health Organisation. Retrieved from

<http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/>