THE PREVENTION COLLABORATIVE

STUDY SUMMARY

IMPACT OF THE RHANI WIVES INTERVENTION ON MARITAL CONFLICT, IPV AND SEXUAL COERCION IN MUMBAI

STUDY FINDINGS AT A GLANCE

The Reducing HIV among Non-Infected (RHANI) Wives intervention is a multi-session intervention for married women focused on building skills to deal with, and respond to, marital difficulties.

This study was conducted to evaluate the impact of RHANI Wives on marital conflict, intimate partner violence (IPV) and sexual coercion in a low-income, urban community in Mumbai.

Geographic areas within the target community were randomised to receive either the RHANI Wives intervention or a single-session control intervention. Participating women were compared on self-reported measures of marital conflict, physical/sexual violence, and sexual coercion.

All participants in both the RHANI wives and control groups reported less marital conflict, lower levels of physical/sexual violence and sexual coercion over time, but RHANI Wives participants reported significantly less marital conflict and sexual coercion than control participants. However, no added benefit of the RHANI Wives programme was observed for self-reported physical/sexual IPV.

BACKGROUND

Intimate partner violence (IPV) is a public health problem in its own right, but studies also indicate that IPV contributes to HIV infection both directly (e.g. via rape, forced drug use) and indirectly (by restricting women's ability to negotiate for protected sex and/or inhibiting their access to HIV-testing and prevention services).[1,2] Excessive alcohol use among men[3] and poverty[4] both exacerbate these risks and make women living in low-income communities with easy access to alcohol particularly vulnerable to multiple negative health outcomes.

These factors are acknowledged as likely contributors to the persistent or increasing rates of HIV among women, even as biomedical prevention and treatment strategies are improving.[5] However, there remains a paucity of effective interventions focusing on reducing IPV- either in general or as a means to mitigate HIV risk- and even fewer interventions adapted, implemented and evaluated in India. The RHANI Wives intervention aimed to address this gap.

CONTEXT

In India, 1 in 3 married women are affected by IPV[6] and, at the time of this study marital violence was associated with increased HIV risk.[7] Estimates from 2012 suggest that nearly 88% of the 2.1 million people living with HIV were exposed via heterosexual sex,[8] mostly commercial sex work.

Intervention campaigns targeting those involved in sex work have been shown to reduce HIV and violence among female sex workers and male clients, but have neglected wives – who are frequently unaware that they are at risk.[9] Unsurprisingly, women make up a growing percentage of HIV cases in India, up from 25% in 2001 to 42% in 2017.[10] Besides structural factors like poverty or geography, marriage is now the primary risk factor for HIV among Indian women.[9]

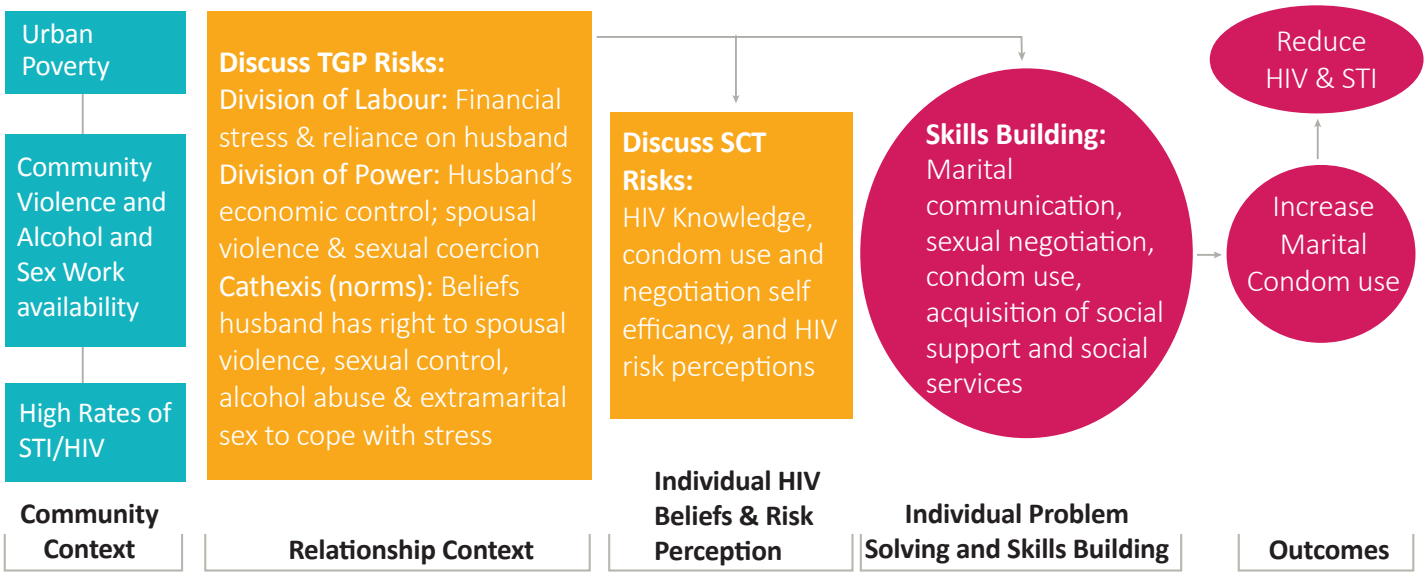
This study was set in low-income, densely populated, urban areas of the Bhandup suburb of Mumbai where there is easy access to both commercial sex and alcohol. At the time of study, Mumbai was considered a high-epidemic area with HIV rates among women nearly twice as high as India as a whole. Moreover, HIV and STI rates in Bhandup were higher than other areas of the city. Nearly 90% of households occupied one-room residences and wage earners primarily worked as day labourers.

PROGRAMME DESCRIPTION

RHANI Wives is based on Social Cognitive Theory[11] and the Theory of Gender and Power[12] and combines elements that have been successful in previous HIV interventions for women including: gender and risk tailoring, use of behavioural change theory, self-management and self-efficacy skill-building, and provision of social support at the community level.

RHANI Wives was adapted from the HIV Intensive Program (HIV-IP),[13] a 12-session group intervention conducted with Latinas in the United States. It was adapted to include four individual sessions conducted in the home and two group sessions in the community. Individual sessions focused on building rapport and marital communication skills, especially around common areas of conflict, condom use and securing resources and social support. Group sessions addressed knowledge gaps, provided connection to services, and gave women the opportunity to build solidarity. Prior to the intervention, implementers conducted awareness-building activities including outreach to local leaders and street plays about the impact of alcohol use and marital violence.

Sessions were delivered over 6-9 weeks by a trained, masters-level counsellor. All counsellors were also trained on the WHO-recommended assessment and safety protocols for IPV survivors.[14] Several quality assurance methods were implemented to verify adherence to the curriculum, track participant engagement and provide support. These included: observation of sessions, review of session notes and attendance records, weekly staff meetings and a client satisfaction survey.



Theory of Change: Application of Social Cognitive Theory (SCT) and Theory of Gender and Power (TGP) in RHANI Wives

KEY FINDINGS

BASELINE DATA

12%
of households with a married woman in the target age range were eligible based on reports of spousal drinking and violence. 77% of eligible women opted to participate.

35%
of all participants reported physical or sexual IPV in the past 90 days.

59%
of all participants reported that their husband was drunk in the last 30 days.

19%
were lost to follow-up. No differences were observed between those lost and those retained.

STUDY DESCRIPTION (IMPACT EVALUATION)

WHAT?	HOW?	WHO?	WHEN?
An impact evaluation comparing marital conflict, physical and sexual IPV and sexual coercion among married women living in areas randomised to receive either the RHANI Wives Intervention OR a single-session control intervention (Local social and medical services for violence and STI testing and treatment).	A low-income, urban community was selected a priori based on poverty level and easy access to alcohol. It was divided into 13 geographic clusters, defined by natural boundaries (e.g., a hill or street) and population density (~300 families). One was used as a pilot cluster and 12 were randomised to receive RHANI Wives programming or a single session control intervention. Individual women within these clusters were recruited and screened by research staff. Study measures were based on two detailed surveys, pre- and post-intervention.	Married women were eligible if they were 18-40, fluent in Hindi or Marathi, area residents for 2+ months with no plans to move in the coming year, and they reported that their spouse engaged in recent heavy drinking or any physical/ sexual IPV. In total, 220 women participated (118 intervention, 102 control).	Families were enrolled between July 2010 and June 2011. Study participation lasted 4-5 months.

OUTCOMES

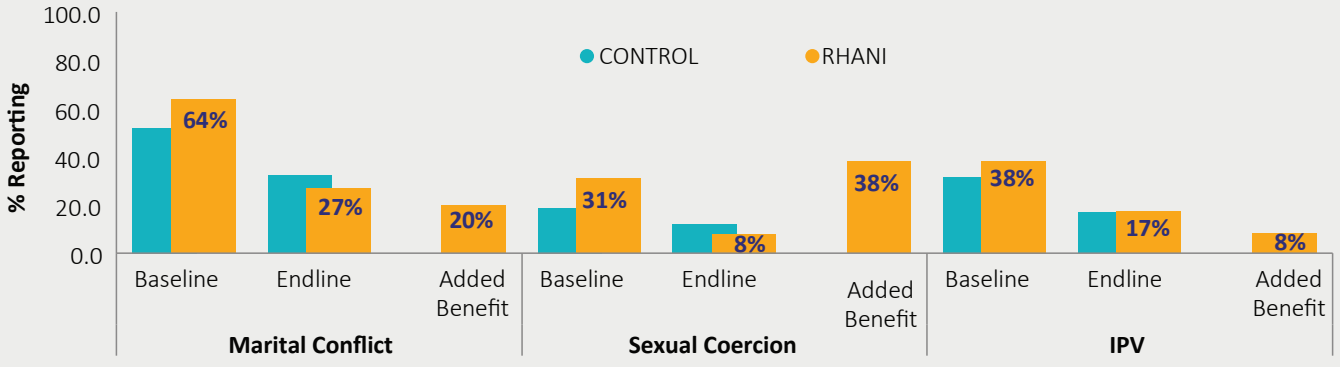
- Marital Conflict, measured by: "Did you and your husband have any argument in the last 3 months?"
- Physical/Sexual Violence, measured by: "Have you and your husband had an argument or fight where he physically or sexually hurt you over the past 3 months?"
- Sexual Coercion, measured by: "Was there any coercion or pressure on you to have sex the last time you had sex with your husband?"[15]

Generalised mixed models for categorical outcomes were used and models were adjusted for age, religion, education, and geographical cluster. Significance was set at p=0.1 for intervention effects.

ENDLINE

- 58% fewer RHANI wives participants and 38% fewer control participants reported marital conflict at follow-up. Declines were statistically significant for both groups, but RHANI Wives participants experienced larger declines (p=0.064).
- 55% fewer RHANI wives participants and 47% fewer control participants reported IPV at follow-up. Declines were statistically significant for both groups and no added benefit of the RHANI Wives programme was observed (p=0.548).
- Of those reporting sexual activity in the past 90 days (n=173), 75% fewer RHANI Wives participants and 37% fewer control participants reported marital sexual coercion at follow-up. These declines were only statistically significant for RHANI Wives participants and were larger among the RHANI Wives participants when compared to the control participants (p=0.082).
- 29% of RHANI Wives participants did not take part in any programme sessions. Analyses adding these women to the control group show similar results as above.
- Other data from the same study documented that RHANI Wives participants reported more condom use with their husbands. Clinical STI data was collected, but was not analysable due to too few positive tests.

Impact of RHANI Wives on Marital Conflict, Sexual Coercion & IPV



IMPLICATIONS FOR POLICY, PROGRAMMING AND/OR RESEARCH

- The RHANI Wives programme is a low-intensity, low-cost intervention that may improve marital dynamics and reduce risk factors for violence and HIV infection for high-risk and under-served women living in low-income, urban communities in India.
- The underlying definitions of marital conflict, physical and sexual violence, and sexual coercion and the questions used to collect information on these outcomes deviate from standardised and validated measures used by Demographic and Health Surveys (DHS) and the World Health Organization (WHO). Care must be taken when comparing these results to those from other studies using more standard definitions.
- Few women reported spousal violence and drinking when initially recruited, indicating a high likelihood of underreporting. Also, husband or family disapproval was a primary reason given for refusing to participate or dropping out of the study. Together, this suggests that women experiencing the most controlling or violent behaviours may be the least able to honestly report their experiences or fully participate in an intervention about IPV. Therefore:
  - Future studies may want to reassess how to target at-risk individuals and/or frame and deliver the intervention to best facilitate participation for vulnerable women.
  - Improvements in outcomes may reflect issues related to self-report, including social desirability bias, rather than actual changes. Using standardised, validated questions, multiple questions, surveying outside of the home, and/or adding supplemental measures not reliant on self-report would increase the reliability of findings.
  - Study results may only apply to women who are at least relatively free from controlling influences or otherwise ready to admit or discuss marital conflict.
- 87% of those participating in any sessions attended all four individual sessions, but only 28% attended the group sessions. Low attendance may have limited the utility of group sessions and indicates that individual sessions are more acceptable in this context.
- Client surveys report low recall for many topics and few women reported any impact of the intervention on husband's behaviours (e.g., alcohol or condom use). The curriculum may need to be refined to include more salient information on low-recall topics. It could also be expanded to directly engage husbands in sessions.
- This is a pilot study, so the sample size is small, potentially making it difficult to detect important differences between the intervention and control group. Also, the follow-up was short, making it difficult to draw conclusions about long-term impact.

SOURCE DOCUMENTS

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15. The phrasing of these questions and the underlying definitions of marital conflict, physical and sexual violence, and sexual coercion deviate from standardized and validated measures.

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