

# Feasibility of screening and referring women experiencing marital violence by engaging frontline workers: Evidence from rural Bihar



## Introduction

Marital violence is widespread in India and the typical reaction of women to violence committed by their husband is silence and toleration. The National Health Mission has identified violence prevention and services for women in distress as a key priority for frontline health workers. Accredited Social health Activists (ASHAs) are sensitised on how to recognise a woman facing violence, take appropriate actions for its prevention, and facilitate access to services for women experiencing violence (National Health Mission, nd). Nevertheless, just 24 percent of women who had experienced marital violence reported that they had sought help from anyone, and less than one percent had approached the health system (IIPS and Macro International, 2007). The hands-off approach of service providers plays an important role in limiting women's care-seeking. Even when treating a woman who shows obvious signs of violence, providers do not seize the opportunity to probe the woman's situation or offer her counselling, treatment, or a referral. In India, where few women would seek a provider and disclose the experience of violence, and where few women have the freedom of movement or the required resources to visit a health facility, there is a compelling need for the health system to play a more proactive role. Such a proactive role may be played by the strong network of frontline workers (FLWs), namely, ASHAs, anganwadi workers (AWWs), and auxiliary nurse-midwives (ANMs).

The *Do Kadam Barabari Ki Ore* (Two Steps Towards Equality) project sought to support ASHAs, AWWs, and, to a lesser extent, ANMs to screen women for their experience of marital violence, inform women about their options in case of such an experience, and provide basic counselling and referral, as appropriate, to women reporting the experience. The Population Council together with partners, the Centre for Catalyzing Change (C3) and the London School of Hygiene and Tropical Medicine, with support from UKaid, implemented the project in one district (Patna) of Bihar. This brief describes the intervention and presents evidence on its acceptability and feasibility from the perspective of women residing in study communities as well as from FLWs charged with implementing the intervention.

## Do Kadam Barabari Ki Ore

The Do Kadam programme was conducted among all FLWs serving nine villages located within a radius of 5–6 kilometres from one primary health centre in one block in Patna district. A three-day training programme, using participatory methodologies, was held, which sensitised FLWs on women's rights and the unacceptability of marital violence; they were also informed about services available for women in distress. The project adapted an available screening tool, namely, the Abuse Assessment Screen,<sup>1</sup> and the project team familiarised FLWs, in the course of training, on the screening tool and on how to administer it in a non-threatening way and record responses. Finally, it sought to develop communication and basic counselling skills of FLWs. Each ASHA and AWW was assigned some 30–50 women who were pregnant or had a child in ages 0–5 and were in ages up to 39 years to screen, inform, counsel, follow-up, and refer as required. ANMs were included in the project as mentors to ASHAs and AWWs and as referral points for women in need.

Over the course of the seven-month intervention, each ASHA and AWW visited the women whom they had been assigned to serve in the course of their regular home visits and administered the screening tool in a conversational way. In subsequent visits to women who had experienced domestic violence, they provided basic counselling and support, and if the violence was severe, referred women to the ANM or to available services (police, legal, helpline) for women in distress. Each woman was provided a brochure in which details of services available were provided. Finally, community events, in the form of street plays, were also organised to sensitise communities more generally to women's rights and inform them about services for women who experience violence. The project team also held monthly refresher meetings with FLWs in which progress and problems were discussed and solutions sought.

In order to evaluate the feasibility and acceptability of the intervention, we interviewed 1,153 women in ages up to 39 years who were pregnant or had children in ages 0–5; they were interviewed at two points in time, namely, before launching the intervention and at its conclusion. We also interviewed in-depth a selected panel of 10 women from intervention villages who had reported the experience of violence in the baseline survey at two points in time—three months after the baseline survey (midline interview) and shortly after the endline survey (endline interview). Finally, we interviewed in-depth, at baseline and endline, all ASHAs (16), AWWs (18), and ANMs (5) serving the intervention villages.

Our baseline survey confirms that violence against women was widespread. Nine in 10 women had experienced emotional, physical, or sexual violence perpetrated on them by their husband or other family members in the year prior to the baseline interview.

## Feasibility and acceptability of interventions by engaging FLWs: Perspectives of women

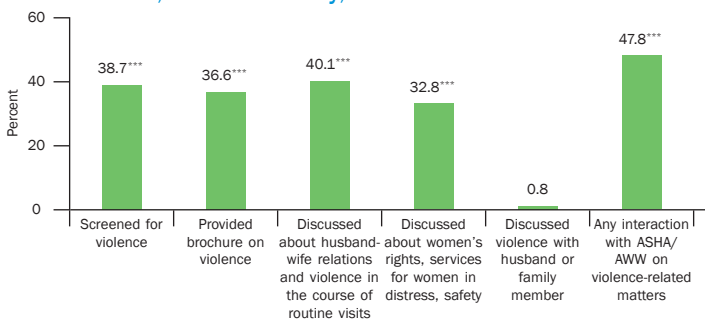
### Interaction with FLWs about marital violence

Interaction with FLWs about marital violence increased considerably over the period of the intervention. While just three percent of women reported at baseline that a FLW had discussed any aspect of violence with her in the previous six months, 48 percent so reported by endline.

<sup>1</sup> We adapted an available screening tool, namely the Abuse Assessment Screen (McFarlane, Parker, Soeken and Bullock, 1992; Basile, Hertz, Back, 2007).

Findings, presented in Figure 1, show that, in all, 39 percent of women acknowledged that the FLW had screened them for violence. Some 33-40 percent of women reported that the FLW had discussed husband-wife relations and/or violence-related matters with them, provided them a brochure on violence and conveyed information to them about women's rights, and services for women in distress. Hardly any women reported that the FLW had engaged their husband or family members in a discussion about the perpetration of violence on women.

**Figure 1: Percentage of women reporting discussion on violence-related matters, screening for violence, and receipt of a violence-related brochure in the six months preceding the interview, endline survey, 2016**



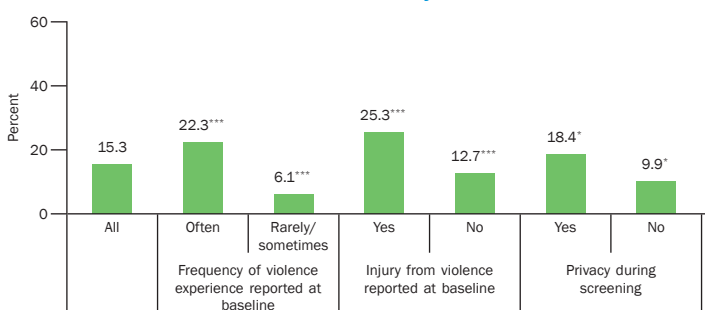
Note:\*\*\* indicates that difference between baseline and endline values was significant at  $p < 0.001$ .

The FLWs were more likely to have interacted on violence-related matters with women from scheduled castes (60%) as compared with those from other backward castes (36%) and general castes (30%), those with no formal education (61%) as compared with educated women, for example, with 12 or more years of education (29%), and those who had worked for wages in the 12 months preceding the interview (62%) as compared with those who had not (39%).

### Disclosure of violence at the time of screening

Just 15 percent of all women who had been screened disclosed their experience of marital violence in the 12 months preceding the interview to the ASHA or AWW (Figure 2); in contrast, 89 percent of all women interviewed in the baseline survey reported the experience of any violence.

**Figure 2: Percentage of screened women who disclosed their marital violence experience to the ASHA or AWW by selected characteristics, 2016, endline survey**



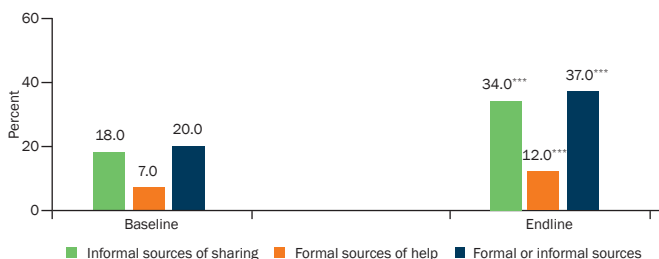
Note:\* and \*\*\* indicate that difference between baseline and endline values was significant at  $p < 0.05$  and  $p < 0.001$ , respectively.

Disclosure of violence was positively associated with frequency of violence experience (22% of women who had experienced it more than once a month in the 12 months preceding the baseline interview versus 6% of women who had experienced it less frequently), experience of injury as a result of marital violence (25% of women who had received injuries in the 12 months preceding the baseline interview versus 13% of those who had not received injuries), and privacy during screening for violence experience (18% of those had been screened in private versus 10% of others).

### Help-seeking

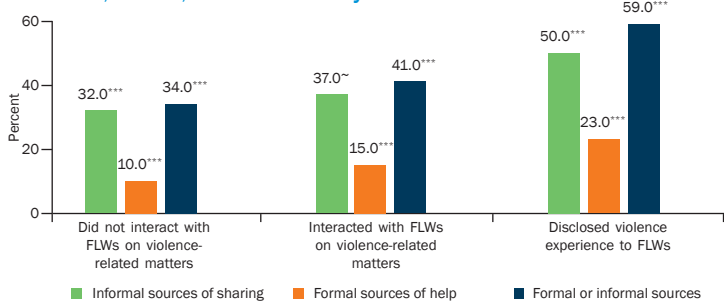
Findings show that help-seeking was far from universal and that many women suffered their experience in silence; (Figure 3). However, a larger proportion of women had shared their experiences with family and friends or had sought services from formal sources at endline than at baseline (37% versus 20%). At endline, women who had interacted with the FLW about violence-related topics were more likely than others to have sought help from informal or formal sources (41% of those who had had such interaction versus 34% of those who had no such interaction; Figure 4). The women who were most likely to have sought help were however those who had disclosed their experiences to FLW, among whom as many as 59 percent had sought help from a formal or informal source.

**Figure 3: Percentage of women who had experienced physical and/or sexual violence in the six months prior to the baseline and endline interviews reporting having sought help from formal or informal sources, baseline and endline surveys, 2015 and 2016**



Note: \*\*\* indicates that difference between baseline and endline values was significant at  $P < 0.001$

**Figure 4: Percentage of women who had experienced physical and/or sexual violence in the six months prior to the endline interview and sought help from formal or informal sources, according to interactions with FLWs on violence-related matters, 2016, endline survey**



Note: ~ and \*\*\* indicate that difference between baseline and endline (shown in figure 3) values was significant at  $p < 0.10$  and  $p < 0.001$ , respectively.

### Feasibility and acceptability of interventions by engaging FLWs: Perspectives of FLWs

#### Orientation about violence-related matters

Orientation of FLWs on violence-related matters prior to the Do Kadam project, as reported in the baseline in-depth interview, was very limited. Capacity-building associated with the Do Kadam project not only reached all FLWs, but also was far more comprehensive than the orientation imparted earlier, and encompassed awareness about violence against women and women's rights, an introduction to the screening tool and its use, ways of approaching women about violence and the services they should offer women, as the narratives below illustrate.

The questions that we had to ask them were on mental, physical, sexual, and domestic violence. [ASHA, endline, ID2]

We were told about the ways through which we can recognise victims of violence. We were also told that the victim will not

tell us her story completely in the first meeting... We were told that some victims may have black and blue bruises on their face, or their face may be swollen and some will panic as well as cry....I learnt how to talk to them so that they reveal their experiences. Earlier we would just talk to them once and then leave the place but now we know how to talk to them. [ASHA, endline, ID11]

Yes, they told us that we are not supposed to go their homes and directly ask them about any violence that they may be facing from their mother-in-law or husband. At first you have to only talk about the things related to the work that you are doing, and slowly come to the main issue. You should not jump directly to such issues....I feel like I have learnt everything now. There was a lawyer who came here as well, and there was a woman also who works at the police station. We were told everything about what needs to be done in various cases. [ASHA, endline, ID15]

We were asked to build a rapport with the woman and make her comfortable about sharing her sorrow. We were told that once she tells us her story, it is our responsibility to meet her husband and make him understand her problem. If he refuses to understand then he should be taken to the village headman or ward member. If the husband still doesn't understand then he should be taken to women helpline for suggestion and negotiation. [AWW, endline, ID 1]

### **Experiences with screening women and referrals**

The interaction between ASHAs/AWWs and women had also undergone considerable change as a result of the intervention. Results from the in-depth interviews with ASHAs and AWWs suggest that by endline, they were far more proactive about approaching, screening, and counselling women about violence than they were at baseline and that they were more confident about screening women for violence and helping women to overcome their reluctance and fears about revealing their experiences to them. They were also sensitive to the need for privacy while discussing violence and the importance of assuring women about confidentiality and posing questions in a non-threatening manner, as reflected in their responses that follow.

Yes, there are cases where ladies face violence while pregnant. But they hesitate to admit this and seek help. They keep saying that there is no violence in their home and that they don't need help from anyone. Gradually, we make them understand and they start coming to us....People were not ready to inform us and did not feel safe while sharing their problems with us earlier... [AWW, endline, ID9]

They all answered the questions but only when they were alone would they answer the questions properly.... No, no one has yelled at me or refused to answer my question because I would ask them questions in a discreet manner. I didn't bombard them with questions at our first meeting... [ASHA, endline, ID10]

Several reported that the project-developed card that they distributed to women had a positive effect on both informing and empowering women about their rights and options. This is evident from the narrative of an ASHA given below.

I gave them advice...the card we gave her made a lot of difference. They understood that what we were telling them is right and thought that whatever we had told them was for their own good. [ASHA, endline, ID16]

However, not all ASHAs and AWWs referred women in distress to the ANM or to other support services; they reported that their own intervention was sufficient to address the woman's problem or that the violence was not 'severe' enough to warrant referral to an ANM or other service, as indicated in their responses below.

No I didn't refer any case to the ANM. We first send the case to the AWW or ask the AWW to accompany us to the victim's home and then we both make efforts to explain to them... [ASHA, endline, ID 10]

No. Cases were not so serious that I needed to refer any women... [AWW, endline, ID 9]

### **Perceptions about changes**

Most FLWs reported that they had observed significant changes among men and women in their villages following the implementation of the Do Kadam project. Many suggested that women had gained awareness and self-confidence and had recognised options other than suicide as a means of escaping violence. Many suggested moreover that husbands had begun to recognise their responsibilities in the family and feared the possible adverse consequences they may face for perpetrating violence. The following excerpts are an indication of positive changes.

Women now talk about the women's helpline and tell their husband 'if you hit me I will take you there.' [AWW, endline, ID 7]

Men tell me that their wife always shows them the card and threatens them, telling them that if they do anything to them then they will call on this number. The woman tells her husband that if she calls on the number then they will come and take him away. [ASHA, endline, ID 12]

Yes, there has been an improvement because now men know that women are associated with the helpline and are aware of many things. [ANM, endline, ID 4]

Notwithstanding the changes that FLWs articulated, many reported that change has not been observed among many women, that many women do not seek help to prevent further violence, and that they continue to fear the consequences for their husband if they lodge a formal complaint:

### **Perceptions about integrating project tasks in the FLW responsibilities and up-scaling the programme**

Most FLWs suggested that the programme was beneficial, that it had built their own confidence about confronting cases of violence, and that its activities, including the implementation of the screening tool, should be integrated into the regular tasks of the ASHA and ANM and the regular supervisory responsibilities of the ANM. They also suggested that the programme should be up-scaled at state level. Their suggestions are reported below.

Our work is mainly to go for home visits in the area that has been allotted to us and during these visits we ask women these questions so it's not time consuming... Yes, asking these questions should be part of our usual work, because it doesn't require us to spend any extra energy on this as we go for our rounds anyway. [ASHA, endline, ID 12]

Everyone should be given this training. Violence is not limited to just our village. It is happening everywhere, within the domestic sphere, so workers in all villages should get training. [AWW, endline, ID 6]

All the workers should be informed, so they will get a chance to help those women who experience violence. That is why the Bihar Government should get all the ASHAs, AWWs, and ANMs trained.... Now this programme is reaching a population of 5,000 or 7,000. It should happen in the entire state of Bihar. [ANM, endline, ID 2]

### **Programme recommendations**

Our model has shown that FLWs can be engaged to screen women on their experience of marital violence, provide information on the options available for women who experience violence, and counsel

those in need. At the same time, our experience has highlighted the need for extensive investments in capacity-building and supportive supervision, so that reducing the incidence of violence becomes as much of a priority in the health system as enhancing pregnancy-related outcomes, improving nutrition levels, and promoting family planning.

### **Build an appreciation of the public health consequences and rights violations of domestic violence**

Programmes are needed that sensitise communities as well as the health system and key community influentials about the adverse public health consequences of domestic and intimate partner violence, as well as the rights violations that such violence implies. Strong advocacy measures must be undertaken not only at community level, but also at the level of the Health and Family Welfare department and the Social Welfare Department, as well as other departments that address women's concerns to enable a deep dive into understanding the health and rights implications of violence.

### **Strengthen capacity-building efforts**

Efforts are needed to strengthen the capacity-building of ASHAs and AWWs, particularly to enable them to communicate empathetically with women in need and develop the confidence to draw out women who suffer violence. ASHA, AWW, and ANM training programmes need to incorporate a strong focus on skill-building and include demonstrations on how to approach women about violence matters, build trust, and provide effective counselling and support to those in need.

### **Prioritise violence reduction as a key component of FLW responsibilities**

Efforts are needed to place counselling and services for violence-related matters at par with other sexual and reproductive health services offered by ASHAs and AWWs and supervised by ANMs; compensation for accompanying women who experience violence to referral points may be considered.

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### **Build stronger links between ASHAs and AWWs and ANMs**

Challenges were also experienced in facilitating a strong and supportive relationship between ASHAs and AWWs on the one hand and ANMs on the other. ANMs need to be better engaged in violence-reduction activities; for example, they must be held responsible for monitoring the work of ASHAs and AWWs, demonstrating to those who are uncomfortable about approaching women how to conduct screening and counselling and mentoring them on how to address difficult cases.

### **Improve links and access to support services and referrals for women in distress**

We acknowledge that the programme was intended to raise awareness among FLWs and women themselves about services available for women in distress. However, we recognise that attention must also be paid to improving the quality of services provided by others, notably, the police and courts, orienting service providers about bringing services closer to women, and making efforts to empower FLWs to accompany women in need to reach these services.

### **Incorporating the Do Kadam experience into the regular responsibilities of ASHAs and AWWs**

Finally, we note that FLWs are ideally placed to screen, counsel, refer, and support women in their communities who experience violence. Many FLWs acknowledged that the inclusion of counselling on violence-related matters and screening for violence was acceptable and could well be incorporated into their regular activities. Findings lend support for the integration of elements of the Do Kadam programme—screening mechanisms, basic counselling, referral linkages—into the FLW capacity-building programmes as well as into their job descriptions and performance-monitoring activities. Findings also call for convergence in frontline worker service delivery responsibilities between the Health and Family Welfare Department and the Integrated Child Development Services (ICDS), Department of Social Welfare.



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