REDUCING GENDER-BASED VIOLENCE AND INEQUITIES TO IMPROVE MATERNAL HEALTH

NOVEL SEXUAL AND REPRODUCTIVE HEALTH INTERVENTIONS FROM INDIA

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Presentation for the Woodrow Wilson Center, April 18, 2013

ACADEMIC-NGO-GOVERNMENT COLLABORATIVE WORK IN INDIA

- Our UCSD research team within the Program on Gender Inequities and Global Health focuses on understanding and reducing gender inequities and gender-based violence (GBV) as a means of improving population health, particularly sexual, reproductive, maternal and child health.

- Since 2005, our team (Raj and Silverman) has collaborated with Population Council India (Dr. N. Saggurti) and the Indian Government's National Institute for Research in Reproductive Health (Dr. D. Balaiah) to focus on these issues in India. Goals:
  - To create and evaluate innovative scalable models of intervention for use in community and clinical settings.
  - To engage in rigorous epidemiologic and qualitative research to guide intervention development and evaluation, as well as policy.

- Purpose of this presentation: *To highlight how we consider and address gender inequities and GBV in our sexual and reproductive health intervention research in India*

HIV AMONG WOMEN IN INDIA

1. NACO, 2009
2. IIPS, 2007 (NFHS-3); Saggurti et al., 2009
3. Silverman et al. 2008 (JAMA)

2.3 million HIV-infected individuals in India[1]

- 39% are women

Women's HIV Risks[2]

- Marriage
- Age 30-34 years, Urban, Middle Income

Married Women's HIV Risks[3]

- Spousal Violence-- IPV
- Husband's Risky Drinking

Few Efforts to Intervene with these At Risk Wives

THE RHANI WIVES HIV INTERVENTION

- **Participants** -- women reporting non-severe IPV or and husbands risky alcohol use, and residing in Mumbai slums with HIV rates and red light areas (N=208)
- **Content focus** -- marital stresses (financial stress, alcohol, IPV) and marital communication, social and formal support
- **Structure** -- 6 week program with 4 individual sessions in the home and 2 group sessions (very low attendance); street theatre prior to women intervention delivery

Funded through the NIH-ICMR JWG Indo-US Agreement (NIMH-- R21MH85614)

RHANI WIVES STREET THEATRE

Street theatre based on the theme that spousal violence is always unacceptable and can be related to both husband's alcohol use and HIV risk

(written by theatre troupe with research team)

RHANI WIVES INDIVIDUAL SESSIONS

- Problem identification and problem solving- using "thermometer" and "cyclical drawings" of how problems inter-relate.
- Storytelling on problems identified, to reduce stigma and highlight possible solutions

Action plan development to create solutions towards reducing the intensity of violence/alcohol and initiate/maintain the practice of condom use.

Identify formal and informal supports in the community to support action plans.

Review action plan implementation, what worked and what did not work.

2 Armed RCT Findings - Intervention Effects on Unprotected Sex with Husband and Condom Use with Husband

Intervention effect on the ratio of unprotected to total number of vaginal sex acts with spouse partner, past 30 days

Simple Effect Level	Comparisons	Rate Ratio Estimate	Lower CL	Upper CL	t-value	P-value
Intervention Group	Follow-up vs. Baseline	0.866	0.794	0.946	-3.20	0.002
Control Group	Follow-up vs. Baseline	1.005	0.936	1.078	0.13	0.899
Follow-up	Intervention vs. Control	0.836	0.753	0.929	-3.34	0.001
Baseline	Intervention vs. Control	0.970	0.897	1.048	-0.78	0.436

Note: Visit by Group Interaction (p-value=0.01)

Intervention effect on the probability of using a condom at last sex with husband

Simple Effect Level	Comparisons	Odds Ratio Estimate	Lower CL	Upper CL	t-value	P-value
Intervention Group	Follow-up vs. Baseline	2.605	1.301	5.216	2.71	0.007
Control Group	Follow-up vs. Baseline	1.118	0.479	2.609	0.26	0.796
Follow-up	Intervention vs. Control	2.401	1.002	5.758	1.97	0.049
Baseline	Intervention vs. Control	1.030	0.426	2.491	0.07	0.947

Note: Visit by Group Interaction (p-value=0.13)

2 Armed RCT Findings - Intervention effects on Spousal Violence: Physical Violence, Past 3 Months; Sexual Coercion, Last Sex

Intervention effect on the probability of physical violence by husband

Simple Effect Level	Comparisons	Odds Ratio Estimate	Lower CL	Upper CL	t-value	P-value
Intervention Group	Follow-up vs. Baseline	0.395	0.210	0.741	-2.90	0.004
Control Group	Follow-up vs. Baseline	0.410	0.204	0.826	-2.50	0.013
Follow-up	Intervention vs. Control	1.191	0.459	3.089	0.36	0.718
Baseline	Intervention vs. Control	1.239	0.590	2.601	0.57	0.571

Note: Visit by Group Interaction (p-value=0.94)

Intervention effect on the probability of sexual coercion by husband

Simple Effect Level	Comparisons	Odds Ratio Estimate	Lower CL	Upper CL	t-value	P-value
Intervention Group	Follow-up vs. Baseline	0.170	0.065	0.442	-3.65	<0.001
Control Group	Follow-up vs. Baseline	0.516	0.232	1.146	-1.63	0.104
Follow-up	Intervention vs. Control	0.473	0.131	1.705	-1.15	0.252
Baseline	Intervention vs. Control	1.437	0.650	3.176	0.90	0.369

Note: Visit by Group Interaction (p-value=0.08)

EARLY MARRIAGE, FAMILY PLANNING AND MATERNAL HEALTH IN RURAL INDIA

Rural India has high and early fertility due to high rates of girl child marriage and low use of spacing contraception (5-8%).

- Contraception Use in India is less likely if:
  - Adolescent wife or married as adolescent
  - DIL rather than wife in household
  - Have no sons

- Early marriage and indicators of non-use of contraception (e.g., short interpregnancy intervals) are associated with maternal and infant mortality
  - 150,000 infant deaths in 2012 were attributable to the combination of young motherhood (<18 years) and low birth spacing.

NFHS-3 Analyses

CHARM Gender Equity Family Planning Intervention for Young Rural Husbands

CHARM Intervention:

- Local village health providers deliver FP counseling inclusive of GE to men at no cost
- GE concepts include: in-law involvement; son preference; IPV; communication and joint-decision-making
- FP methods (pill, condom) provided by VHP at no cost.
- One session required, 2nd optional. 3rd optional session for couples.

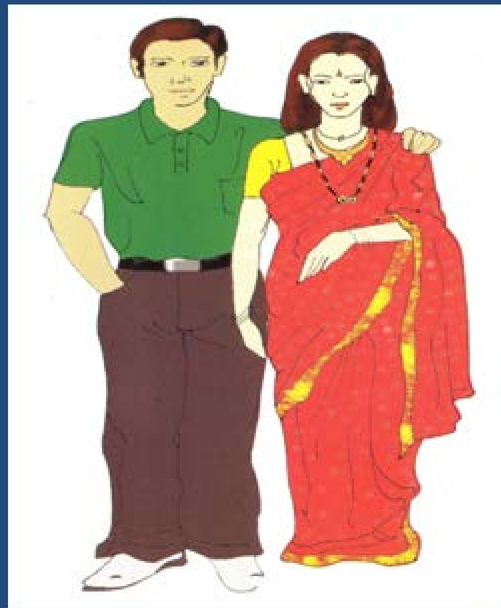
1 or 2 Individual sessions with men

1 Couples' Session (Optional)

Public Private Partnership Model

Funded by Indo-US NICHD/ICMR Grant R01HD061115

Marital communication



Married Couples' Joint Decision Making on Family Planning

"I have understood that girls and boys are same and if we give education and good values then girls also can take care of parents in their old age so I don't give preference to boy child."

"Whether it is boy or a girl child , it is important to have healthy baby, and for that I will regularly visit to the PHC"

"It is my prime responsibility, to take care of my wife during pregnancy, after the delivery"

Marital communication

- Unhealthy marital communication can lead to arguments, unhealthy relationship, unequal division of responsibilities and finally family suffers
- Good communication habits are the foundation of a successful marriage.
- It is important during a disagreement to express oneself clearly and calmly.
- There are healthier ways to resolve arguments and negotiate or compromise to reach a solution.
- husband and wife should know each othe by expressing respect, affection and giving attention to each other.

Decision Making

Married Couples' Joint Decision Making on Family Planning

- Majority of couples/in-laws feel that it is compulsory to have first child soon after marriage. Parenthood is big responsibility and both husband and wife should be mentally prepared to take that responsibility.
- Both should respect each other's opinion and decide mutually.
- Husband should understand that his wife is also equally important and she also have right to express her views and take decision regarding family planning.
- A good husband shares information about sexual and reproductive health issues with his wife. A husband should take responsibility by using or supporting his wife's contraceptive use.
- Family planning can be used regardless of how many children you already have or want for the future.

CURRENT STATUS AND BASELINE DATA FINDINGS

50 villages surveyed. 1000 couples participated in the 2 armed RCT study. Intervention in the field.
Participants: 18-30 year old husbands; no sterilization

WIVES:

- Age 16-30 years
- 18% no education
- Age at marriage- 2-30 yrs
- 86% had previously given birth; 21% pregnant
- 6% reported contraception use prior to first birth
- Most (62%) have never used modern contraception
- 33% IPV; 10% IPV past 6 mo

HUSBANDS:

- Age 18-30 years
- 8% no education
- Age at marriage- 11-30 yrs
- Justifications for IPV, if wife…
  - Goes out w/o telling him: 34%
  - Neglects children 47%
  - Argues with him: 31%
  - Refuses sex: 19%
  - Does not cook food properly: 13%
  - Shows disrespect to in-laws: 35%

YOUTH-CARE

YOUTH CAPACITY BUILDING TO ADVOCATE FOR REDUCTION OF EARLY MARRIAGE AND EARLY PREGNANCY

- Field survey on rural girls' (14-18), boys' (16-21) and parents' beliefs on early marriage, contraception use, and gender equity for youth intervention creation.

Funded by Indo-US NICHD/ICMR
Grant R01HD061115-Supplement

YOUTH CARE FINDINGS

	Fathers	Mothers	Boys (16-21)	Girls (14-16)
No formal Education	8%	22%	0%	1%
Any + effects of girl marriage <18 yrs	1%	1%	0%	1%
Girls should not be able to choose				
who to marry.	49%	34%	22%	19%
when they marry.	43%	19%	23%	10%
Contraception should not be used in marriage	44%	58%	42%	86%
It is acceptable for a husband to beat his wife:				
• If she goes out without telling him	15%	15%	6%	8%
• If she neglects the house or the children	25%	28%	22%	13%
• If she argues with him	22%	26%	22%	19%
• If she doesn't cook food properly	3%	8%	1%	3%
• If she shows disrespect for her in-laws	26%	20%	19%	14%

More traditional beliefs were associated across groups.

YOUTH CARE NEXT STEPS

- Findings disseminated
- Curriculum is being developed.
- Focus is beyond early marriage and will include girls' choice, spousal violence, and FP education

Boy and girl Youth CARE Advocates will work in their communities via conversations to educate and alter norms on these issues:- gender equity, gender-based violence, and family planning/contraception.

CONCLUSION AND IMPLICATIONS

- Across areas of focus on issues of sexual and reproductive health, gender inequities and gender-based violence heighten health vulnerabilities
- On the ground community and clinical gender equity focused interventions show promise with women, men and youth in India.
- Issues to Consider- Are these approaches being prioritized?
  - Development and upstream gender equity approaches, like girl child education, are receiving much focus and funding. However, these alone are unlikely to create change in a timely fashion.
  - Innovative programmatic models like these are being developed, but few are being rigorously evaluated. Scale up is occurring prior to evaluation and with no implementation science components.
- Evidence-based interventions and rigorous evaluation of these must be prioritized to better address GBV and maternal health.

ACKNOWLEDGEMENTS

- Study participants
- UCSD Team: Jay Silverman, Anindita Dasgupta, Julie Ritter, Daniela Abramowitz, Lotus McDougal
- Population Council Team: Niranjan Saggurti, Madhusudana Battala
- NIRRH Team: Donta Balaiah, Saritha Nair, DD Naik, Mohan Ghule, and the large number of team members led by Dr. Balaiah and his scientists across these research studies.
- Funders: ICMR, DBT, NIMH (W Pequegnat), NICHD (S Newcomer, D Raiten), Packard Foundation (L Coutinho)