Impact of SAFE intervention on sexual and reproductive health and rights and violence against women and girls in Dhaka slums

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LIST OF ACRONYMS

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
BDHS	Bangladesh Demographic and Health Survey
BLAST	Bangladesh Legal Aid and Services Trust
CCM	Connector change makers
CIDV	Citizen's initiative against domestic violence
DiD	Difference-in-Difference
ERC	Ethical Review Committee
FGD	Focus group discussions
FP	Family planning method
HIV	Human immuno deficiency virus
IDIs	In-depth interviews
KII	Key informant interviews
MDES	Minimum detectable effect size
MR	Menstrual regulation
MSCRT	Multisite cluster randomised controlled trial
NGO	Non-government organisation
OCC	One-stop crisis centre
OD	Optimal design
OSC	One-stop service centres
PIL	Public interest litigation
PNC	Postnatal care
RCT	Randomised control trial
RTI	Reproductive tract infections
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted diseases
VAWG	Violence against women and girls
VSC	Victim support centre
WHO	World Health Organisation

EXECUTIVE SUMMARY

In 2011, "Growing Up Safe and Healthy (SAFE)" began in 19 slums from three neighbourhoods in Dhaka. The programme, designed with the objective of improving sexual and reproductive health and reducing intimate partner violence among women and girls in urban slums, ran for 20 months. Its implementation and concurrent evaluation produced valuable evidence on violence reduction programming in the urban slum context, encouraged women to exercise their rights through legal remedies, and spurred important gains in policy in Bangladesh.

Dhaka is one of the most rapidly grown metropolises globally. Its population is expected to exceed 20 million by 2015. Young men and women move to the city in unprecedented numbers every year in search of work. Migration to the city represents a significant departure from the past for women; urban lifestyles and shifting norms resulting from women's entry into the work force challenge existing gender roles. The change in gender roles, however, does not result in enhanced rights for slum dwelling women and girls. On the contrary, women and girls in urban slums experience poorer sexual and reproductive health (SRH) outcomes and are more vulnerable to violence.

As urbanisation continues to increase globally, innovative projects to address health issues in the urban slum context are critical. Efforts at generating useful knowledge through intervention research included testing alternative strategies of working in the community with groups of men and women. In addition to combined health and legal aid campaigns, the SAFE programme evaluation tested new combinations of interventions to address the poor sexual and reproductive health status and the epidemic of violence experienced by women living in urban slums.

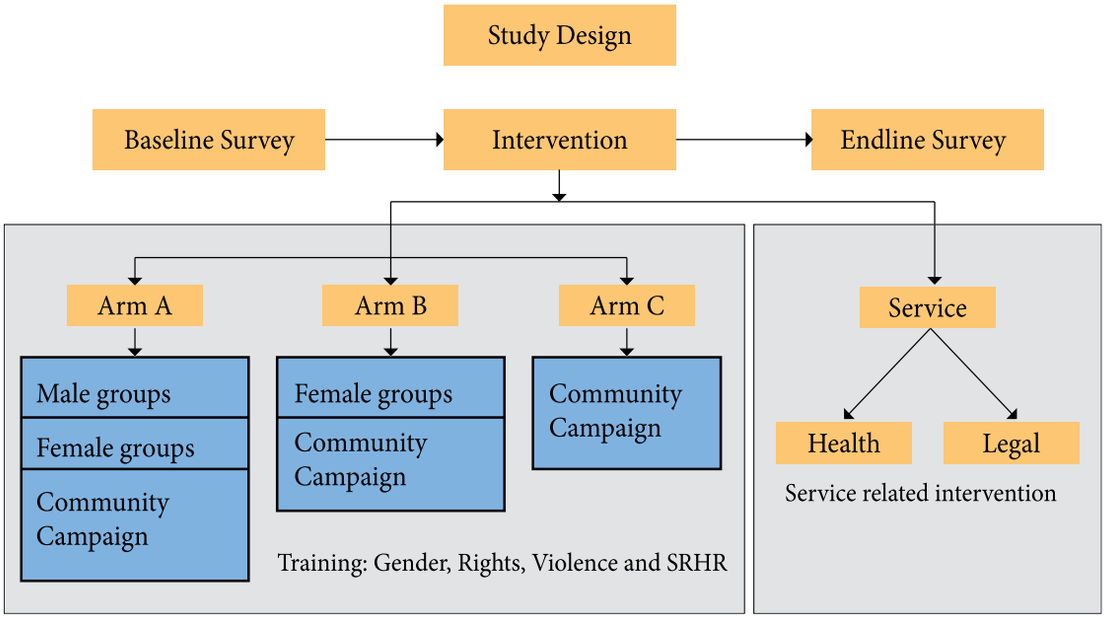
The SAFE programme

SAFE was an action research programme in Dhaka, Bangladesh led by icddr,b. The consortium of implementing partners included Bangladesh Legal Aid and Services Trust (BLAST), Marie Stopes Bangladesh, Nari-Maitree/We Can Campaign and Population Council. The consortium of partners implemented SAFE in slum populations of Dhaka over a 20-month period from March 2012 to October 2013. SAFE worked in the community and in service delivery locations to improve access to critical SRH and violence-related services offered in conjunction with prevention programmes. The intervention approach combined several established strategies of prevention and service delivery into a single integrated approach that included access to health and legal services, interactive sessions with men, young women and girls and awareness-raising campaigns in the community.

The SAFE evaluation

The evaluation included strong quantitative and qualitative research components that identified and measured SRH and violence-related improvements among participating women and reasons for programmatic success or failure. Evidence gathered included: impact analysis data and results, process indicators and qualitative evaluative narratives before, during and after interventions. The research explored a range of outcomes measuring sexual and reproductive health, gender based violence and marriage and childbearing indicators. Figure 1 displays the evaluation's study design.

Figure 1: SAFE evaluation study design



Methods

The evaluation utilised a multi-cluster randomised controlled trial so that changes associated with the interventions would be confidently attributed to the interventions. The three arms of the study varied in terms of presence or absence of group sessions. In order to measure additional benefits of group sessions among men and women (Arm A), group sessions with women only (Arm B) and with no group session (Arm C). Community campaign activities and health and legal services were provided in all arms. A baseline survey was conducted in 2011-2012 prior to the implementation of interventions and an endline survey was conducted in 2014 with a randomly selected sample of over 9,000 women and 3,000 men living in the community. In complement to the survey data, a team of qualitative researchers conducted key informant, focus group and in-depth interviews in the catchment area at baseline, during implementation and at endline.

SAFE's impact

<u>Sexual and reproductive health</u>

The interventions raised awareness about women's sexual and reproductive health and rights (SRHR) and gender based violence, and increased access to support services in the community. The group sessions reached nearly 17,000 men, women and girls living in the project area. The project goal was to improve the quality of life of women and girls by providing access to services and resources. The interventions raised strategic awareness about gender, rights and laws regarding marriage, dowry and SRHR. Project partners provided improved access to reproductive/maternal health and legal services to realise rights and seek recourse. These services were a combination of health and legal services. In the communities where men were also engaged use of modern contraception increased significantly and the practice of menstrual regulation declined. In the same arm (where men were engaged through group sessions) the proportion of marriages that involved dowry also declined.

Spousal violence against women and girls

The SAFE programme demonstrated how integrated interventions that included campaigns and interactive group sessions and services could successfully address gender inequitable attitudes among females and males as well as spousal violence against women and girls in the community. These results can be summarised as follows:

- Engaging men through interactive group sessions was most effective in addressing gender inequitable attitudes among males and females in the community
- The SAFE is the first programme in the developing world demonstrating a reduction in spousal violence against women and girls in the community
- Physical or sexual spousal violence against adolescent girls reduced when both females and males were offered group sessions.
- Economic violence against adolescent girls increased when only females were targeted, but decreased when men were targeted.
- Interactive female group sessions reduced economic violence against women aged 20 to 29.
- Married adolescent girls benefitted more from the interventions relative to older women aged 20 to 29.

Lessons learned

The SAFE evaluation generated important information on what works to make life safer for adolescents and young women living in Dhaka's urban slums. The results demonstrated that it is possible to raise levels of correct and strategic knowledge about violence prevention, SRHR and legal services by introducing an integrated programme, which included interactive group sessions, community campaigns and services. The evaluation demonstrated that working with men, as well as women and girls, significantly improved attitudinal and behavioural outcomes. The programme changed behaviours related to use of modern contraception and perpetration of spousal violence against women and girls. These changes were greater among married adolescent girls.

Qualitative research conducted in conjunction with quantitative impact assessment and intervention monitoring and evaluation elucidated the SAFE programme's theory of change. Among group members, the SAFE programme catalysed change via sensitisation about GBV and rights as well as promotion of skills in communication, negotiation and conflict resolution. SAFE research showed that it was critical to reduce women and girls' isolation of women and girls in order to increase their confidence levels, which in turn, enhanced agency to seek recourse and support when they did experience violence.

At the community level, several factors led to positive change. The presence of organisations promoting awareness about sexual and gender-based violence was an important contributor to reducing violence and improving access to sexual and reproductive health. Enhanced knowledge about laws and legal provisions combined with available and accessible legal services through community campaigns was also important. Networks established between local police stations and other service providers as well as activism led SAFE group members and community volunteers (connector change makers) led to reduction of gender inequitable attitudes in the community.

In short, several SAFE approaches contributed to positive change:

- Integrated programme intervention design;
- Targeted efforts towards vulnerable girls and women, particularly married adolescent girls;
- Interactive group sessions; and
- Activism involving community members.

Policy implications

Several findings and lessons from SAFE hold promise for policy and programmes.

- An integrated approach is effective when:
  - Interactive group sessions are combined with community mobilisation and service provision;
  - Females and young men, as well as the community as a whole are targeted;
  - NGOs and community volunteers work hand in hand.
- Successful programmes must begin early in life and include adolescent girls before they are already encumbered with disadvantages of early marriage and childbearing.
- Engaging men helps to shift gender norms and change behaviours and practices.
- Prevention programmes (of risky reproductive health behaviours and violence) are more effective than response programmes.
- Strengthening informal and not just formal support systems is important for effectively responding to the needs of the women and girls.

The report that follows will provide further detail on the SAFE programme and its evaluation. Chapter 1 describes the intervention strategy, programme components and sample characteristics; Chapter 2 describes results related to marriage change and sexual and reproductive health knowledge and practices; Chapter 3 reports on results related to spousal violence against women and girls and Chapter 4 describes pathways of change based on quantitative and qualitative data. This work was made possible via the support of the Embassy of the Kingdom of Netherlands based in Dhaka. DANIDA and the MacArthur Foundation provided additional support to the Population Council.

CHAPTER 1

Growing up safe and healthy (SAFE): Addressing sexual and reproductive health and rights and violence against women and girls in urban Bangladesh

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Introduction

Context: Gender-based violence, sexual and reproductive health and rights, and urbanisation

The interrelated issues of child marriage, gender-based violence and poor fulfilment of the right to sexual and reproductive health are significant problems in Bangladesh. Though it is illegal for a man over 21 years of age to marry a girl under 18, or for anyone to arrange, conduct or register her marriage, more than 60% of girls in the country are married before they reach 18.[1] Fifty-five percent of girls are married before the age of 16.[a] Early marriage and early childbearing affect sexual and reproductive health outcomes. Women enter marriage and childbearing at a young age with limited knowledge and awareness of sexual and reproductive health. These young women may face violence with limited recourse to seek help. According to the 2007 Bangladesh Demographic and Health Surveys, 53% of ever-married women reported experiencing physical and/or sexual violence perpetrated by husbands,[1] with the youngest women being most likely to report experiencing violence. Research shows that less than 2% of married women who have experienced physical violence seek any kind of institutional remedy or service.[2]

a Authors' calculation using Demographic and Health Survey 2011 data.

Urban poverty and health in Bangladesh

High rates of rural to urban migration have led to rapid urbanisation in Bangladesh. Starting from a largely rural and agrarian society at the time of its 1971 independence, the country is expected to be more than 50% urban by the year 2050.[3] Dhaka's growth contributes greatly to the country's urbanisation. The country's capital now ranks among the world's megacities with one of the highest growth rates in the world. In light of this growth, meeting the needs of recent migrants to urban areas is of increasing priority. The challenges of population growth are perhaps most evident in the slums of Dhaka where many migrants reside during their transition from village to city-dweller. The city is ill prepared to manage the explosion in population and its accompanying challenges. Poverty, insecure living arrangements, frequent squatter evictions, weak social networks, the absence of civic society institutions, the lack of public services, and poor

coordination make the urban slum a difficult place to thrive.

Many of the new arrivals to Dhaka are women. Young women make up 54% of migrants pouring into Dhaka. Opportunity for work in the garment industry or as domestic help draws many.[1] Simply living in the urban slum puts young women at risk. For example, child marriage and gender-based violence prevalence is higher in slum populations than in rural populations or among urban non-slum populations. According to the 2006 Bangladesh Urban Health Survey, approximately 42% of currently married women (ages 15 to 49 years) and 56% of currently married women (ages 15 to 19 years) living in urban slums were not using any contraceptive methods.[3] Other service indicators are low in urban slums. ANC rates were lower among slum dwelling women than among their non-slum dwelling urban counterparts (62% and 85% respectively). Rates of postnatal care (PNC) and institutional delivery are also lower among women living in urban slums.[3] Many women simply do not have access to modern health care services because of insufficient information, awareness and affordability.[4]

The SAFE programme

Programme approach

The Growing up safe and healthy (SAFE) programme was designed as an integrated multi-sectoral programme with aims to:

- Promote sexual and reproductive health and rights; and
- Reduce child marriage and gender based violence.

The target population for these aims was adolescent girls and young women in urban Bangladesh. The programme's theory of change is built on the recognition that an integrated programme, involving service providers and researchers with multi-disciplinary backgrounds, would be more effective than a siloed intervention. For example, to address violence against women, access to health services and to legal services should be offered in the same space or in nearby locations. The approach draws on evidence based action research projects aimed at addressing gender-based violence. In particular, the SAFE project has been influenced by a programme named IMAGE[5] that was shown to reduce intimate partner violence in South Africa. However, in designing the SAFE program it was felt that interactive group session approach used for awareness raising in IMAGE could benefit from community campaign interventions implemented by Raising Voices in Uganda[6] and We Can Campaign in Bangladesh.[7] In contrast to IMAGE, SAFE did not involve microfinance considering that women and girls in the Dhaka slums were already exposed to economic opportunities. Previous rigorously studied VAWG intervention involved either group sessions or community mobilization.

A consortium comprising of Bangladesh Legal Aid and Services Trust (BLAST), icddr,b, Marie Stopes Bangladesh (MSB), Nari-Maitree/ We Can Campaign and Population Council implemented the programme. Nari-Maitree/ We Can Campaign carried out community mobilisation, but also conducted sessions. Additional sessions were carried out by health service organisation Marie Stopes Bangladesh and legal aid organisation BLAST. The project was funded by the Embassy of the Kingdom of the Netherlands, with additional support to the Population Council from the MacArthur Foundation and DANIDA.

SAFE interventions

The project intervention activities promoted increased access and awareness of laws and services related to sexual and reproductive health and rights and gender based violence. The interventions were designed to inform women about rights as well as to promote their capacity to exercise these rights. Interventions also provided access to services. Outreach personnel provided referrals to encourage utilisation of health and legal services. Training materials provided information on rights and

laws related to marriage registration, recovery of maintenance and dowry money, the role of marriage witnesses, early and child marriage, dowry, abandonment, polygamy and divorce. Group sessions were also organised to discuss sexual harassment, rape, domestic violence and other forms of violence. During these sessions, information about locally available services was provided to group members.

Interventions falling under the SAFE project were delivered for 20 months from March 2012 to October 2013. These interventions included:

- Group sessions to raise awareness
- Community mobilisation campaigns
- Health and legal aid services
- Networking and advocacy

These interventions were delivered to four target populations:

- Adolescent girls and young women aged 10-29 in the project areas
- Young men aged 18-35 from the project areas
- Community leaders from the project areas
- Different stakeholders in Dhaka (e.g., judiciary, parliamentarians, police, NGOs, etc.)

The SAFE project's catchment areas included three neighbourhoods in Dhaka (Mohakhali, Jatrabari and Mohammadpur). These sites all included urban slums.

Core Activities

1. Awareness-raising through group sessions

Marie Stopes organised two hundred community groups in 3 sites (600 groups in total). Initial group membership was 10,800 and later increased to 16,491 individuals. The fluctuation in size was largely attributed to in and out-migration, a typical characteristic of urban slums. The average group size was 15. As shown in Table 1.1, there were 150 groups of females, aged 10-29. Out of 150 female groups, 84 included married women aged 15-29, 50 included unmarried women aged 15-29, and 16 included unmarried girls aged 10-14. There were 50 groups of males, aged 18-35, in each site. Out of 50 male groups, 25 included married men aged 18-35 and 25 included unmarried men of the same age category.

A total of 13 sessions were conducted separately with females and males. On average, a SAFE member attended 5.9 sessions. Married females attended 5.8 sessions on average, unmarried females attended an average of 5.8 sessions and unmarried girls (aged 10-14) attended an average of 6.9 sessions. Married males attended an average of 5.7 sessions and unmarried males attended an average of 6.0.

Table 1.1: Sessions attended and group sessions convened by gender, age and marital status.

Group characteristics	Average # of sessions attended	Total # of groups in each site	Total # of groups in 3 sites
Married women (15-29 yrs. Age)	5.8	84	252
Unmarried women (15-29 yrs. Age)	5.8	50	150
Unmarried girls (10-14 yrs. Age)	6.9	16	48
Total female		150	450
Married men (18-35 yrs. Age)	5.7	25	75
Unmarried men (18-35 yrs. Age)	6	25	75
Total male		50	150
Total	5.9	200	600

BLAST, Marie Stopes, and Nari Maitree/We Can Campaign conducted group sessions with married and unmarried women and men. Session topics included SRHR issues, life skills for exercising the right to SRH, the rights of women to lead violence-free lives, and available legal recourse to address violence including legal rights within family and society specifically regarding marriage, sex and childbearing. Women's rights to consent and choice were stressed in each session.

Activities were developed with curricula and materials designed by icddr,b and Population Council, with input from BLAST, Marie Stopes, Nari Maitree/We Can Campaign (http://www.safeprojectbd.org/resources/bcc-materials/). Curricula design drew on local and global resources. icddr,b conducted formative research to pilot and test materials, tailoring them to the local context. Separate modules were developed for females and males. A separate module was also developed for unmarried girls of 10-14 years.

2. Community mobilisation campaigns

Nari Maitree/We Can Campaign conducted community mobilisation and periodic, community-wide campaigns throughout the intervention period. Community mobilisation also included the recruitment of community change makers who worked to sustain advocacy efforts beyond special activities.

Community support groups

Community mobilisation included the formation of community support groups with representation from community leaders, local police, political leaders, NGO activists, and influential business owners in the locality. Almost all participants were male. Community support group members also participated in trainings and orientations. Participants' training also included curricula designed to alter their own attitudes towards gender and spousal violence against women and girls (VAWG). There were nine community support groups with an average of 20 members in each group. The groups were equally distributed throughout the three catchment areas.

Community-wide campaigns

Community campaigns applied methods developed by the Oxfam-led global initiative, We Can Campaign.[7] Nari Maitree/We Can Campaign organised campaign events and engaged slum dwellers in community campaigns through celebration of national and international day observations (e.g. International Women's Day, 16 Days of Activism against VAW). Nari Maitree/We Can Campaign distributed posters, installed billboards, commissioned wall paintings, and held street plays and public screenings of documentary films. The campaign activities included observation of national and international days such as International Human Rights Day, International Women's Day and Begum Rokeya Day through mobile van campaign, cultural events, video shows, banner campaigns, issue based dialogues and competitions, and reflective dialogues with the SAFE group members who had been trained as change makers. Nari Maitree We Can Campaign organised a total of 9 rallies, 11 video shows, 11 folk music concerts, 11 mobile van campaigns, 3 quiz competitions, 6 reflective dialogues and 8 banner campaigns.

Connector change makers

Nari Maitree/We Can Campaign enrolled 277 volunteers from the catchment area for activism activities. These volunteers were called "connector change makers" (CCMs). Nari Maitree/We Can Campaign selected CCMs based on observed leadership qualities, rapport with the community and willingness to work on campaign activities. Nari Maitree/We Can Campaign provided support to CCMs to arrange community campaigns and worked to foster change in gender-related attitudes in the community. The CCM also worked with community support groups. Finally, CCMs received messages from Nari Maitree/We Can Campaign to alter their own attitudes and practices regarding gender and spousal VAWG.

Service uptake from One-stop service centre

Photo Courtesy: Sigma Ainul, Population Council

3. Health and legal service provision

One-stop service centres

The SAFE intervention included the establishment of "One-stop service centres" (OSC's) in communities. OSC's provided health, legal and other support services to female survivors of violence. The OSCs (found within or near existing Marie Stopes/Nari Maitree clinics) were focal points for the dissemination of information regarding services, advice, service provision and referrals. Marie Stopes provided SRH services such as contraceptives, menstrual regulation (MR), counselling on STI/RTI and HIV and treatment of STI/RTI. BLAST provided legal services (advice, mediation and litigation, as well as referrals whenever appropriate) to clients. Nari Maitree/We Can Campaign and CCMs referred women to OSCs.

During the intervention period a total of 201 women and 9 men received health and legal services. Service delivery was further supplemented through cross-referrals from outreach workers and other project volunteers and affiliates and a resource mapping of service providers at the beginning of the project. Implementing partners met with the Dhaka-based One stop crisis centre (OCC), the National VAW helpline, the Victim support centre (VSC), police stations within the catchment areas and other NGO service providers to increase coordination and quality of services for survivors.

SAFE hotline

Services were also delivered through SAFE hotline numbers. BLAST operated the hotline. It was available 24/7 and enabled first hand screening and access to confidential and secure services for callers. From October 2012 to June 2013, 27 women and 1 man used SAFE hotline services.

4. Networking and advocacy

General advocacy activities

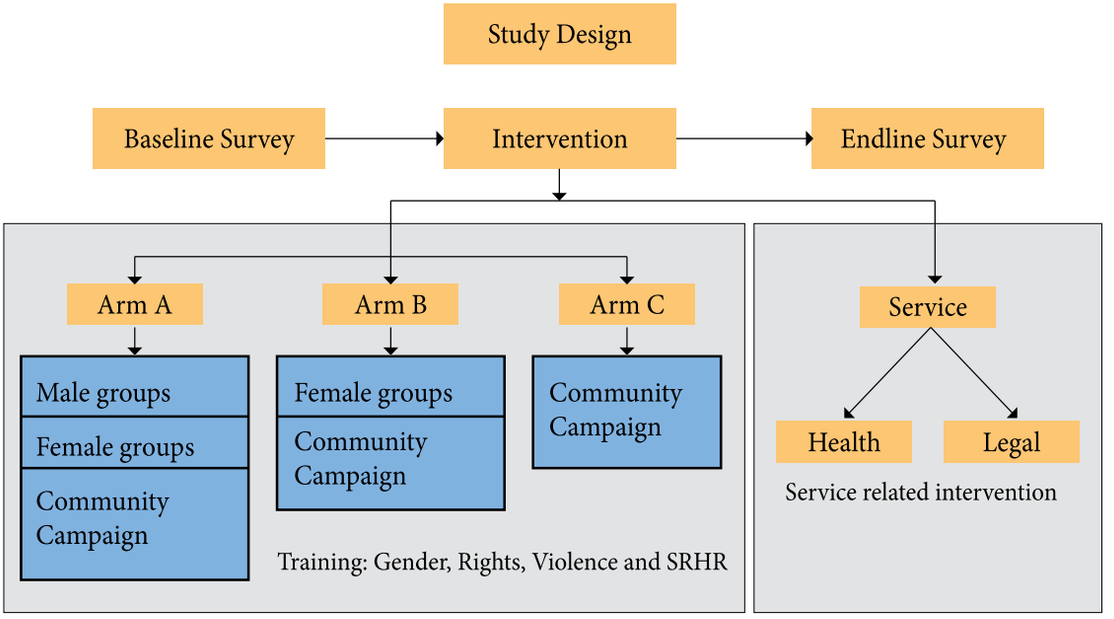
The SAFE intervention included broadly targeted advocacy activities. BLAST led these advocacy efforts at a national level. Advocacy themes included prevention of child marriage, provision of SRH services, VAW prevention and access to legal services. Activities engaged lawmakers and policy makers with particular focus on key actors within the justice system. Significant advocacy activities included:

1. Formation of an informal coalition of NGOs and service providers that provided support to survivors of violence and established a referral system within catchment areas.
2. Review of protocols for medico-legal examination of rape survivors. The review's purpose was to understand the nature of medical evidence recorded and its possible legal implications within the context of the criminal justice system in Bangladesh. Government guidelines on gathering of medical evidence in rape cases were also reviewed.
3. Convening expert meetings with forensic and legal experts. Discussion included review of current policies, practices and procedures governing the collection of medical evidence in rape cases.
4. Drafted protocol for legal providers on how to respond to requests/applications from survivors of domestic violence.
5. Targeted advocacy efforts at critical parties. Kazis, (Marriage Registrars) received information on marriage registration, age verification, and women's right to consent and choice in marriage and police received information on gender and police duties of referral under the Domestic Violence (Prevention and Protection) Act of 2010.
6. Conducting training on gender and laws on violence against women for police officials.

Policy changes

The most successful outcome of SAFE's advocacy work was its contribution to the recent public interest litigation (PIL) seeking a ban of the "two-finger" test. The two-finger test is a method of medico legal evidence collection in cases of alleged rape. Following research on medical evidence collection procedures and consultations with various stakeholders, BLAST organised a national conference in 2013 advocating for changes in policy regarding the two-finger test. The conference included the Minister for Women and Children Affairs. At the conference, over 100 health and legal experts, women's rights activists and human's rights activists called upon the Government to ban the 'two finger test'. As a result of these consultations and the national conference, a memorandum was submitted initially to the National Human Rights Commission and subsequently to the Ministry of Family and Health Welfare demanding a ban of the 'two finger test' as a medico legal evidence collection procedure, and review of existing guidelines. Having received no governmental response to these advocacy initiatives, BLAST, along with six other human rights and legal services organisations and two individuals, filed public interest litigation in October 2013 before the High Court Division of the Supreme Court of Bangladesh. The petition sought the prohibition of the 'two-finger test' as a method of medico legal evidence collection in rape cases and comprehensive revision of the existing guidelines in this respect to clearly delineate the scope of responsibilities of all stakeholders, including health workers. In response, the High Court Division issued a Rule Nisi that required the Government of Bangladesh to explain why the practice should not be declared unconstitutional. The Bangladesh government responded to the Order by establishing a committee under the aegis of the Ministry of Health and Family Welfare, involving civil society experts. The committee created new guidelines that, if implemented, will ban the practice of the 'two finger test' and put in place gender and victim sensitive procedures for collection of medico legal evidence. SAFE partners provided constant external support to the committee set up by the Ministry of Health, and ensured that WHO guidelines and comparative materials and best practices were shared. Subsequently, this order was nominated for the Gender Justice Uncovered Awards. The annual award ceremony, instituted by the international organisation Women's Link Worldwide, seeks to highlight decisions or statements made in the context of a legal process by judges, members of human rights committees, asylum offices, prosecutors, or ombudspersons which had a positive or negative

Figure 1: SAFE evaluation study design



impact on gender equality. The Order given by the High Court Division, Supreme Court of Bangladesh, won the silver gavel award. It is hoped that the new guidelines formulated by the Ministry of Health & Family Welfare will be put in practice immediately, effectively banning the 'two finger test'.

Media and advocacy

Nari Maitree/We Can Campaign led advocacy efforts in the media. These efforts included a live Talk Show, titled Proti Shonglap (In Conversation). A total of 12 episodes covered gender issues such as discrimination, rights, SRHR, and Spousal VAWG, among others. Proti Shonglap received notable positive response from viewers. Beyond the duration of the SAFE programme, the broadcasting television channel later decided to continue the talk show.

Other media-based advocacy activities included radio spots and informational voice messaging on cell phones. SAFE partners were actively involved in other civil society networks such as the 'Girls not Brides' Initiative and the Citizen's Initiative against Domestic Violence (CIDV).

The SAFE evaluation

Research design

The SAFE programme's genesis included a commitment to generate and document evidence around best practices in Spousal VAWG. icddr,b and the Population Council designed the SAFE evaluation to measure SAFE's impact and processes of change. The evaluation measured impact on young people's vulnerability to harmful marriage practices, violence, their ability to seek recourse and services, and specific reproductive health knowledge, skills, and preventive behaviours. The evaluation employed mixed methods. Data was collected over a 20-month period from March 2012 to October 2013.

The SAFE evaluation used a multisite cluster randomised controlled trial (MSCRT) design, to test intervention strategies across three study arms using blocking before randomising clusters at the three study sites – Mohakhali, Mohammadpur and Jatrabari in Dhaka City. Intervention strategies were 1) female-only and male-only groups, or 2) female-only

groups. (See Figure 1.1) The baseline and endline surveys were cross-sectional samples of individuals aged 15 to 29 for women and 18-35 for men.

- Study Arm A included community awareness-raising, access to one-stop service centres and separate group sessions **with female and male participants**.
- Study Arm B included community awareness-raising, access to one-stop service centres and group sessions **with only female participants**.
- Study Arm C, the comparison arm, included community awareness-raising and access to one stop service centres, but had no group sessions.

Methods

Quantitative research methods

The sampling selection for baseline and endline survey respondents appears in Appendix A. Table 1.2 displays a summary of female and male survey sample sizes. The baseline and endline surveys were independently sampled cross-sectional surveys of adolescent girls and women between the ages of 15 and 29 and young and adult men ages between 18 and 35 living in the sample area at the time of the survey. Survey samples were stratified by age group and marital status to include: 15-19 year old unmarried and married girls; 20-29 year old married and unmarried females; and 18-35 year old married and unmarried males. Samples were drawn separately for these three groups of respondents.

Survey sample characteristics

Analysis and comparison of results from baseline and endline surveys determined SAFE's impact at the community level. In order to assess impact using the baseline and endline, it was critical to ensure that samples were comparable at different data collection times and that the composition of the sample did not change within arms.

Table 1.2: Sample size by intervention and comparison arm, baseline (2011- 2012) and endline (2014) surveys

Arms	Baseline		Endline	
	Female	Male	Female	Male
Arm A (Community+ Female + Male)	1487	537	1504	542
Arm B (Community + Female)	1491	532	1560	536
Arm C (Community)	1480	548	1517	542
All Arms	4458	1617	4581	1620

Female sample

Table 1.3 displays several key background characteristics of the female sample in the baseline and endline surveys by intervention arm. Comparison across arms showed that the baseline and endline samples were similar in terms of age and marital status. The endline female sample respondents were more educated and women were more likely to work.

In the female sample (Table 1.3) the average age of respondents in the baseline was about 23 years and in the endline the average age was nearly 22 years. Overall, in the baseline one in four women had no education, whereas a little less than one in five women in the endline had no education. 33% of women in the baseline and 36% of women in the endline had some secondary education or more. In the baseline women had a little less than four years of schooling, whereas in the endline they had a little less than five years. Marital status for both the baseline and the endline was very similar with a little over three out of four women being married and almost five percent being divorced, separated or widowed. Almost 18% in the baseline and 20% in the endline were single.

Thirty-three percent of women were reported to be working in the baseline. In the endline, 45% of women were currently working. This

Table 1.3. Background characteristics of the female sample by intervention and comparison arms at baseline and endline (weighted percentage distribution)

Background characteristics	Community + Female + Male		Community + Female		Community		All Sites	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
n	1487	1504	1491	1560	1480	1517	4458	4581
Age								
15-19	31.9	31.2	31.1	32.2	31.6	31.9	31.6	31.8
20-24	35.9	36.8	36.1	32.0	34.5	35.4	35.5	34.7
25-29	32.1	32.0	32.8	35.8	33.9	32.6	32.9	33.5
Mean	23.1	21.8	23.3	21.9	23.2	21.9	23.2	21.9
Educational attainment*								
No education	24.8	19.8	23.2	21.0	25.9	17.1	24.7	19.3
Primary incomplete	25.8	25.3	26.2	25.8	28.0	24.2	26.6	25.1
Primary complete	15.2	19.5	14.4	19.9	17.1	18.8	15.5	19.4
Secondary incomplete	28.4	27.4	28.1	25.9	23.4	31.0	26.6	28.1
Secondary complete or higher	5.8	8.0	8.2	7.4	5.6	9.0	6.5	8.1
Mean *$	4.1	4.7	4.4	4.6	3.8	4.9	3.8	4.8
Currently in school*	5.2	11.0	5.7	15.0	4.4	12.8	5.1	13.0
Marital status								
Currently married	78.0	76.6	78.1	76.7	78.1	75.1	78.1	76.1
Divorced/separated/ widowed	4.7	5.0	4.2	4.7	3.6	3.9	4.1	4.6
Never married	17.3	18.3	17.7	18.6	18.4	21.0	17.8	19.3
Work status								
Currently working	33.0	45.8	32.6	46.3	33.4	44.2	33.0	45.4
Occupation*								
Garment worker	49.2	49.9	50.7	47.2	49.8	51.8	49.9	49.6
Domestic worker	19.8	17.3	17.9	22.3	16.3	14.0	18.0	18.0
Other salary/wage	16.5	13.5	15.7	13.2	16.3	13.1	16.2	13.3
Other	14.5	19.3	15.7	17.3	17.7	21.0	16.0	19.1
Group/NGO membership- Yes*	25.4	18.8	24.1	19.2	22.0	14.7	23.8	17.6

** Difference between arms is statistically significant (P<0.05) at endline*
$ Difference between arms is statistically significant (P<0.05) at baseline

was a significant change, but expected since high numbers of young women migrated to the cities for work. Changes in the characteristics of the sample were consistent with patterns of in-migration of young women from rural areas for work. Among women who were working, 50% were in the garment sector in both survey periods. About 24% of the sample in the baseline were affiliated with a NGO whereas, 18% of the sample were affiliated with a NGO in the endline. This reduction in membership in NGOs was also consistent with, and may have been driven by, increased workforce participation as working women may have less time for NGO participation.

Female samples were comparable in the three arms with regard to age and marital status. However, the women in the comparison arm (Arm C) were more educated and less likely to be working (than the intervention arms or from baseline to endline). Those who did work were more likely to be employed in the garment sector. Women in the comparison sample were less likely to report involvement in a NGO than in the intervention arms.

The changes observed in the sample characteristics over a two-year period may reflect overall trends in the population—the surveys were repeated cross-sections and the difference between the survey samples was probably driven by in-migration of women from rural areas.

Male sample

Table 1.4 shows comparisons of the male samples in terms of age, marital status and education at baseline and endline. In the male sample, respondents were 27 years old on average at baseline and endline. At baseline a little over one in three men had no education, while a little less than one in three men in the endline had no education. About the same proportions of one in three men had some secondary education or more. In the baseline, men had three plus years of schooling on average and in the endline, they had four plus years of schooling. Men's marital status at baseline and the endline was very similar with a little over 70% of men being married and about one percent being divorced, separated or widowed. Almost 27% in the baseline and 28% in the endline were single.

Thus, as with the female sample, the male baseline and endline survey samples were similar in terms of age and marital status. The respondents were more likely to be educated in the endline relative to the baseline. This may be because in-migration of more educated men to the cities.

The distribution of the male sample within intervention arms shows that the arms were roughly comparable.

Apart from differences between baseline and endline, there were some important contrasts between the male and female samples. Compared to the female sample the men had slightly less education, which may be explained by the younger age of women in the sample and the rapid expansion of educational opportunities over time generating differentials by age. The male sample, although older on average, were less likely to be married than women in the female sample.

Qualitative research methods

Qualitative data were collected via 11 key informant interviews (KIIs), 98 in-depth interviews (IDIs) and eight focus group discussions (FGDs) conducted between February 2013 and June 2014 (Table 1.5). Out of 11 KIIs, five were conducted with married women working with SAFE partners as Connector Change Makers (CCMs) while two were conducted with unmarried CCMs. All married female CCMs interviewed were also SAFE group members except for one. KIIs also included three married and one unmarried male SAFE group members. IDIs included 34 married (four of whom were CCMs) and 33 unmarried female group members, and 21 married and 10 unmarried male group members. Four gender segregated FGDs were conducted with married and unmarried group members, one with married CCMs, one each with married and unmarried female non-group members, and married male non-group members.

Table 1.4. Background characteristics of the male sample by Intervention and Comparison arms at Baseline and Endline (weighted percentage distribution)

Background characteristics	Community+ Female + Male		Community + Female		Community		All Sites	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
n	537	542	532	536	548	542	1617	1620
Age&								
18-24	35.6	35.2	35.1	33.0	28.9	32.5	33.1	31.8
25-29	30.8	31.4	29.6	29.1	29.6	30.4	30.0	34.7
30-35	33.5	33.4	35.3	37.9	41.4	37.1	36.9	33.5
Mean&	26.3	26.4	26.5	26.9	27.2	26.9	27.2	26.7
Educational attainment*								
No education	36.4	30.2	32.6	33.8	35.5	30.1	34.8	31.3
Primary incomplete	19.7	20.3	21.1	18.5	24.8	26.9	21.9	21.9
Primary complete	12.0	12.7	12.6	14.9	12.9	10.9	12.5	12.8
Secondary incomplete	22.1	26.5	23.8	24.1	21.1	19.6	22.3	23.4
Secondary complete or higher	9.8	10.3	9.8	8.8	5.7	12.5	8.4	10.5
Mean &	3.9	4.4	3.9	4.1	3.4	4.3	3.4	4.3
Marital status								
Currently married	70.3	69.6	68.5	73.3	73.0	71.9	70.7	71.5
Divorced/separated/ widowed	0.8	1.3	1.1	1.3	2.1	0.9	1.4	1.2
Never married	28.9	29.2	30.4	25.4	24.9	27.2	28.0	27.3

** Difference between arms is statistically significant (P <0.05) at endline*
$ Difference between arms is statistically significant (P<0.05) at baseline

Table 1.5: Number of Interviews and FGDs conducted for evaluating SAFE's impact in Dhaka slums

Tools	Female		Male (age 18-35)		Total
	Married (age 15-29)	Unmarried (age 15-19)	Married	Unmarried	
In-Depth Interviews	34	33	21	10	98
Key Informant Interviews	5	2	3	1	11
Focus Group Discussion					
Group members	1	1	1	1	4
CCMs	1	-	-	-	1
Non-group members	1	1	1	-	3

Five female and three male researchers with post-graduate degrees in the social sciences collected the data. The data collectors completed a seven-day intensive training. Study participants were purposively selected based on their age, marital status and the capacity in which they were involved with SAFE.

Data collection took place in two sites – Mohakhali and Mohammadpur. On an average, each interview lasted about two hours. FGDs lasted for an hour. All the informants agreed to be re-interviewed if necessary. Follow up visits were made for collecting additional or missing data.

Interviews and FGDs were transcribed verbatim in Bengali and then coded using the software Atlas.ti version 5.2. A code list was developed following the main themes of the study (e.g. exposure to safe intervention, changes in experience of spousal VAWG, how change in spousal VAWG occurred) and was finalised by adding relevant themes emerging from the data. The coded data were retrieved and analysed systematically by themes. Additionally, IDIs were analysed by case, using a case study approach. Different tools of data collection allowed triangulation of the data.

Ethical considerations

The study followed World Health Organisation (WHO) recommendations for researching violence against women.[8] Informed consent was obtained from participants before beginning interviews. Interviews were conducted in private. They were rescheduled or conducted in multiple sessions per participants' availability or when privacy could not be maintained. De-identified data were analysed. Pseudonyms were used for referring to informants throughout the study. The data were used for research only and audio recordings of qualitative data were erased after transcription. The qualitative study was approved by the Ethical Review Committee (ERC) of icddr,b, while the quantitative study was approved both by icddr,b's ERC and the Population Council's Institutional Review Board.

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CHAPTER 2

Sexual and reproductive health and rights: Knowledge, practices, and utilisation of SRH services in the SAFE programme

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SAFE was an integrated programme focusing on promoting sexual and reproductive health and rights and prevention of spousal violence against women and girls. The programme targeted reduction of child marriage as well as improvement of sexual and reproductive health for women residing in the slums of Dhaka. The evidence and analysis in this chapter reflect the impact of the SAFE intervention on (1) marriage and related rights (2) SRHR knowledge; (3) SRHR practices and (4) SRHR institutional service utilisation among young women (age15-29) living in Dhaka slums. The intervention's impact on violence is covered in later chapters.

Introduction

Bangladesh's family planning programme has long afforded women reasonably good access to modern contraceptive services. The average family size has fallen from 5.1 in 1989 to 2.3 in 2011.[1] These gains, however, are not universally experienced. Adolescent girls marry early and bear children early. Indeed, 65% of women marry before the age of 18[1] and 55% of women marry before the age of 16. Social norms discourage SRH education for adolescent girls before marriage and many women become sexually active without adequate knowledge or understanding of sexual and reproductive health and rights (SRHR). Further, many newly wed adolescents experience social pressure to conceive children early in their relationship as an indication of fertility.

Problems associated with early marriage and childbearing are generally worse for women in urban slums.[2] Several factors contribute to increased vulnerability to reproductive health risks in the urban slum setting. In the absence of secure housing, women tend to move frequently and have insufficient access to basic utilities and services.[3] Rates of contraceptive use are lower than national averages in urban slums. According to the 2006 Urban Health Survey, 56% of currently married women living in urban slums, aged between 15 to 19 years were not using any contraceptive method. Approximately 33% of women living in urban slums did not receive any antenatal care (ANC) service and 82% did not receive any postnatal care (PNC) services during their last pregnancy. Untrained birth attendants attended half (54%) of all deliveries.[4]

With a 5% rate of urbanisation, programmes must begin to focus on urban slum areas.[4] Many programmes utilise models for health service delivery developed in rural contexts. These models, may not work in urban settings. The public health infrastructure found in rural Bangladesh is non-existent in urban slum areas. Government hospitals cannot be built in illegal settlements.

Literature review

There is a small but growing body of literature that provides insights into programming for sexual and reproductive health and rights (SRHR) using rigorous research designs. Findings from these evaluations offer a comparative lens for the evaluation of the SRH component of the SAFE intervention and are reviewed here briefly.

Many well-evaluated programmes with impact on SRH were HIV programmes. The Stepping Stones interventions were designed to prevent high-risk sexual behaviour associated with HIV and evaluated in a randomised controlled trial in South Africa. While the interventions did not have the desired impact on HIV prevalence there were significant changes in related behaviours. In particular, condom use reported by men increased in a manner attributable to the knowledge interventions.[5] Several interventions that engaged men showed impact in terms of their own reported behaviour.[6] A Kenyan programme on HIV intervention conveyed messages of relative risk associated with choice of sexual partner and HIV risk, resulting in reduced pregnancy rates by 28%.[7] Kishori Abhijan girls in intervention villages in Bangladesh reported higher HIV knowledge (47 percentage points) and pregnancy knowledge (7 percentage points) at follow-up. Girls from intervention villages were 19 percentage points more likely to report always using condoms at follow-up; use of other contraceptives increased by 8 percentage points. Girls in intervention villages were 3 percentage points less likely to have a child.[8]

The literature review did not identify any programmes that positively impacted dowry practices – a prevalent problem in Bangladesh as well as other South Asian countries. In fact, evidence from Kishori Abhijan suggests that dowry payments actually increased due to an increase in age of marriage.[8] One programme, Kishoree Kontha, in southern Bangladesh, implemented a programme of four interventions in 307 of 460 target villages. The programme tested a delayed marriage "package" which included the provision of incentives for avoiding dowry payments. The results of this intervention are forthcoming.[9]

Results from a randomised controlled trial (RCT)-based impact evaluation of BRAC's Empowerment and Livelihood for Adolescent (ELA) programme in Uganda showed significant improvement in HIV and pregnancy related knowledge. Targeted populations were almost 29% less likely to report being a mother, and among those that were sexually active, routine condom usage increased by almost 50%.[10]

A rigorous evaluation using a quasi-experimental design in rural Bangladesh showed statistically significant increase in reproductive health knowledge and delayed marriage relative to girls in control groups.[8] The impact was strongest among poor girls. A study in Ethiopia also documented significant delay in marriage but only among the youngest adolescents.[11] The PRACHAR study in Bihar gathered evidence that knowledge about contraceptives increased in both intervention and comparison, though more significantly in intervention.[12]

In conclusion, the literature review suggested that there are relatively few instances of rigorous evaluation of sexual and reproductive health programmes. In particular, while programmes were able to demonstrate change in terms of knowledge and attitude, few interventions were able to document significant behaviour change.

Methods

The sample for this chapter came from the larger SAFE evaluation sample described in Chapter 1. The sample included 4,458 young females aged 15-29 year from the SAFE baseline and 4,581 females aged 15-29 from SAFE endline surveys. These women were selected randomly from each cluster.

Since many unmarried women were not yet sexually active, a sub-sample of ever-married females (2,989 from baseline and 2,950 from endline) provided information for SRHR practices/behaviours questions. The SAFE evaluation baseline and endline surveys, from which the sample was drawn, were repeated with cross-sectional samples of individuals. Difference-in-difference (DiD) estimates of baseline and endline were carried out to evaluate SAFE's impact using STATA SE12.1. Indicators of outcomes of interest were:

- **Marriage and related rights** indicators were: timing of marriage, incidence of multiple marriages, registration and consent to and in marriage and dowry and knowledge of marriage related rights (including maintenance payment, and rights on divorce, and freedom from violence).
- **SRH knowledge** indicators were: knowledge of adverse effect of teen pregnancy, knowledge about MR, knowledge about family planning methods, knowledge of STI and knowledge of HIV.
- **SRH practice** indicators were: use of modern FP methods and use of condoms in the last 12 months for preventing STI.
- **SRH institutional service** indicators were: utilisation of Antenatal Care (ANC) and Postnatal Care (PNC) services, delivery at facility and service seeking for STI in last 12 months.

Results

Background characteristics

Table 2.1 shows background characteristics of the ever-married women constituting the sample for this chapter. The samples of ever-married women in the baseline and endline within each intervention group (Arms A, B, and C) were similar and comparable in terms of age, marital status, place of origin, migration status and orphan hood. However, with regard to education and work status, there were differences between samples. The endline sample was more educated and more likely to be working. Approximately 22% of women in the endline had no education compared to 28% in the baseline. Forty-one percent were currently working as opposed to 29% in the baseline. These differences among ever-married women, as with the sample as a whole, were probably attributable to the higher rates of in-migration of young women with education who moved to the slums seeking work opportunities.

Table 2.1: Background characteristics of ever-married women

Background Characteristics	Community+ Female + Male		Community + Female		Community		All Sites	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
n	987	980	998	1013	1004	958	2989	2950
Age								
15-19	16.7	17.6	17.6	17.9	16.5	16.9	16.9	17.5
20-24	39.8	42.6	41.4	37.6	41.9	41.0	41.1	40.4
25-29	43.5	39.8	40.9	44.5	41.7	42.1	42.0	42.2
Education[$]								
No education	30.1	22.4	28.3	23.6	25.6	19.3	28.0	21.8
Primary incomplete	28.0	26.0	25.3	26.4	26.5	24.6	26.8	25.7
Primary complete	16.7	19.4	14.7	19.4	14.5	18.7	15.3	19.2
Secondary incomplete	20.5	25.2	26.4	24.1	25.9	30.0	24.3	26.4
Secondary and above	4.7	6.9	4.7	6.5	7.5	7.4	5.7	7.0
Marital status								
Divorced/ separated/ widowed	4.4	6.2	5.7	5.8	5.0	4.9	5.0	5.6
Currently married	95.6	93.8	94.3	94.2	95.0	95.1	95.0	94.4
Current work status								
Not working	71.5	58.8	70.5	57.6	71.9	61.1	71.3	59.1
Working	28.5	41.2	29.5	42.4	28.1	38.9	28.7	40.9
Home division[$]								
Dhaka	47.8	49.0	49.8	49.2	49.4	48.9	49.0	49.0
Barisal	28.7	25.7	24.2	26.4	22.3	25.6	25.1	25.9
Chittagong	10.9	12.3	14.1	10.2	14.8	11.2	13.3	11.2
Rangpur	3.8	5.1	3.7	6.4	5.8	6.5	4.4	6.0
Khulna	3.7	4.2	3.9	3.7	4.6	4.1	4.1	4.0
Rajshahi	3.2	3.0	3.1	2.2	2.1	2.8	2.8	2.6
Sylhet	1.7	0.7	1.1	2.1	1.0	0.9	1.3	1.3
Migration status								
Migrated to Dhaka	80.2	82.1	82.8	83.2	82.6	82.8	81.8	82.7
Born in Dhaka	19.8	17.9	17.2	16.8	17.4	17.8	18.2	17.3
Orphan-hood								
Only one parent/ none alive	34.0	33.8	31.6	34.7	32.4	33.1	32.7	33.9
Both parents alive	66.0	66.2	68.4	65.3	67.6	66.9	67.3	66.1
Wealth quintile								
Lowest	30.2	27.3	29.8	25.7	28.8	23.4	29.6	25.5
Second	10.0	8.5	8.1	9.9	7.4	9.2	8.5	9.2
Middle	19.5	21.5	22.5	22.8	22.8	18.9	21.6	21.1
Fourth	19.8	23.0	18.5	22.7	17.9	25.1	18.7	23.6
Highest	20.6	19.7	21.0	19.0	23.1	23.5	21.6	20.7

[$] *Significant (P<0,01) at baseline for arm-wise comparison*

Table 2.2: Marriage and dowry issues

Issues	Intervention	Change in outcome before and after intervention, %			Change in outcome due to intervention by arm		
		Before (%)	After (%)	After - Before (%)	Additional Impact of Female Group [(c+f)-c]	Additional Impact of Male Group [(c+m+f)-(c+f)]	Additional Impact of Male + Female Groups [(c+f+m)-c]
Among all women aged 15-19 years married in the year prior to the survey:							
Got married before 15 years	A. Community +Female +Male	13.8	11.2	-2.6*	0.9	0.3	1.2
	B. Community + Female	16.4	13.5	-2.9*			
	C. Community	16.0	12.2	-3.8**			
Among all married women:							
Married more than once	A. Community + Female + Male	7.4	5.2	-2.2*	-0.6	0.7	0.1
	B. Community + Female	8.3	5.4	-2.9**			
	C. Community	6.2	3.9	-2.3*			
Multiple marriage of spouse	A. Community + Female + Male	12.8	7.8	-5.0***	3.1	-2.0	1.1
	B. Community + Female	11.9	8.9	-3.0*			
	C. Community	12.5	6.4	-6.1***			
Marriage was registered	A. Community + Female + Male	89.3	96.4	7.1***	1.9	-2.1	-0.2
	B. Community + Female	85.6	94.8	9.2***			
	C. Community	87.4	94.7	7.3***			
Woman's consent was sought at the time of marriage	A. Community + Female + Male	29.7	45.5	15.8***	3.3	0.5	3.8
	B. Community + Female	30.4	45.7	15.3***			
	C. Community	32.3	44.3	12.0***			
Did not experience any dowry demand	A. Community + Female + Male	72.1	75.7	3.6	-0.1	-4.0	-4.1
	B. Community + Female	67.0	74.6	7.6***			
	C. Community	67.4	75.1	7.7***			
Did not pay any dowry	A. Community + Female + Male	75.0	89.4	14.4***	-0.3	-5.6*	-5.9**
	B. Community + Female	70.4	90.4	20.0***			
	C. Community	71.0	91.3	20.3***			

**** p<0.01; ** p<0.05; * p<0.1*

Marriage and related rights

The data suggested several changes in marriage patterns in the sample over a twenty-month intervention period. Marriage related indicators improved in the sample (Table 2.2). Among respondents who were married in the year prior to the survey the proportion that married at ages younger than 15 declined. Marital instability, as reflected in women and men marrying multiple times, declined. The number of women who were married more than once and the number who were married to men who were married more than once also declined.

In Bangladesh, the proportion of marriages that are officially registered is high, particularly among Muslims. Although there are serious penalties against dowry demands, the registration of marriages does not discourage the practice of dowry demand. Although the bride and groom are formally required to consent to the marriage, it is common practice for women to remain silent and not provide formal consent for the marriage. Her silence would imply consent, or a guardian, usually a father, would speak on her behalf. The proportion of marriages that were registered and where women gave their consent prior to marriage increased.

Neither of the outreach interventions was significantly more effective at changing marriage and marriage- related rights than the community mass campaigns alone.

This study also explored dowry practices (Table 2.2). Proportion of dowry demanded and dowry paid declined in the endline across all the arms. A decline in reported dowry was reassuring but unexpected. The decline was greater in the comparison arm where group sessions with men and women were not held; suggesting campaigns to raise awareness in all three arms played a role. In another study in rural Bangladesh where adolescent clubs impacted age at marriage significantly for the poor, there was a commensurate rise in dowry associated with later marriage.[8]

There was an improvement in awareness of legal rights for married women (Table 2.3). A little over 50% of respondents were aware of the legal minimum age at marriage at the baseline. This percentage rose to over 80% in the endline. Similarly, while less than 50% were aware of marriage registration processes at baseline, the overall level rose to around 75% at endline. Only one-quarter of women knew they had the right to refuse a marriage at baseline. By endline this number rose to over one-third of women. Similarly, knowledge about legal recourse against dowry increased from around 60% to around 70%.

There was substantial positive change in almost all the marriage-related indicators. However, these changes occurred in the intervention and non-intervention arms. Declines in dowry related practices were greater in the arm of the intervention where there was no group activity with men or women.

SRH knowledge

> *"Getting pregnant every year was common; if you became pregnant you would simply get an MR to get rid of it. Now we are aware and we tell others it is better to prevent and take precaution in the first place. Now, we do not want to be pregnant nor do we want MR."*
>
> FGD_CCM_Married Women

At baseline and endline, women were asked whether they knew about modern family planning methods, menstrual regulation (MR- see Box 2.1) and their ability to correctly identify potential adverse effects of teen pregnancy for the mother and the child. Table 2.4 shows responses to these indicators in the three different arms. At baseline and endline, awareness levels of modern family planning methods and adverse effects of teen pregnancy were high with little room for improvement at endline relative to baseline. Awareness for MR increased between baseline and endline in all arms (44-47% vs. 65-71%).

Table 2.3: Awareness about marriage-related rights

Indicator	Intervention	Change in outcome before and after intervention, %			Change in outcome due to intervention by arm		
		Before (%)	After (%)	After - Before (%)	Additional Impact of Female Group [(c+f)-c]	Additional Impact of Male Group [(c+m+f)-(c+f)]	Additional Impact of Male + Female Groups [(c+f+m)-c]
Legal minimum age in marriage	A. Community + Female + Male	53.2	85.2	32.0***			
	B. Community + Female	55.6	84.7	29.1***	-1.6	2.9	1.3
	C. Community	53.1	83.8	30.7***			
Importance of consent in marriage	A. Community + Female + Male	55.9	66.3	10.4***			
	B. Community + Female	52.1	61.7	9.6***	-0.2	0.8	0.6
	C. Community	50.0	59.8	9.8***			
Marriage registration	A. Community + Female + Male	52.1	76.2	24.1***			
	B. Community + Female	49.9	75.8	25.9***	-1.0	-1.8	-2.8
	C. Community	47.1	74.0	26.9***			
Right to refuse to get married	A. Community + Female + Male	31.5	42.7	11.2***			
	B. Community + Female	25.9	38.3	12.4***	-0.5	-1.2	-1.7
	C. Community	24.9	37.8	12.9***			
Legal recourse against dowry	A. Community + Female + Male	65.6	75.5	9.9***			
	B. Community + Female	64.0	72.6	8.6***	-7.3**	1.3	-6.0**
	C. Community	58.5	74.4	15.9***			

*** p<0.01

Box 2.1: What is menstrual regulation?

Menstrual regulation (MR) is a chemical, mechanical or surgical procedure through which menstruation is inducted to non-pregnancy within a few weeks of a menstrual cycle.13 MR has been a part of Bangladesh's national family planning programme since 1979 and has been declared by the Government of Bangladesh (GoB) as an "interim method of establishing non-pregnancy" for a woman at risk of being pregnant, regardless of whether she is actually pregnant [13,14] In Bangladesh, MR has been exempted from the regulation of the Penal Code of 1860 that allows it to achieve a legal status unlike induced abortion.[15]

Table 2.4: Awareness about FP methods, MR & adverse effect of teen pregnancy

Knowledge Indicator	Intervention	Change in outcome before and after intervention, %			Change in outcome due to intervention by arm		
		Before (%)	After (%)	After - Before (%)	Additional Impact of Female Group [(c+f)-c]	Additional Impact of Male Group [(c+m+f)-(c+f)]	Additional Impact of Male + Female Groups [(c+f+m)-c]
Adverse effect of Teen Pregnancy	A. Community + Female + Male	97.2	99.3	2.1***	-1.4	0.2	-1.2
	B. Community + Female	97.2	99.1	1.9***			
	C. Community	96.1	99.4	3.3***			
Heard about MR	A. Community + Female + Male	44.3	64.9	20.6***	7.5**	-5.6*	1.9
	B. Community + Female	44.3	70.5	26.2***			
	C. Community	46.5	65.2	18.7***			
Heard about FP methods	A. Community + Female + Male	89.0	97.2	8.2***	-1.9	-0.1	-2
	B. Community + Female	89.3	97.6	8.3***			
	C. Community	87.4	97.6	10.2***			

**** p<0.01; ** p<0.05; * p<0.1*

Knowledge of MR increased more in the arm where female group sessions (Arm B) were held than in the comparison arm (Arm C). The increase in knowledge about MR attributable to outreach with female groups was statistically significant (DiD 7.5 percentage points; p-value<0.05). By contrast, the change in women's MR knowledge in the arm with male and female groups (Arm A) was lower than the arm where female groups and the community awareness campaigns (Arm B) were given. Awareness of service delivery increased across all three arms.

All women were also asked about their knowledge of sexually transmitted infections (STI) and HIV/AIDS. Their responses are presented in Table 2.5. Results indicated similar changes across all programme arms.

Table 2.5: Awareness about STI & HIV/AIDS

Knowledge Indicator	Intervention	Change in outcome before and after intervention, %			Change in outcome due to intervention by arm		
		Before (%)	After (%)	After - Before (%)	Additional Impact of Female Group [(c+f)-c]	Additional Impact of Male Group [(c+m+f)-(c+f)]	Additional Impact of Male + Female Groups [(c+f+m)-c]
Aware of STI	A. Community + Female + Male	49.2	85.9	36.7***			
	B. Community + Female	44.7	85.3	40.6***	1.8	-3.9	-2.1
	C. Community	48.4	87.2	38.8***			
Aware of HIV	A. Community + Female + Male	47.2	85.5	38.3***			
	B. Community + Female	43.0	84.5	41.5***	1.5	-3.2	-1.7
	C. Community	46.8	86.8	40.0***			

**** p<0.01; ** p<0.05; * p<0.1*

The SAFE evaluation also explored respondents' knowledge about service delivery for both reproductive & sexual health related problems. Table 2.6 shows increased levels of awareness regarding service delivery across all three arms.

Table 2.6: Awareness about service delivery points for reproductive and sexual health problems

Knowledge Indicator	Intervention	Change in outcome before and after intervention, %			Change in outcome due to intervention by arm		
		Before (%)	After (%)	After - Before (%)	Additional Impact of Female Group [(c+f)-c]	Additional Impact of Male Group [(c+m+f)-(c+f)]	Additional Impact of Male + Female Groups [(c+f+m)-c]
Reproductive health problems	A. Community + Female + Male	85.7	99.3	13.6***	-0.6	2.4	1.8
	B. Community + Female	87.6	98.8	11.2***			
	C. Community	87.7	99.5	11.8***			
Sexual health problems	A. Community + Female + Male	72.0	97.3	25.3***	4.4**	1.8	6.2***
	B. Community + Female	73.7	97.2	23.5***			
	C. Community	78.7	97.8	19.1***			

*** $p<0.01$; ** $p<0.05$; * $p<0.1$

The relative change (endline–baseline)/baseline in SRHR knowledge varied widely across indicators. Changes in knowledge regarding complications in teen pregnancy were small. Knowledge about sexual health problems, MR and STI changed substantially more.

SRH practices

> *"From SAFE, I have learned about emergency contraception and MR. One of my friends had an incident of unintended pregnancy, she came to me crying and asked for help. I advised her to get an MR and took her to the Marie Stopes clinic."*
>
> IDI_Laila_group member_ unmarried_ Private tutor

Women were asked about their use of modern family planning methods and menstrual regulation (MR) services regardless of their marital status. Very few never married women responded to these questions, thus only ever-married women's responses were considered in analysis. Table 2.7 displays these indicators at both time points across the three different arms. Very few ever-married women reported experiencing an MR in the last 12 months (2% vs. 6%). Women who lived in communities that received outreach sessions with both men and women (Arm A) indicated largest increases in use of modern FP methods. These increases were highly significant (DID 6.9 percentage points; p-value<0.05). The change in use of modern methods in the other two arms was very small.

Table 2.7: Family planning and menstrual regulation among ever-married women

Practice Indicator	Intervention	Change in outcome before and after intervention, %			Change in outcome due to intervention by arm		
		Before (%)	After (%)	After - Before (%)	Additional Impact of Female Group [(c+f)-c]	Additional Impact of Male Group [(c+m+f)-(c+f)]	Additional Impact of Male + Female Groups [(c+f+m)-c]
Use of modern FP methods	A. Community + Female + Male	64.7	75.2	10.5***	-0.6	6.9**	6.3
	B. Community + Female	67.2	70.8	3.6			
	C. Community	69.8	74.0	4.2*			
Used a condom to prevent disease in the last 12 months	A. Community + Female + Male	9.2	9.8	0.6	-1.3	0.4	-0.9
	B. Community + Female	8.7	8.9	0.2			
	C. Community	9.3	10.8	1.5			
Experienced MR in last 12 months	A. Community + Female + Male	5.5	1.8	-3.7***	2.4	-1.7	0.7
	B. Community + Female	3.9	1.9	-2.0***			
	C. Community	6.2	1.8	-4.4***			

**** p<0.01; ** p<0.05; * p<0.1*

The overall levels of change in condom use to prevent disease and/or as a contraceptive method was small but significantly greater in the arm where men and women received outreach services (Arm A). The relative change in experience of MR was much greater. Changes in MR were greater in locations in which men and women both received sessions; an important consideration for interventions with aims of increasing safe abortion knowledge and practices.

SRH institutional service utilisation

All women who said they experienced an STI in the last 24 months were asked if they sought services for STI management. Only ever-married females who had given birth in the last two years were asked whether they sought ANC and PNC services as well as the type of delivery. In analysis of STI service uptake and ANC and PNC service uptake, increases in intervention areas occurred (Table 2.8). There was little change in the proportion of institutional deliveries. Differences between arms were not statistically significant for any of the institutional service utilisation indicators.

Table 2.8: Institutional service utilisation

Service utilisation	Intervention Arm	Change in outcome before and after intervention, %			Change in outcome due to intervention by arm		
		Before (%)	After (%)	After - Before (%)	Additional Impact of Female Group [(c+f)-c]	Additional Impact of Male Group [(c+m+f)-(c+f)]	Additional Impact of Male + Female Groups [(c+f+m)-c]
Currently pregnant or gave birth within 2 years	A. Community + Female + Male	47.7	45.5	-2.2	-2	2.9	0.9
	B. Community + Female	48.8	43.7	-5.1			
	C. Community	45.1	42.0	-3.1			
ANC service uptake[2]	A. Community + Female + Male	31.7	57.6	25.9***	9.2	-6.8	2.4
	B. Community + Female	25.7	58.4	32.7***			
	C. Community	34.8	58.3	23.5***			
Facility Delivery[2]	A. Community + Female + Male	44.6	47.7	3.1***	-0.3	2.9	2.6
	B. Community + Female	38.7	38.9	0.2***			
	C. Community	43.2	43.7	0.5***			
PNC service uptake[2]	A. Community + Female + Male	16.6	38.8	22.2***	0.8	7.4	8.2
	B. Community + Female	17.2	32.0	14.8***			
	C. Community	17.7	31.7	14.0***			
STI management[3]	A. Community + Female + Male	29.2	49.2	20.0***	-6.1	-6.3	-12.4
	B. Community + Female	33.6	59.9	26.3***			
	C. Community	34.6	67.0	32.4***			

[2] Calculated using ever married & given birth within 2 years preceding the surveys subsample.
[3]Calculated using those who have experienced an STI.
**** p<0.01; ** p<0.05; * p<0.1*

Discussion

SAFE interventions had impact on the following SRH indicators:

Indicator	Community + Female + Male	Community + Female	Community
Did not pay dowry		✓	✓
Knowledge about legal recourse against dowry			✓
Knowledge of MR		✓	
Knowledge of SRHR service delivery points	✓	✓	
Use of modern FP method	✓		

To summarize, in terms of difference-in-difference estimates associated with group activities with women and men, there was significant increase in modern contraceptive use attributable to working with men's groups but no significant change associated with working with female groups only. Interventions differentially increased knowledge about service delivery outlets and MR. These changes were significant for additional impact of female groups only for MR but not significantly associated with male group sessions. Improvement in knowledge about SRHR service delivery points was significant for male and female and as well as female groups. Since these measures of knowledge increase are measured for women only, it is not surprising that there are no additional benefits of working with men in these outcomes. Overall the proportion of family planning method use was slightly higher than current contraceptive (any modern method) usage rate reported at BDHS 2011 (52%). The overall use of male condoms reported by SAFE participants was almost double the rates reported in national surveys (5.5% vs. 11% at endline). However, change in condom use associated with the different SAFE group activities was not significant.

Knowledge and awareness

There was limited change in knowledge associated with SAFE group activities. One reason for this was the remarkable positive change in indicators in the 'comparison arm' (Arm C) where only health services and community campaigns occurred. It was also noteworthy that for a number of outcomes, knowledge was nearly universal at the endline across arms. In the case of universal knowledge, there was little difference across arms. In other words, while the baseline and endline results indicated that the interventions improved awareness in general, no significant differences across groups was detected because overall levels of knowledge were high in all groups. This was also true for knowledge and awareness of laws and women's rights with regard to marriage, adverse effects of teen pregnancy, knowledge of family planning and services for sexually transmitted diseases.

Notably, the research design has limitations. It is impossible to attribute all changes in SRH knowledge and awareness to the intervention. Some changes may be a reflection of secular change or due to other interventions taking place in the study area. However, the magnitude of change over a relatively short period of time, and the fact that all of the communities received quite substantial input in terms of enhanced fixed site services, results in the informed conclusion that the observed changes were at least partially attributable to SAFE.

Behaviour change

While there was significant improvement in most of the knowledge and awareness related indicators in all three categories of communities, positive change in behavioural indicators was more modest. There were substantial changes in the uptake of antenatal and postnatal care services but relatively small changes in institutional delivery and use of services for treatment of sexual health. Relative to the baseline, the use of menstrual regulation declined while use of modern contraception increased in a manner suggesting that access to and effective use of contraception reduced the need for abortion services. In general, when there were significant differences across arms, outreach services to women were more likely to be significant compared to reaching out to men.

Challenges

While it was possible to change knowledge levels through interventions such as SAFE, behavioural change was more difficult to affect. To the extent that behaviour change in contraceptive use was documented, it was clear that SRH behaviour change required the active support and participation/ action of men. Change in service seeking documented in ANC and PNC use was much greater than institutional delivery, suggesting that factors other than knowledge impede access to services.

Promising achievements

The SAFE programme's evaluation further illuminates the promise of working with men. Modern contraceptive use increased when men were engaged. This finding was mirrored in other findings on gender-based violence (discussed in Chapter 3) and in evaluations of other interventions such as Program H.[16] Further, a review of the literature suggests that the magnitude of change on dowry payment indicated in this analysis was notable; interventions have struggled to limit dowry exchanges. The SAFE intervention is unique from other interventions in that it approached dowry exchange by raising awareness about the legal sanctions against dowry in much the same way it incorporated awareness about punitive measures associated with violence against women and children generally. These positive findings served as a testament to the innovative potential of integrated, multi-sectoral interventions to address complex issues such as dowry and gender based violence.

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CHAPTER 3

Impact of SAFE on spousal violence against women and girls and help seeking behaviour

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Introduction

Intimate partner violence is the most common type of violence against women.[1] The prevalence of spousal violence against women and girls (VAWG) is high in Bangladesh. According to the 2007 Bangladesh Demographic and Health Survey (BDHS), 53% of ever-married women of reproductive age reported experiencing physical and/or sexual violence perpetrated by their husbands.[2] Almost one-quarter of these women reported experiencing sexual or physical violence in the last 12 months.[2] Approximately 32% of currently married women reported being economically abused by their husbands.[3] Spousal VAWG rates in urban areas were slightly higher than in rural areas of Bangladesh.[2,4] Within urban areas, rates were higher in slums (66%) than in non-slum areas (45%),[4] suggesting that slum-dwelling women and girls were more vulnerable to violence than their non-slum dwelling counterparts.

Despite the high prevalence of spousal VAWG in Bangladesh, disclosure of violence is low. In one study, 44% of physically abused women shared their experience with others and about 40% of urban and 49% of rural women received help. Help generally came from informal sources, not legal channels. Only 2% of women ever sought help from institutional sources.[5]

Spousal VAWG is widely recognised as a major public health and human rights issue.[6,7,8,9,10,11] As such, families in Bangladesh bear high social and economic costs due to spousal VAWG.[12] Despite the prevalence and impact of the problem, effective interventions to curb spousal VAWG remain a challenge for several reasons. First, evidence on effective interventions is thin worldwide.[13,14] Secondly, though local activism did successfully result in the passing of important national legislation,[15,16] policy implementation remains insufficient. Thirdly, many interventions work in silos, but a complex problem such as spousal VAWG demands multi-sectoral and multi-tier interventions. As is evident from existing literature, many violence-focused programmes are vertical (i.e., focusing on only health or only legal aspects of VAWG) and often target only one tier of society (e.g., individual or community). Existing interventions often either focused on response (e.g., Victim Support Centre) or on primary prevention (e.g., We Can Campaign). Some interventions focused on service provision (e.g., Multi-Sectoral Programme on Violence against Women), whereas others targeted community mobilisation. Many interventions focused on women only, though it is widely recognised that including men is critical in addressing spousal VAWG.[13,17] Finally, few interventions included rigorous evaluations or documentation, limiting

opportunities to learn from past experiences in spousal VAWG prevention and response.

The SAFE programme design drew upon existing local, contextually relevant evidence about urban slum-dwelling, young Bangladeshi women and girls and their vulnerability to spousal VAWG,[2,4] as well as globally recognised best practices in addressing intimate partner violence.[18,19] SAFE's evaluation contributes to the dearth of rigorous evaluation of spousal VAWG interventions.

In this chapter, we present findings from survey data on the aggregated community level impact of SAFE on spousal VAWG and help seeking behaviours. The chapter concludes with qualitative findings on the impact of SAFE on spousal VAWG among SAFE group members.

Methods

Quantitative research methods

Measuring spousal VAWG

Spousal VAWG was measured using a modified version of the Conflict Tactics Scale (CTS).[20] The questionnaire explored physical, sexual, and economic violence perpetrated by a husband during a woman's lifetime and the last 12 months. Different forms of spousal VAWG were measured using behaviourally explicit questions about acts of violence. For each act of physical and sexual violence, ever-married women were asked to report how often (once, a few times or many times) they experienced the act during the last 12 months. Women who reported exposure to physical and sexual violence were also asked whether they sought any help during the last 12 months and if so, from which source.

The specific questions on physical violence were whether the most recent husband: (1) slapped or threw something at you that could hurt you? (2) pushed or shoved you? (3) hit you with a fist or with something else that could hurt you? (4) kicked you, dragged you, beat you up, choked you or burnt you intentionally? (5) threatened to use, or actually used, a gun, knife or other weapon against you? The last three acts (3-5) of physical violence were considered 'severe physical violence'. The frequency of physical violence was coded as 'not many times' if it happened once, twice or a few times and as 'many times' if it happened more than a few times.

The following items measured sexual violence perpetrated by a most recent husband: (1) Did he physically force you to have sexual intercourse when you did not want to? (2) Did you ever have sexual intercourse that you did not want because you were afraid of what he might do? (3) Did he ever force you to do something sexual that you found degrading or humiliating? The frequency of sexual violence was coded following the same strategy as physical violence items.

The items used for measuring economic violence were, has your most recent husband: (1) prohibited you from getting a job, going to work, trading or earning money? (2) taken your money, gold or any of your valuable things against your will? (3) thrown you out of the house? (4) kept money from his earnings for alcohol, drug, gambling, tobacco or other things for his own use when he knew you were struggling to afford household expenses?

Measuring help seeking behaviours

Sources of help were categorised into two groups: informal and formal. Informal sources included relatives, neighbours, friends, co-workers, landlords, local leaders/leader's wives, and other non-institutions. Local clubs, NGOs, legal service providers, police, doctors, pharmacists/ compounders, and religious healers were treated as formal sources of support.

Quantitative data analysis

Only currently married women living with their spouses during the last 12 months were included in analysis. This decision was made in order to capture the impact of SAFE on spousal VAWG; the programme was implemented for 20 months and phased out four months prior to data collection. The prevalence of each form of violence (i.e., physical, sexual, economic) was defined as the proportion of currently married

women who reported having experienced any act of that specific form of violence in the last 12 months. The predominant type of sexual violence was physically forced sex, which was included in this analysis. Separate analyses were performed for married adolescents (aged 15-19) and married young women (aged 20-29) due to statistically significant differences in their background characteristics. The rate of help seeking was defined as the proportion of abused women who sought any help in the last 12 months.

The data were adjusted using age-specific weights. A difference-in-difference estimator was used to identify the change attributable to the SAFE intervention (Appendix C). Statistical analyses were performed using STATA version 12.

The SAFE programme's legal service records were analysed in order to understand the nature of the complaints related to spousal VAWG and the services availed. This analysis included all spousal VAWG complaints filed by females, aged 15-29, residing in SAFE intervention sites.

Qualitative research methods

Qualitative data complemented quantitative efforts to evaluate SAFE's impact on spousal VAWG. A subset of qualitative data consisting of five key informant interviews (KIIs) with CCMs, 34 in-depth interviews (IDIs) with married women, and five gender segregated focus group discussions (FGDs), carried out between February 2013 and June 2014 (Table 3.1) were included in the current analysis.

Results

The results section includes background information on study participants in the quantitative survey, followed by presentation of SAFE's community level impact on spousal VAWG and spousal VAWG survivors' help seeking behaviours. The section also includes an analysis of SAFE's legal service uptake records. Finally, qualitative results on the impact of SAFE on spousal VAWG among the group members are presented.

Background characteristics of the sample

There were statistically significant differences between the married adolescent (age 15-19) sample and married young women sample (age 20-29) at baseline and endline (Table 3.2). The married adolescent sample was relatively more educated. The duration of marriage was about 3 to 3.5 times higher among the young women compared to the adolescent girls. Approximately 89% of the young women had at least one child, whereas 41-47% of the adolescents had at least one child. A lower proportion of the adolescents were currently working (20% at baseline and 26% at endline) compared to the young women sample (27% at baseline and 41% at endline). Rates of membership in NGOs, or other organisations, were about 13% higher among the young women compared to the adolescents both at baseline and endline. The husbands of the adolescent girls were younger and more educated than the husbands of young women.

Table 3.1: Number of interviews and FGDs conducted for evaluating SAFE's impact on spousal violence against women and girls in Dhaka slums

Tools	Married female (age 15-29)	Married male (age 18-35)	Total
In-Depth Interviews	34	-	34
Key Informant Interviews	5	-	5
Focus Group Discussions: Group member	1	1	2
Non-group member	1	1	2
CCM	1	-	1
Total FGDs	3	2	5

Table 3.2: Background characteristics of currently married adolescent girls and young women in baseline (n=2666) and endline (n=2670), %

Characteristics***	Baseline		Endline	
	Adolescent girls aged 15-19 (n=1277)	Young women aged 20-29 (n=1389)	Adolescent girls aged 15-19 (n=1186)	Young women aged 20-29 (n=1484)
Education, mean, year	4.4	4.0	5.2	4.4
Education, %				
No education	19.5	29.4	12.3	22.7
Grade 1-4	29.5	26.6	25.4	26.2
Grade 5	16.5	15.1	19.8	19.3
Grade 6-9	30.9	22.7	35.1	25.1
Grade 10 or above	3.6	6.2	7.4	6.7
Currently working, %	20.0	27.1	26.4	40.9
NGO membership, %	16.6	29.8	11.1	24.0
Marriage duration, year	2.5	8.3	2.4	8.4
Have at least one child, %	46.5	89.2	40.6	88.7
SAFE group membership, %	-	-	2.2	3.7
Husband's age, mean, year	24.6	30.6	24.3	30.6
Husband's age, %				
16-25	71.6	14.9	71.9	13.0
26-60	28.5	85.0	28.1	87.0
Husband's education, mean, year	5.1	4.6	5.7	4.9
Husband's education, %				
No education	20.7	29.1	15.6	25.9
Grade 1-4	12.1	11.4	13.9	14.0
Grade 5	17.2	14.7	19.1	18.4
Grade 6-9	28.2	22.0	32.8	25.6
Grade 10 or above	9.2	11.4	14.1	12.9
Don't know	12.6	11.5	4.4	3.2

****p<0.01*

Impact of SAFE on prevalence of spousal VAWG at the community level

Impact on adolescent married sample and on married young women

As shown in Table 3.3, spousal VAWG prevalence was very high at baseline and at endline. However, a lower proportion of the female study participants in each arm[b] reported physical, sexual and economic spousal VAWG at the endline compared to baseline. Thus, in the adolescent group, prevalence of physical and/or sexual violence was reduced by 9-20%, any physical violence was reduced by 10-19%, very frequent physical violence by 2-9%, and severe physical violence by 9-18%. Reduction of sexual and economic violence from baseline to endline among adolescent girls was between 9-17% and between 16-26% respectively. Similarly, violence against young women underwent substantial reduction from baseline to endline.

Impact in different intervention arms

The main analysis focused on the SAFE intervention's impact in reducing different forms of violence in three different arms. The results indicated that the SAFE intervention contributed to the reduction of physical spousal VAWG in terms of both its frequency and severity (Table 3.3).

Female and male group intervention (Arm A) in the community reduced physical and/or sexual violence by 11.4 percentage points. Both female and male group interventions reduced physical spousal VAWG by 9.8 percentage points and reduced severe physical violence by 7 percentage points. The female group intervention (Arm B) reduced 'very frequent' experiences of physical spousal VAWG by 6.6 percentage points and severe physical violence by 8.2 percentage points. Interestingly, the female group intervention alone (Arm B) resulted in increased spousal economic violence (10 percentage points higher) among adolescent girls. But, in the arm, where the male group intervention was delivered in complement to the female group intervention, spousal economic violence reduced among adolescent girls by 8.1 percentage points. The female group intervention reduced spousal economic violence by 8.7 percentage points among young women.

SAFE's impact on spousal violence against adolescent girls

- Reduced physical or sexual violence in communities, where both females and males received group sessions
- Reduced severity of physical violence and physical and/or sexual violence, where both females and males received group sessions
- Reduced frequency and severity of physical violence, where only females received group sessions
- Increased economic violence, where only females were offered group sessions
- Reduced economic violence, where men received group sessions

Impact on young women

- Reduced economic violence, where females receive group sessions

b The "arms" referred to in the findings are defined as: A) community mobilisation+ service provision + female group sessions + male group sessions. B) community mobilisation + service provision + group sessions with females only; and C) community mobilisation + service provision

Table 3.3: Impact of SAFE intervention on spousal violence experienced by currently married adolescent girls and young women in Dhaka slums

		Change in outcome before and after intervention, %			Change in outcome due to intervention by arm		
Indicator	**Intervention arm**	**Before (%)**	**After (%)**	**After – Before (%)**	**Additional Impact of Female Group [(c+f)-c]**	**Additional Impact of Male Group [(c+m+f)-(c+f)]**	**Additional Impact of Male + Female Groups [(c+f+m)-c]**
Adolescent girls aged 15-19							
Physical and/or Sexual violence	A.Community+Female+Male	70.3	50.1	-20.2	-4.9	-6.5	-11.4**
	B.Community+Female	71.9	58.1	-13.8			
	C.Community	67.7	58.8	-8.9			
Physical violence	A.Community+Female+Male	59.5	40.3	-9.5	-5.6	-4.1	-9.8*
	B.Community+Female	60.0	45.0	-15.0			
	C.Community	57.2	47.7	-19.2			
Physical violence, many times	A.Community+Female+Male	14.4	8.2	-6.2	-6.6*	2.4	-4.2
	B.Community+Female	19.3	10.7	-8.6			
	C.Community	13.2	11.1	-2.1			
Severe physical violence	A.Community+Female+Male	29.8	13.4	-16.4	-8.2**	1.3	-7.0*
	B.Community+Female	33.5	15.9	-17.6			
	C.Community	26.3	16.9	-9.4			
Sexual violence	A.Community+Female+Male	46.7	29.9	-16.8	-2.8	-5.0	-7.7
	B.Community+Female	45.9	34.1	-11.8			
	C.Community	43.6	34.6	-9.0			
Economic violence	A.Community+Female+Male	54.2	30.1	24.1	10.0**	-8.1*	1.9
	B.Community+Female	51.1	35.2	15.9			
	C.Community	56.8	30.9	25.9			
Young women aged 20-29							
Physical and/or Sexual violence	A.Community+Female+Male	71.7	60.1	-11.6	3.7	-1.6	2.1
	B.Community+Female	70.2	60.2	-10.0			
	C.Community	68.9	55.2	-13.7			
Physical violence	A.Community+Female+Male	58.5	51.6	-6.9	4.6	2.7	7.3
	B.Community+Female	58.4	48.8	-9.6			
	C.Community	58.2	43.9	-14.3			
Physical violence, many times	A.Community+Female+Male	18.5	13.9	-4.6	2.7	-1.7	1.0
	B.Community+Female	16.4	13.5	-2.9			
	C.Community	15.7	10.1	-5.6			
Severe physical violence	A.Community+Female+Male	34.2	21.6	-12.6	1.1	-1.9	-0.8
	B.Community+Female	33.0	22.2	-10.8			
	C.Community	28.5	16.7	-11.8			
Sexual violence	A.Community+Female+Male	49.2	33.4	-15.8	-2.7	-3.2	-6.0
	B.Community+Female	48.5	35.9	-12.6			
	C.Community	45.3	35.5	-9.8			
Economic violence	A.Community+Female+Male	49.8	30.5	-19.3	-8.7**	4.6	-4.1
	B.Community+Female	47.5	23.6	-23.9			
	C.Community	40.7	25.4	-15.3			

**** p<0.01; ** p<0.05; * p<0.1*

Impact of SAFE on help seeking of survivors

The rate of help seeking was very low at both baseline and endline. Still, a higher proportion of survivors sought help at endline in each study arm compared to the baseline (Table 3.4). The rate of help seeking from an informal source increased by 4-13%, while help seeking from formal sources increased only slightly (0.3 – 0.5%). The results demonstrate that the SAFE female and male group intervention in the same arm contributed to a statistically significant increase in help seeking from informal sources (8.3 percentage points). In other arms, changes in help-seeking rates were not statistically significant. The insignificant change in help-seeking indicators and large standard errors (not shown here) suggest that the sample did not have the power to demonstrate statistical significance.

> Help seeking from informal sources increased when females and males were both targeted

Help seeking for sexual violence was lower than for physical violence (data not shown here). No statistically significant results were obtained in relation to help seeking for sexual violence.

Despite limited statistically significant findings, there were some notable changes in help-seeking behaviours. In cases where women did seek some help, qualitative data provided insight into why and how the SAFE intervention affected their reactions to spousal VAWG. Group members and CCMs were encouraged by SAFE to follow a certain sequence for help seeking, where attempts at resolving the issue through informal support sources preceded any use of legal measures. One interview illustrated this sequence, in which the importance of informal sources was clear. The respondent mentioned legal services last when describing her help seeking sequence.

> *"They (SAFE field workers) said, 'If you see a boy harassing a girl you need to intervene by talking to the boy. If he does not stop, then all the 20 of you (SAFE group members) will try to change him. If this does not work you have to involve the influential community members. If this does not work as well you need to involve us.' They will then provide legal support. … They also said, 'If it concerns domestic violence, you yourself need to motivate the father and mothers-in-law (first). …Use the same strategy if it is about violence by husband."*
>
> IDI_Naima_CCM_Married_Homemaker

Qualitative data further explained the small quantitative increase in help seeking from formal source. The data suggested a host of factors discouraging survivors from seeking legal services. Fear of marriage breakdown, retaliation, a sense of futility, lack of trust in the services or in the legal system, inability to deal with the system, and inability to bear the related costs were the main barriers. As one SAFE group member pointed out,

> *"I advised her (an abused woman) to go to (SAFE office for legal services). However, suggesting women to take legal action does not always make them access such services. They are slum dwellers. They prefer to secure/ protect their marriage no matter if they (the husbands) beat them or tear them apart. They know that reporting to the police would result in husband's arrest. The legal system will cause a lot of harassment even if a fair verdict is reached at the end."*
>
> IDI_Jui_Group member_Married_ Homemaker

Thus, legal services were considered only as a last resort and very few women accessed such services.

Utilisation of legal services in response to spousal VAWG: Experiences from SAFE

Seventy-five women utilised spousal VAWG related legal services via the SAFE programme. Although all these women were from the SAFE intervention area, only seven of them were SAFE group members. This clearly demonstrated a diffusion of knowledge regarding spousal VAWG

related SAFE services in the community. The mean age of these women was 23 years. They were married for 6.2 years on average. Nine women mentioned that their husbands were either addicted to drugs or to alcohol, while five were involved in gambling.

Women typically sought legal services in response to severe physical (61 out of 75) and economic violence (48 out of 75). Severe physical violence included severe beating (e.g., by hammer) as well as burning with the intention to kill. Many women sought help for economic violence. The most common types of economic violence reported by women were not providing for the family and demanding dowry post-marriage. The women also reported being thrown out of their house. Threats of another marriage, harming family members with the intention of punishing the wife, imposing divorce without following proper legal procedures, and deprivation of child custody were common complaints. In most cases, physical and economic violence overlapped.

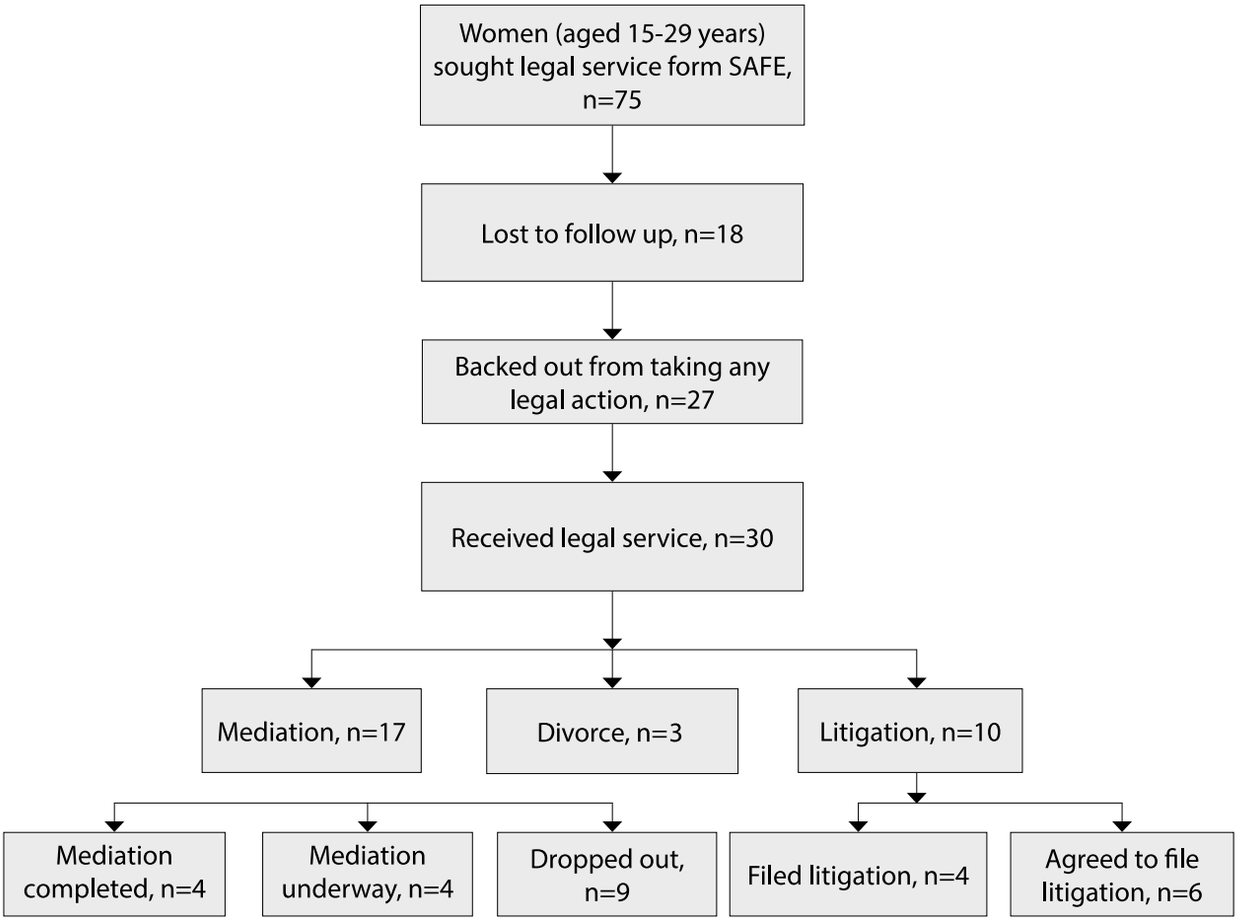
Outcomes of SAFE's legal services are presented in Figure 3.1. The legal facilitators explained legal service options to women. After consultation with the legal facilitator, 18 women were lost to follow up. Twenty-seven women decided not to take any action. Among the rest more than half (17 out of 30) preferred to remain in their marriage and access the services of a mediator to help with conflict management. Legal facilitators carried out mediation in four cases. Nine women initially agreed to mediation conducted by SAFE after consultation with the legal facilitator and then changed their mind. Eight women were convinced from the beginning that the situation would not improve and in accordance expressed their preference for a divorce. Three women successfully divorced their husbands (Case Study 3.1) and one ceased to seek legal services. Most cases were eligible for filing litigation under the current law. However, only four women actually filed litigation, while an additional six women agreed to do so.

Table 3.4: Impact of SAFE intervention on help seeking behavior of physically abused currently married women in Dhaka slums

		Change in outcome before and after intervention, %			Change in outcome due to intervention by arm		
Source of Help	**Intervention arm**	**Before (%)**	**After (%)**	**After – Before (%)**	**Additional Impact of Female Group [(c+f)-c]**	**Additional Impact of Male Group [(c+m+f)-(c+f)]**	**Additional Impact of Male + Female Groups [(c+f+m)-c]**
Informal	A.Community+Female+Male	7.8	20.0	12.5	3.7	4.6	8.3**
	B.Community+Female	10.9	18.5	7.9			
	C.Community	9.9	13.7	4.1			
Formal	A.Community+Female+Male	0.46	0.73	0.27	1.1	-0.3	0.7
	B.Community+Female	0.6	1.03	0.55			
	C.Community	1.0	0.55	-0.45			
Legal	A.Community+Female+Male	0.4	0.4	0.0	1.0	-0.3	0.7
	B.Community+Female	0.4	0.7	0.3			
	C.Community	0.7	0	-0.7			

*** p<0.01; ** p<0.05; * p<0.1

Figure 3.1: Outcomes of legal service uptake from SAFE for addressing spousal violence against women in Dhaka slums



Case study 3.1: Ripa seeks escape from a violent marriage

Ripa, a garment worker married Kamruzzaman, a money lender in 2010. Two years into the marriage, Kamruzzaman began to frequently beat Ripa. She discovered that her husband had intimate relationships with other women. Ripa suspected that one of these women managed commercial sex work and she assumed that her husband was involved. Ripa found the phone numbers of several girls in her husband's cell phone and assumed that the numbers belonged to sex-workers. Whenever Ripa questioned Kamruzzaman he would attack her and beat her up. During one such episode Kamruzzaman broke her teeth.

Kamruzzaman regularly demanded that Ripa give up her job. He threatened that he would take all her earnings if she continued to work. He also started to harass her at work by telling Ripa's co-workers that she had an extra-marital relationship with the factory owner. To avoid scandal, the owner fired Ripa. She found work in a different garment factory. Kamruzzaman continued insisting that she leave her job. He threatened to further damage her reputation if she did not comply. Ripa was afraid he would force her into commercial sex work.

Kamruzzaman forced Ripa to sign a blank piece of paper by threatening to kill their two-year old daughter. Having no clue about the nature and content of the paper, Ripa was frightened of the consequences. So she took her daughter and moved to her natal home. Kamruzzaman continued to threaten Ripa. He printed and distributed some posters containing Ripa's name, photo and contact information with the text "this woman – Ripa, is a fraud, she gets involved in intimate relationships with men and cheats them. She has been repeatedly married. Ripa's sister and parents are also part of this game. Beware of this woman!" He posted them all over the neighbourhood twice.

Ripa was not a SAFE group member, but she was residing in a SAFE working area. She found out about the legal services offered by SAFE from the SAFE group members. At first, she shared her problem with a SAFE field worker, who referred her to SAFE's legal facilitators. The SAFE legal facilitators advised her to file a complaint at the police station. The legal facilitators also offered her a place at a shelter home facility, which Ripa refused. The police did not cooperate with her the first time she tried to lodge the complaint. In order to ensure police cooperation a Project Coordinator and a legal facilitator accompanied Ripa to the police station. The legal facilitator helped her to draft the complaint.

Ripa came to SAFE's legal clinic several times. In her case, the only course of action available was litigation but she chose not to pursue it. Although Ripa wanted her husband to be punished for his offences, her priority was to divorce him and be free from the cycle of violence and any legal obligations. She obtained the divorce with legal support from SAFE.

After the divorce Ripa resumed her work. During a follow-up visit the legal facilitator found that her husband was still harassing her. Ripa planned to approach SAFE to pursue criminal proceedings if the situation worsened. Several months later, another follow-up visit by the legal facilitator revealed that Ripa's husband had stopped harassing her.

Impact of SAFE on spousal violence against female group members

Qualitative data gathered from SAFE group members suggested that SAFE reduced physical, sexual and economic violence by spouse. Khadija's case clearly demonstrated positive changes in terms of physical and economic violence. Her interview sheds light on how these changes happened (Case Study 3.2). Group sessions stimulated Khadija to take action for stopping the violence. She sought help from her fellow group members and the SAFE field worker. They held repeated discussion with Khadia's husband emphasising advantages of a violence free life for him and for the family. Their strategy worked and the violence stopped. Data from the group members suggest that similar change was common among them.

Many group members felt that increase in inter-spousal communication and negotiation due to SAFE was particularly helpful in reducing sexual violence. Thus, for example, Shefa said,

"Many husbands abuse their wives sexually. But it is not right to force someone to have sex. My life went through a change in this regard. I have asked other group members and they are also experiencing a positive change in this. We argue (with our husbands) that if we are sick and tired we would not like to have sex. If we are willing, sex will be pleasurable and there will be no need to get it by force."

IDI_Shefa_Married_Housewife

Case study 3.2: SAFE stopped violence in Khadija's life

Khadija, is an active SAFE group member. She lives with her husband, two daughters and a younger sister. Currently, Khadija's husband runs a small shop where the couple works together. Her life changed radically after she joined SAFE. Her husband never had a steady income and the family struggled financially. To support the family, Khadija had to start working in a garment factory.

When Khadija started earning a living for the family, her husband stopped contributing financially. So, whenever Khadija failed to go to work, the family had to go without food. Khadija's husband not only stopped providing for the family, but also started demanding money from Khadija regularly. He used to beat her up severely if she refused. Often, he beat her without any particular reason. Despite the hardship, Khadija never sought help from anyone and tried to protect her husband when her employer and neighbours tried to help.

SAFE group sessions changed Khadija. When she learned about SAFE's legal services for abused women, she decided to seek help. First, she shared her problems with the group facilitators. The facilitators and her fellow group members convinced Khadija's husband that what he did to his wife and the family was wrong and that he should change. They emphasised the importance of ensuring a better future for their children and harmony in the family. The facilitators helped him to understand how important his contribution could be to his family. They also told him about the policies against violence against women, provisions for legal support and availability of BLAST services for the abused women in the neighbourhood.

Although Khadija's husband often joked about women's empowerment and legal provisions for addressing violence against women, the beating stopped. Other changes were also observed. Following advice from Khadija, her group members and the SAFE field workers, he took a loan (Tk. 12,000) from a charitable organisation and started his small shop. He now contributes to the family regularly, enabling Khadija to feed her family and to send her daughters to school.

Khadija has not enrolled as a connector change maker due to her time constraints. But she actively participated in community campaigns for raising awareness on violence against women by distributing leaflets in her neighbourhood. She encouraged other abused women to seek help. On several occasions she participated in collective action for responding to violence. She claims that they were successful in reducing the frequency of wife beating, at least in one case. Together with her fellow group members she managed to prevent a child marriage by persuading the girl's parents. Through participation in SAFE, Khadija not only brought changes to her personal life, but also tried to positively change lives of other women and girls in the community.

Some group members claimed that emotional violence was also addressed as a result of the SAFE intervention. For example, one woman was able to address feelings of blame placed on her by her family following the birth of her daughter. Honufa's husband was angry with Honufa for having a daughter and stopped talking to her for an extended period of time after the child's birth. When Honufa became a SAFE group member and attended sessions on SRHR she learned that the child's sex was actually determined by the father. She read the SAFE booklet on SRHR, brought it home and let her husband read them. She told her husband,

> *"See what is written here (in the booklet)? You did not talk to me for a long time after I gave birth to a girl. …This girl child is coming from you – not from me. He read (the booklet) and found I was telling him the truth. I was happy being able to make him understand his mistake."*
> IDI_Honufa_Married_Housewife

Najma's case portrays that participation of both spouses in SAFE helped a couple to overcome physical and sexual violence, and ultimately, improved the quality of the relationship (Case Study 3.3).

Case study 3.3: SAFE stops sexual violence within marriage

Najma, a garment worker was married to Mamun. He did not earn a regular income and did not contribute financially to the family on a regular basis. He would forcibly take Najma's money and spend it on drugs or gambling. He also used to put pressure on Najma to demand money from her natal family. Four years ago, Najma used connections with her relatives to help her husband get involved in a business. Once he started earning a regular income, he demanded that Najma leave her job. There was a lot of conflict between the two regarding Najma's mobility and her job.

In addition to working long hours at the factory Najma would also do all the household chores and take care of the children. The heavy workload made her extremely tired at the end of the day when her husband would demand sex. If she refused, he suggested that she was having an extramarital relationship and used physical force to obtain sex. If he failed to have sex he would beat her up. In order to please Mamun, Najma had to leave the job and focus on child and family care.

When SAFE started working in the area, both spouses became group members. At the beginning Mamun would make sarcastic comments about the group sessions and say that he "does not have time for such crap". But Najma wanted him to attend and so she encouraged him to attend the sessions by saying that she believed he would find the sessions useful when the time came. After attending several sessions Mamun changed radically. He read SAFE's advocacy materials and internalised their messages. He discussed the content of the sessions and the materials with Najma. Mamun stopped abusing her physically or sexually. He stopped doubting Najma. He now values Najma's opinions. Najma attributes all of these changes to SAFE intervention.

Discussion

There are very few RCTs measuring the impact of interventions focusing on spousal VAWG in developing countries. Comparison of SAFE with other well known RCTs such as Stepping Stones,[19] SASA![21] and IMAGE,[18] carried out in Africa, suggests that SAFE has been relatively effective in addressing spousal VAWG at the community level. Stepping Stones used a participatory learning approach using a 50-hour curriculum. The impact of Stepping Stones was measured at the level of the participants. The intervention did not show any effect on spousal VAWG.[19] Community mobilisation carried out by SASA! showed positive changes in attitudes of women, but not of men. Spousal VAWG, however, did not reduce in the SASA! evaluation.[21] IMAGE measured the impact of a credit programme combined with a participatory learning and action curriculum. It demonstrated a 55% reduction in spousal VAWG among group members, but no impact at the community level.[18] SAFE had no credit programme, but it added community mobilisation and service delivery to a participatory learning curriculum, which reduced gender inequitable attitudes among females and males (See Chapter 4) and reduced as well spousal VAWG at the community level. Thus, it appears that stand alone interventions such as only participatory learning or only community mobilisation are not effective in reducing spousal VAWG at the community level. SAFE's success underlines the importance of an integrated approach.

Improving outcomes for adolescent girls in the community

Married adolescent girls benefitted from the SAFE intervention in terms of spousal VAWG reduction more than married young women. This is an important achievement as the literature repeatedly indicates that this group is more vulnerable to spousal VAWG than older women.[22,23,24] Literature also indicates that young men are amenable to change and that they become allies of movements for eliminating VAWG in different settings.[25,26] Thus, SAFE's greater positive impact among adolescent girls may be attributable to the fact that their husbands were much younger and had a higher education than the husbands of the young women sample -- characteristics typically associated with openness to new ideas.

Spousal physical violence against adolescent girls reduced in two arms: the 'female only groups' arm and the 'female and male groups' arm. This indicates the importance of targeting females and the contribution of females in reducing physical violence against adolescent girls. Physical violence is known to start quite early in marriage.[1] The duration of marriage was shorter among the adolescent sample. Thus, it can be assumed that spousal violence was a relatively new experience for the adolescent girls in comparison to young women. Young age, higher levels of education and relatively new experiences of spousal violence may have made the adolescent girls more proactive in dealing with physical spousal violence, contributing to its reduction. "New" practices of perpetrating violence, that have not yet been normalised in a relationship, may also be easier to address.

The relationship between economic violence and physical violence

Exclusive interaction with females proved to be a double-edged sword. Results suggest that exclusive targeting of female groups might actually increase spousal economic violence against adolescent girls. Indeed, income earning by females increases the likelihood of intimate partner violence in many low income patriarchal settings, including Bangladesh.[27,28,29,30]

The inverse relationship between physical violence and economic violence witnessed among adolescent girls in the arm with female only group may be explained by several factors. First, when married adolescents learned about their rights and demanded them, husbands may have resorted to a different strategy of controlling their spouses. Thus, physical violence in this arm may have been replaced by economic violence. Second, economic violence within an existing relationship cannot be prosecuted in the same way that physical violence can. Third, with

increased awareness of physical violence related laws, legal provisions and legal services, men may resort to other tools of control. This inverse relationship dissipated when men were also part of sensitisation activities. In fact, in those cases, economic violence reduced. Thus, male involvement was critical for violence prevention and reduction.

The SAFE female group intervention reduced economic violence among young women, in direct contrast to the experience of married adolescent females. This reduction may have been possible in this relatively older age group due to their greater life experience and consequential ability to better negotiate their economic rights. It is also possible that the presence of children made it easier for them to negotiate reductions in economic violence. The absence of impact on physical violence against young women was most probably due to the fact that this violence is very much a part of the relationship dynamics developed over time and thus may be more difficult to change.

The importance of engaging men and women

The results from our quantitative analyses present compelling evidence on the importance of working with both female and male groups in reducing physical and economic spousal VAWG. It is evident that the SAFE intervention had greatest community level impact on reducing physical and economic violence of adolescent girls. Qualitative data suggest that among some group members, SAFE successfully addressed physical and economic violence mirroring the quantitative findings. The qualitative data further suggest that in some cases, impact was made in the arena of sexual violence as well.

Help-seeking and utilisation of legal services

In the male and female group intervention, informal help seeking increased, lending further support to an integrated programme approach. This was probably facilitated by a shift towards gender equitable attitudes in this arm (Chapter 4). Small changes in help seeking in the other arms were not statistically significant at the community level. Qualitative data showed that informal help seeking increased in the community due to SAFE's strategy, which promoted a sequence of help seeking from different informal sources and created multiple layers of support within the community. This was not surprising in light of women's preference for restorative rather than punitive justice and the barriers they faced in seeking formal services.[5,31]

Analysis of SAFE's legal service uptake data show that only severely abused women sought legal services. However, many among them dropped out after carefully weighing the pros and cons of using legal services. There was diffusion of knowledge regarding SAFE's legal services in the community. Consequently, many non-group members accessed legal services, indicating SAFE's success in mobilising the community. The results highlight that it was extremely challenging to substantially increase legal service uptake in cases of spousal VAWG. These findings on help seeking suggest that both informal and formal sources of support should be strengthened for survivors The mere presence of and access to these services did seem to help in reducing spousal VAWG. Implementation of broader policies for creating alternatives to marriage and ensuring minimum economic and social security, seems absolutely necessary for promoting spousal VAWG survivors' utilisation of legal services.

Limitations

Questions may arise as to why SAFE did not achieve a greater magnitude of impact. The following factors need to be considered in understanding the small change in spousal VAWG compared to, for example, the IMAGE study, where a 55% reduction in IPV was demonstrated.[18] First, the impact of SAFE was measured at the community level and not at the group level, where intervention was much more intensive. Only 2-4% of currently married women living with their husbands were SAFE group members in the survey sample (Table 3.2). Second, the control group was not a true

control group. Even where there was no group intervention, community was mobilised and services were provided. The decision to provide some services in control areas was an ethical decision made in light of the high prevalence of violence in slum communities. Since the additional impact of community mobilisation and service provision was not measured, the impact of SAFE's full package remained unknown. Third, the impact assessment may have been diluted because of high mobility among slum populations.

Social desirability bias in reporting experiences of violence is usually an issue leading to under reporting of violence by male respondents. This analysis is free from this particular bias as spousal VAWG in this case was measured based on responses of the female sample. Women, however, also under report violence due to multiple factors, e.g., fear of repercussion, or of being blamed, or not believed.[5,31] We argue that this, however, was not the case here as greater awareness about spousal VAWG, due to the SAFE intervention, was expected to increase reporting rather than reducing it.

Conclusions

A cautionary note needs to be made about raising expectations of women and girls unduly regarding the possibility of stopping spousal VAWG through the legal system. The SAFE experience showed that raising awareness regarding laws, legal provisions and legal services must go hand in hand with careful provision of support for survivors by institutions working closely with the community. Otherwise, the attempts of women and girls to access these services may backfire making them more vulnerable to violence from their spouses, families, communities, and even law-enforcement institutions.

Sustaining positive changes in spousal VAWG-related behaviours will largely depend on CCMs' capacity, their knowledge of and contact with available services in Dhaka, and their involvement with the social movement against VAWG facilitated by other organisations, such as Nari Maitree/ We Can Campaign. The presence of NGO workers in the community is also essential for sustainability. Their role must be to advise survivors on their rights and remedies, to convince perpetrators not to use violence, to sensitise community members about laws and legal provisions and to ensure the accessibility of legal services. A period of fostering and nurturing positive changes at the community level will be absolutely necessary for ensuring sustainability and growth of the movement.

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CHAPTER 4

Pathways of change in spousal violence against women and girls in SAFE areas

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Introduction

There are very few impact evaluations employing rigorous research methods to measure intervention impact on intimate partner violence against women and girls in developing countries.[1,2,3] The number of studies shedding light on the pathways to violence reduction are even fewer.[4] Information on pathways through which violence can be reduced is critical for effective policy and programmes in Bangladesh and elsewhere.

Literature suggests that rates of intimate partner violence are higher in settings where violence is condoned.[5] Studies conducted in Bangladesh clearly show that attitudes condoning gender inequity and violence were associated with an increased likelihood of wife abuse.[6,7,8] Attitudes accepting partner violence are prevalent in many countries around the world.[9,10,11] In one study, male acceptance of intimate partner violence ranged from 29% in Nepal to 57% in India.[11] Attitudes of acceptance are not limited to men; indeed, in the same study, rates of acceptance were higher among women than men. In Bangladesh, the 2006 Urban Health Survey reported that in urban slums, 39% of men and 48% of women justified violence against a wife in at least one scenario presented to them.[12] The SAFE baseline survey showed that 67% of men living in urban slums, aged 18-35, agreed that there were times when a woman deserved to be beaten and 64% believed that a woman should tolerate violence to keep her family together.[13]

SAFE's theory of change

The intervention's theory of change hypothesised that changing attitudes regarding violence against women and girls (VAWG) would be a critical step in the pathway of change resulting in spousal VAWG reduction. A related assumption was that increased knowledge of rights and VAWG, as well as remedies for VAWG imparted through interactive sessions with female and male groups, would help reduce gender inequitable and violence condoning attitudes and practices among SAFE group members and in the community. Promotion of communication and negotiation skills would enhance women's agency in addressing spousal VAWG. Given the relatively low and limited levels of power enjoyed by women and girls in Bangladeshi society, it was essential to create an enabling environment in the community for enabling them to address spousal VAWG. Community campaigns were expected to enhance creation of such the supportive environment. It was also assumed that multiple sources of support for survivors of spousal VAWG would be necessary to increase women and girls' agency and promote help-seeking behaviours. In addition, CCM and group member-led activism was hypothesised to reduce spousal VAWG in the community.

Chapter 3 included evidence that the SAFE intervention reduced spousal VAWG at the community level. In this chapter, we attempt to test SAFE's theory of change using quantitative and qualitative data to illustrate the pathways leading to improved response to spousal VAWG and its reduction.

Methods

Quantitative research methods

Detailed survey methodology was presented in Chapter 1. The data, measurement and analysis of gender inequitable and violence related attitudes are presented below in order to demonstrate evidence for pathways to change. Attitudes towards gender and violence against women were measured using a four-item Likert scale, featuring responses ranging between strongly agree and strongly disagree with agree and do not agree in between. The statements covered the following themes: (1) gender roles; (2) male prerogatives; (3) sexual and reproductive health and rights; (4) and VAWG.

Attitudes regarding gender roles were assessed by the following statements: (a) A woman's most important role is to take care of her home and cook for her family; (b) Men should share the work around the house with women such as doing dishes, cleaning and cooking; (c) If someone insults a man, he should defend his reputation with force.

Attitudes regarding male prerogative were assessed using the following statements: (a) A woman should obey her husband; (b) A man should have the final say in all family matters; (c) Women should have the right to divorce; (d) People should be treated the same whether they are male or female.

SRHR related attitudes were measured using the following statements: (a) Men need sex more than women do; (b) A man should be outraged if his wife asks him to use a condom; (c) It is a woman's responsibility to avoid getting pregnant.

The following statements were used for assessing VAWG related attitudes: (a) A woman cannot refuse to have sex with her husband; (b) When a woman is raped, she is usually to blame for putting herself in that situation; (c) There are times when a woman deserves to be beaten; (d) A woman should tolerate violence in order to keep her family together.

In the analysis, all the responses to these statements were coded to represent positive attitudes regarding gender and VAWG. Male and female participants whose responses indicated positive attitudes towards the majority of statements under each theme were coded as '1' and otherwise, '0'. Age-specific weights were used for adjusting the data.

As mentioned in Chapter 1, all (three) intervention arms were exposed to community mobilisation and service provision. In one of the arms, a female group intervention was added. In the other arm, both female and male group interventions were implemented. The difference-in-difference (DiD) estimator measured the impact of different interventions on attitudes regarding gender and VAWG.

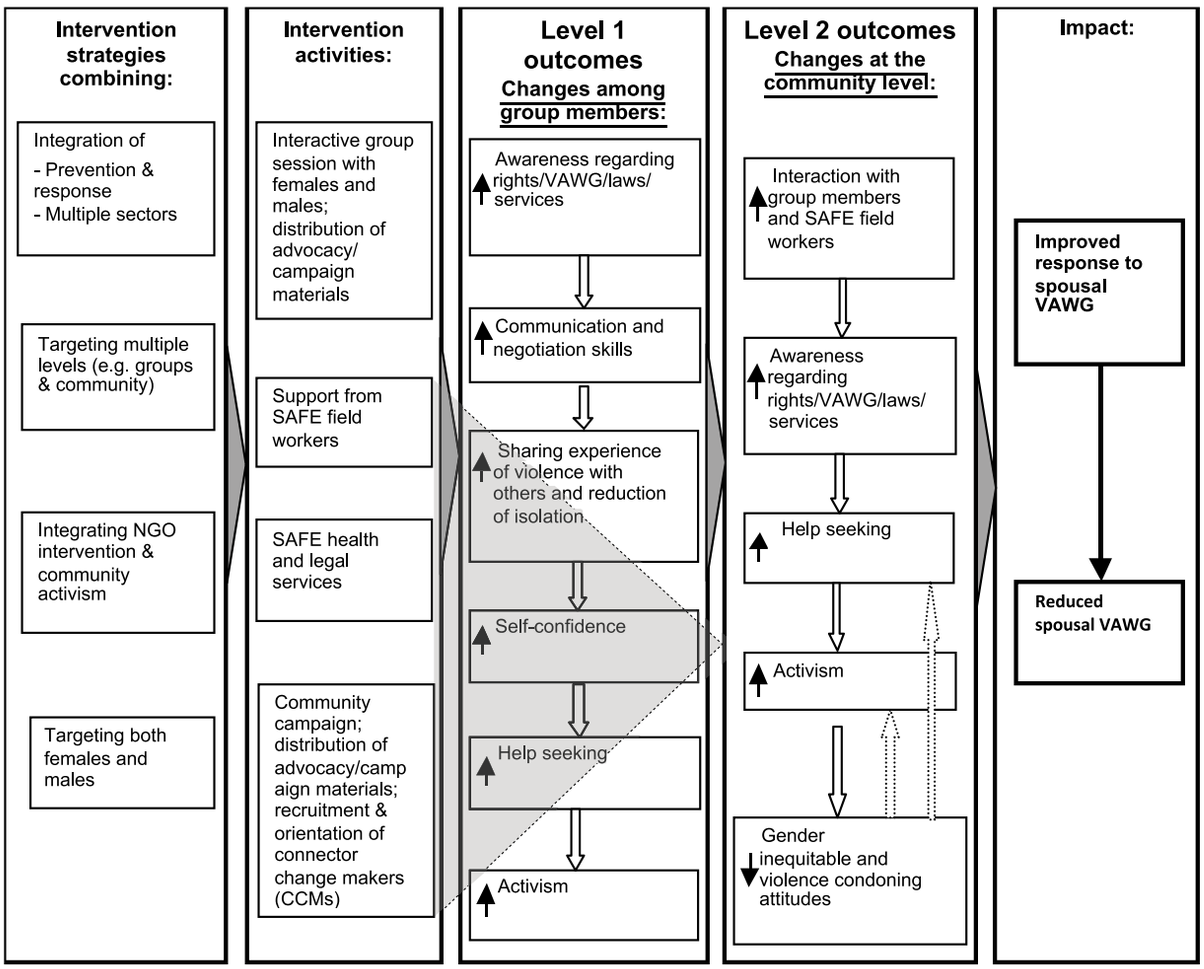
Qualitative research methods

The qualitative component of the SAFE endline has been described in full in Chapter 1. This section includes analysis of a subset of the qualitative data relevant for spousal VAWG. This subset included seven key informant interviews (KIIs), 55 in-depth interviews (IDIs), and eight focus group discussions (FGDs) conducted between February 2013 and June 2014 (Table 4.1). Key informants included five married CCMs and two unmarried CCMs. All married CCMs interviewed were SAFE group members except for one. IDIs included 34 married female group members (four of whom were CCMs) and 21 married male group members. There were eight FGDs. Four gender segregated FGDs were conducted with married and unmarried group members, one with married CCMs, one with married and unmarried female non-group members respectively, and one with married male non-group members.

Table 4.1: Number of Interviews and FGDs conducted for evaluating SAFE's impact on spousal violence against women and girls in Dhaka slums

Tools	Female		Male (age 18-35)		Total
	Married (age 15-29)	Unmarried (age 15-19)	Married	Unmarried	
In-Depth Interviews	34	-	21	-	55
Key Informant Interviews	5	2	-	-	7
Focus Group Discussion					
Group member	1	1	1	1	4
CCM	1	-	-	-	1
Non-group member	1	1	1	-	3

Figure 4.1: Pathways of change in spousal violence against women and girls in SAFE intervention areas



Results

It is clear from Chapter 3 that spousal VAWG did not reduce uniformly across target population and across intervention arms. With that being said, this chapter focuses on answering the question: what intermediate changes led to reduction of spousal VAWG in SAFE areas.

Data analysis suggests clear pathways through which SAFE improved response to spousal VAWG and concurrently, its reduction among SAFE group members and in the community. Figure 4.1 displays the relationship between SAFE activities and their outcomes at the group member and community levels. SAFE activities (i.e., group sessions with females and males, community campaigns, and service provision) increased group members' awareness of gender, rights and remedies relating to VAWG, and available services. The groups provided women and girls space for interaction regarding spousal VAWG, which reduced survivors' feelings of isolation. SAFE group activities increased participant's skills in communication, negotiation and conflict resolution leading to improved effective spousal communication and negotiation around spousal VAWG. The above mentioned activities subsequently enhanced female group members' self-confidence and encouraged survivors' help seeking from group members, SAFE field workers and CCMs. CCMs and some group members engaged in activism by sharing their knowledge acquired through SAFE group participation with community members who were not SAFE group members. Group members also provided support to survivors of spousal VAWG, employing multiple help seeking strategies. They advised women about effective communication and negotiation strategies; informed them about legal provisions and available services; persuaded men to stop violence; and involved SAFE field workers in providing further support.

SAFE's community wide campaigns, the presence of SAFE field workers in the community, and community accessible integrated health and legal services, facilitated shifts in spousal VAWG in the community. CCM and group member driven activism was key in diffusing changes in attitudes and practices from group members to

Table 4.2: Male attitudes regarding gender, SRHR and VAWG before and after the SAFE intervention in Dhaka slums

		Change in outcome before and after intervention, %			Change in outcome due to intervention by arm, %		
Equitable attitudes regarding:	**Intervention arm**	**Before (%)**	**After (%)**	**After – Before (%)**	**Additional Impact of Female Group [(c+f)-c]**	**Additional Impact of Male Group [(c+m+f)-(c+f)]**	**Additional Impact of Male + Female Groups [(c+f+m)-c]**
Gender roles	A.Community+Female+Male	27.8	27.3	-0.5			
	B.Community+Female	35.5	27.9	-7.6	1.3	7.1*	8.5**
	C.Community	35.0	26.1	-8.9			
Women's sexual and reproductive health rights	A.Community+Female+Male	44.3	56.3	12.0			
	B.Community+Female	50.2	53.3	3.1	-1.8	8.9**	7.1
	C.Community	46.9	51.9	5.0			
Male Prerogative	A.Community+Female+Male	19.7	21.8	2.1			
	B.Community+Female	22.6	17.9	-4.7	-6.3*	6.8*	0.5
	C.Community	20.7	22.4	1.7			
Violence against women and girls	A.Community+Female+Male	24.4	27.9	3.5			
	B.Community+Female	32.5	28.2	-4.3	-3.1	7.8*	4.8
	C.Community	26.2	25.0	-1.2			

**** p<0.01; ** p<0.05; * p<0.1*

Table 4.3: Female attitudes regarding gender, SRHR and VAWG before and after the SAFE intervention in Dhaka slums

		Change in outcome before and after intervention, %			Change in outcome due to intervention by arm, %		
Equitable attitudes regarding:	**Intervention arm**	**Before (%)**	**After (%)**	**After – Before (%)**	**Additional Impact of Female Group [(c+f)-c]**	**Additional Impact of Male Group [(c+m+f)-(c+f)]**	**Additional Impact of Male + Female Groups [(c+f+m)-c]**
Gender roles	A.Community+Female+Male	42.3	35.9	-6.4			
	B.Community+Female	47.2	34.0	-13.2	-3.0	7.2**	4.2
	C.Community	48.1	37.5	-10.6			
Women's sexual and reproductive health rights	A.Community+Female+Male	44.8	74.6	29.8			
	B.Community+Female	54.0	74.0	20.0	-1.3	9.7***	8.4***
	C.Community	54.5	75.9	21.4			
Male Prerogative	A.Community+Female+Male	31.0	42.5	11.5			
	B.Community+Female	31.8	44.5	12.7	1.3	-1.3	0.1
	C.Community	32.5	43.9	11.4			
Violence against women and girls	A.Community+Female+Male	33.0	57.3	24.3			
	B.Community+Female	37.7	52.6	14.9	-4.5	9.3***	4.8
	C.Community	39.3	58.8	19.5			

**** p<0.01; ** p<0.05; * p<0.1*

the community. Awareness regarding gender, rights, VAWG, laws and services increased in the community. Males and females' gender inequitable and violence condoning attitudes were reduced creating an enabling environment for addressing spousal VAWG. As a result, responses to spousal VAWG improved and there was a reduction in spousal VAWG.

Below, we present the evidence supporting the pathways depicted in Figure 4.1. While the pathways were explored using predominantly qualitative data, attitudinal changes among males and females in the community were measured quantitatively. This section opens with presentation of the quantitative findings, which appear in Figure 4.1 as 'level 2 outcomes'.

Changes in gender inequitable attitudes at the community level

Table 4.2 and Table 4.3 display changes in attitudes of males and females in three different arms of SAFE at baseline and endline as well as the impact of SAFE on gender equitable attitudes. As baseline and endline comparison shows in Table 4.2, the arm receiving all the interventions, namely community mobilisation and services, female and male group intervention achieved greatest increase in gender equitable attitudes among men compared to the other arms. It is notable that in the other arms gender equitable attitudes among men measured by some of the indicators (e.g., gender roles, VAWG) actually reduced from baseline to endline. Thus, the contribution of the SAFE intervention was not only in increasing gender equitable attitudes as in case of SRHR, but also in deterring deterioration of gender equitable attitudes (e.g., in relation to VAWG). As indicated in Table 4.2 male group intervention was most effective in addressing gender inequitable attitudes (by 7.1-8.9 percentage points). Combining female and male group intervention helped in avoiding reduction of gender equitable attitudes in relation to gender roles. The female-only group intervention did not promote any positive changes in men's gender attitudes. On the contrary, in the arm targeting female groups exclusively, the

intervention had a negative impact on men's gender equitable attitudes regarding male prerogative.

Table 4.3 demonstrates an increase from baseline to endline in gender equitable attitudes in all domains except gender roles. The male group intervention was clearly most effective in promoting gender equitable attitudes among women in relation to SRHR (9.7 percentage points) and VAWG (9.3 percentage points). This intervention also helped in deterring reduction of gender equitable attitudes regarding gender roles. Combining female and male group intervention increased gender equitable attitudes regarding SRHR by 8.4 percentage points.

Changes among SAFE group members

The group sessions and community campaigns made important contributions to shifts in group members' perceptions and attitudes regarding gender, rights and VAWG. The following quote from Munira, a CCM, highlights how SAFE group sessions helped members in recognising VAWG. Munira told the interviewer,

> *"We used to think …a woman is bound to be beaten by her husband. We never recognised this as violence. …We treated snatching money as the only type of economic violence and never considered appropriation of money through coercion as a variant of economic abuse. We did not understand that teasing is an emotional abuse. We used to ignore such things. But teasing actually hurts. We did not realise earlier that teasing/taunting may lead to deprivation of different opportunities in life."*
>
> *KII_Munira_CCM_Unmarried_ Student*

Information about an abused woman's rights and the existing laws protecting spousal VAWG survivors was new for many group members. As Asmani, a group member, said,

> *"From SAFE sessions we came to know that if I cannot tolerate violence anymore I can initiate a divorce. After getting the divorce I'd still be entitled to maintenance payments for me and my children (despite the fact that I initiated the divorce). I'd also receive the amount mentioned in the kabin [marriage contract]. This was the first time I ever heard of this! The other new thing I learned is that one can file a case if the family members try to damage her reputation."*
>
> IDI_Asmani_Group member_Married_ Homemaker

The group members also learned about SAFE's legal services for addressing spousal VAWG. They appreciated the recognition of women's rights and existence of legal provisions.

> *"During the session we were told that if there is conflict between spouses, the woman can either go to the office or make a phone call using the number they (SAFE field workers) gave. If called, they will come and try to make both sides come to an agreement. They will try to correct him. If this fails they will advise the woman about available legal recourses and ways of processing them. …If a man screams at his wife she may decide not to put up with the suffering and leave the relationship. …These services open up a great opportunity for women."*
>
> IDI_Honufa_Group member_Married_ Homemaker

As pointed out by Hanif, a male SAFE group member, a combination of strategies was important in effectively sensitising males about gender and VAWG and reducing wife abuse.

> *"Imparting the messages repeatedly is important. Even if someone reads the materials it is important to reinforce the written messages through repeated face-*

to-face discussion. Otherwise, even if men remember the text they observe wife abuse in the community and think that it is okay for them to do the same. Due to presence of SAFE, its campaign, and its efforts in repeatedly explaining things using varied strategies, these problems were addressed to a large extent."

IDI_Hanif_Group member_Married_ Shopkeeper

The group sessions helped the members to develop interpersonal communication, negotiation and conflict resolution skills. Many survivors began to utilise a communication strategy in which they avoided engagement in verbal disputes during a conflict with their spouse. They waited for an opportune moment to present their arguments, when their spouses were more likely to listen. Women found this strategy very useful in reducing violence.

"Earlier I could not understand how to deal with thrashing by [my] husband. I used to think there is nothing I can do. Now, if he beats me or insults me in public I get back to him at a later point in time and try to make him understand that he should not mistreat me, particularly in public, which is humiliating. This I learned from the group sessions. This strategy has reduced violence in my life."

KII_Shumona_CCM_Married_ Homemaker

Shumona further explained:

"Let me give you an example from what happened yesterday. There was a dispute between the two of us the day before yesterday. Yesterday, when he came for lunch I said, 'You can't stand me'. He asked, 'Why do you think so?' I said, 'You must know the reason yourself because it is you, who mistreats me any time any place. It hurts me a lot.' His face broke into an apologetic smile. …

In the evening he called me over the phone and asked me to take my children and meet him in a place nearby. When we arrived I asked him, 'Where are we going?' He said, 'Just a little farther.' He took us to a shopping centre and told me 'Get whatever you want.' I bought four or five items. I was very pleased. I realised that he must have understood the extent of the pain that made me say those words. This is why he wanted to make me happy."

SAFE's presence in the community and their newly gained knowledge of laws addressing spousal VAWG encouraged group members to speak up against violence. The project's presence also helped survivors' overcome feeling of isolation. Naima, a group member and CCM made this point very clear. She said,

"Almost all of those who attended the group sessions gained the courage necessary to speak out. This is particularly true for the CCMs. The group members have also changed and they now come to us for help."

Citing an example from her own life she further stated,

"Earlier I couldn't protest against any violence by my husband and mother-in-law. …and I virtually did not spend a day without getting beaten…Now I came to know about the laws and gained courage. I don't consider myself helpless anymore as I know where to go for legal services. Recently, after getting beaten by my husband, I called my father, mother and sister-in-laws and asked them to resolve the problem. At first they screamed at him and then they started screaming at me. I said,

'Why would you scream at me when your son is the person who beat me up for no reason at all?' This made them call me names. Then I said, 'Don't you call me names. Nowadays there are lots of laws in this country. If you behave this way I'll be bound to get legal help'. Then they scolded my husband and left. …I did not have the courage to say such things earlier. Now I can talk back and scare them saying that there are laws in favour of women."

IDI_Naima_CCM_Married_Homemaker

Although Naima was glad that she was able to put a stop to verbal abuse from her in-laws, she realised that asking for help from her in-laws would not stop the violence. So she sought advice from an influential man from the community who supported SAFE by encouraging eligible females and males to join SAFE groups. He suggested that she file a complaint at the police station, which she did. But Naima's attempt to get services from the police proved to be futile. The police sought to extort bribes from her during both of their encounters. Naima stopped approaching the police. Naima's story further demonstrated the challenges involved with seeking help and accessing spousal VAWG services, given corruption among law enforcing agencies.

Many SAFE group members who had survived violence used SAFE booklets and leaflets explaining gender, women's rights, VAWG and the benefits of not resorting to violence in response to their spouses' violent behaviours. They took the materials home and made their husbands read them. In many cases, the couples reportedly discussed these materials. Data analysis reveals this was useful in two different ways. First, the informational materials helped women explain what SAFE was about to their husbands. That, in turn, helped to overcome any of husbands' unwillingness to allow their wives to attend group sessions. Second, sharing materials helped to make the husbands aware of gender, rights, spousal VAWG and related laws, and available services. The learning materials helped to create space for couple's communication and negotiation.

Men became interested in what their wives learned at SAFE sessions. Reportedly, some willingly read the SAFE's training and advocacy materials that their wives brought home. They became aware that spousal VAWG was a punishable offense for which they could face legal consequences and, according to the CCMs and group members, this resulted into a reduction of physical violence in their lives. As Mohima, a group member and CCM, mentioned, often the men jokingly asked their wives,

"What did you discuss in your group? Did they advise you on how to restrain us?"

IDI_Mohima_CCM_Married_Homemaker

According to Mohima in such instances the women replied,

"Now we will put you behind the bars".

IDI_Mohima_CCM_Married_Homemaker

Some of the group members reinforced these strategies by actively seeking help from their fellow group members, the CCMs, and the SAFE field workers, who tried to convince men not to use violence. This support led to reduction of survivors' feelings of isolation. As Naima mentioned,

"Those who attended SAFE training now have the courage to speak up. If they face any trouble (conflict with husband) they come to us and share their experiences"

IDI_Naima_CCM_Married_Homemaker

When these strategies failed, some women sought legal services directly from SAFE. The SAFE legal facilitator explained available legal options to women. Then, depending on the nature of the applications and women's preference, either mediation was arranged or a case was filed in the concerned court. Khadija's interview illustrates part of this process. She said,

"Four or five of us used to go and talk to men who used to beat their wives. … We told them 'Why do you fight? Why do you abuse your wives? Do you know that this is harmful?' … The bad ones used to tell us that it is their personal matter and wanted to know why do we care? We used to inform our Apa (female SAFE field worker). Apa used to come and talk to them. After that things would improve a bit."

IDI_Khadija_Group member_Married_ Family business

Depending on the gravity of the situation, women also contacted SAFE legal facilitators first, skipping the initial steps. In those cases when possible the legal facilitators accompanied women to get legal services from SAFE offices.

Changes in the community

While group sessions played the most important role in sensitising members about gender and spousal VAWG, community campaigns and activism carried out by CCMs and the group members with support from SAFE field workers were critical for sensitising and knowledge building among the non-group members (Case Study 4.1).

CCM and SAFE group member-led activism included encouraging community members to join SAFE groups and community campaigns regarding spousal VAWG (e.g., community meetings, rallies, wall painting). The CCMs had the highest involvement in such campaigns due to their commitment, leadership quality, wide social network, and strong communication skills. In a few cases, group members with similar qualities were as active as the CCMs in mobilising the community. Recruitment of group members and activists was particularly difficult during the initial period. Communities were unsure about the SAFE programme's motives and purpose, affecting the public's confidence in participation in its activities. The CCMs spent significant time convincing community members of SAFE's good intentions (Case Study 4.1). After attending the first few events, many community members became interested in further involvement with SAFE. They looked forward to attending more events, stating that they were informative, useful and enjoyable. They participated in processions, carried festoons and placards, and chanted slogans. Piya, a CCM, described her experience of participating in a procession as follows.

"I participated in a procession and a campaign using a three-wheeler. … Ten to twelve of us participated in these events from this area. There were participants from other areas as well. We went door to door for motivating people (to stop violence against females). … We distributed leaflets and booklets among people. Those materials included information on what to do if a woman experiences violence. Those who can read can learn from these materials (how to prevent violence against women)"

KII_Piya_CCM_Married_Homemaker

During campaign events, female participants otherwise confined mainly to home or to work place, had an opportunity to interact with a much wider group of people. In such gatherings, they shared their experiences and learning regarding spousal VAWG and ways of dealing with it.

Another group member and CCM, Naima said,

"I attended an event that was held outside. It was far away; I went by bus. There was a discussion on women's issues. … I also attended a public discussion on violence against women. The group also talked about child marriage. … I try to attend all events so that we get to know more about issues related to us."

IDI_Naima_CCM_Married_Homemaker

Case study 4.1: Johura created a difference

Johura, divorced her husband seven years ago when he married another woman without her permission. Johura, a single mother of a ten-year-old daughter, lives with her mother. She works as a cleaner in an office and runs a small business. Johura joined SAFE as a group member. Soon she impressed the SAFE field workers with her sincerity, presentation skills and leadership qualities. They encouraged her to become a connector change maker (CCM) and Johura gladly agreed.

Once Johura became a CCM she participated in rallies, campaigns using a three-wheeler, discussion, and a video show within and outside of her own slum. She distributed leaflets and posters at these gatherings. She informed women about laws, legal provisions and services for responding to violence against women and girls.

Johura motivated people from her community to join these campaigns using SAFE's advocacy materials. She informed the potential female participants about the upcoming events ahead of time so that they had enough time to inform and convince their husbands about their participation in the campaign. Johura often faced opposition from men of her community for distributing campaign materials. Some men sarcastically asked Johura what she could do for men who were abused by their wives. In such instances, Johura calmly advised them to talk to male SAFE field, just as abused women spoke to female SAFE field workers. Some said that Johura was talking "rubbish" while others mockingly called her a ***Netree*** (female leader). Johura ignored the intimidation and carried on with her activism.

Johura tried to convince men in her community not to beat their wives. Johura's brother always found excuses to beat his wife regularly. Johura wanted to take her sister-in-law to the SAFE field worker for help, but she refused to, avoiding getting divorced by her husband. Johura sought support from her family members who were sympathetic to her sister-in-law and jointly started to convince her brother to stop the violence. She introduced the couple to one of the female SAFE field workers. The SAFE worker also tried to convince Johura's brother to stop abusing his wife. Unfortunately, all these attempts failed. So, as a last resort, Johura told her brother that she would call the police if he assaulted his wife anymore. This strategy worked and he stopped using violence. In order to sustain this change, Johura still threatens her brother with possible legal measures.

Many CCMs faced challenges mobilising people to join SAFE groups or to participate in SAFE campaigns. They were successful at times. Moina, who managed to convince a group of women to join a SAFE event said,

> *"They (women, who were not SAFE-group members) trusted me and went to the meeting with me. Initially they were sceptical about what the events [were]. I convinced them to join by sharing with them our experiences as CCM. Now they look forward to attending more events. … Isn't it good? … Fifteen women trusted me. This is what made me happy."*
> IDI_Moina_CCM_Married_Homemaker

The CCMs and group members shared the knowledge acquired through SAFE group sessions and campaigns regarding gender, rights, VAWG and related laws and services with their families and neighbours. Moina, a group member and CCM described how she shared her learning with her neighbours, her sisters and their husbands.

> *"Husbands and wives fight in families, where husbands do not earn regularly. ... I try to convince them not to fight. … Divorce is not a good thing you know. It is better to resolve this through mediation so that legal measures will not be needed. I've seen what happens when legal support is sought. … I advise my sisters and their husbands that it is good to have harmony for the betterment of the family, about the bad sides of divorce, broken family and*

hassles associated with legal actions."
IDI_Moina_CCM_Married_Homemaker

On several occasions the CCMs and the group members, individually and/or collectively, provided support to non-SAFE members abused by their husbands (Case Study 4.1). Sometimes they intervened instantly when the abuse was taking place. They tried to convince the perpetrator to stop violence by highlighting adverse effects of spousal VAWG on children, on spousal relationships, and on the family as a whole. They emphasised the necessity of peace and harmony in the family for a better future. The CCMs advised couples to find solutions to their problems by properly communicating with each other rather than resorting to violence. As the women in general preferred to mend the relationship rather than getting a divorce the CCMs discussed adverse consequences of divorce with men. They made abusive husbands aware of legal provisions against spousal VAWG and the availability of services for survivors (Case Study 3.1, Chapter 3) and highlighted to the perpetrators the hassles that come with legal procedures. This sometimes helped reducing violence. Piya shared the following experience regarding preventing spousal physical and sexual violence against a non-SAFE member,

"She used to work as a domestic worker. After work, she cooked the family meal and looked after her two children. She used to get tired. He used to beat his wife up every night and forced her to have sex. … I gave booklets to the woman and said, 'Show this to your husband and convince him (to stop the violence). If he reads them he might be convinced.' …I also requested my husband, 'You are a man (and you can) convince him.' He did so. That man has changed a bit (i.e., reduced the abuse) (after this)."
KII_Piya_CCM_Married_Homemaker

Sometimes activists used fear as a tool for stopping spousal VAWG. Piya's narrative of another case illustrates this well. She told the interviewer,

"A man used to beat his wife. I told him, 'What would you do if your wife filed a case against you?' To scare him I (intentionally) advised his wife (within his earshot), 'Go and file a case against him'. It scared him. (Later) he asked his wife whether she had (actually) filed any such case. … I suggested to her, "Be strong (and lie). … If you say that you didn't file a case he would never change". She listened to me and told her husband, 'Why shouldn't I? What else can I do if you abuse me?' He came and asked me about it. … I (took this opportunity to) convince him (to stop violence). … He told me, 'Apa (sister), you are a good person. You have convinced me. (I now understand that for the time being) she told this (lie) to scare me. (But) she may very well file a case in the future and then what (happens to me)?' I said, 'Now you see?' The man said he would never do anything bad to his wife again."
KII_Piya_CCM_Married_Homemaker

The qualitative data suggested a change in the community environment that, in turn, facilitated reduction of spousal VAWG. Khadija put it as follows:

"We have received a lot of assistance from SAFE. The women field workers supported us. Now the men are afraid of women. They understood that it is risky to abuse women too much. We used to participate in processions chanting, "Stop violence against women". They (SAFE field workers) used to give us booklets and leaflets, where things were explained. Those who are educated read them and many of them changed."
IDI_Khadija_Group member_Married_ Family business

Another group member Lotifa mentioned,

> *"After I became a SAFE member he was scared and decided that he would not be able to beat me or abuse me in any other way. This is the benefit I gained from being a SAFE member."*
> IDI_Lotifa_Group member_Married_ Homemaker

SAFE strategies' success largely depended on the characteristics of the men and women involved. For example, education played a strong role SAFE's impact on women. Women with some education more easily internalised the concept of women's rights. Education also helped women to more easily master interpersonal communication skills and conflict negotiation. Women with some education that sought help seemed to benefit more from the SAFE intervention and succeeded in reducing violence by spouse.

The data also suggested that educated men exposed to SAFE materials on couple communication and spousal VAWG related issues were more likely to change than uneducated men exposed to the same materials. Some men changed when they realised that there were legal implications for their actions. However, men who believed that spousal VAWG was a private matter did not allow group members and/or SAFE staff to intervene. Some perpetrators were very powerful in the community, making it difficult for SAFE CCMs and community groups to approach them. These socially powerful men did not change despite the SAFE intervention.

Corruption, bureaucracy, and lack of motivation among law enforcing agencies in providing services to abused females worked as impediments to achieving positive outcomes. Unequal capacities and levels of participation between and within categories of CCMs also posed challenges. For example, it was difficult for CCMs with childcare responsibilities to dedicate much time to community activism. Unmarried adolescent CCMs' young age and marital status undermined their social status in the community, making it difficult for them to mobilise the public to address spousal VAWG. Unmarried adolescent CCMs' protest achieved some success in reducing spousal VAWG in the family though.

Discussion

The results confirmed SAFE's hypotheses about the pathways through which spousal VAWG reduced in the community. Below we discuss the significance and implications of these findings.

Change gender attitudes to change behaviours

Gender inequitable and violence condoning attitudes are important determinants of spousal VAWG. [6,14] One study from Bangladesh shows the importance of addressing these attitudes both at the individual, community and district levels.[6] Thus, interventions must not only address individual attitudes, but also bring about positive changes in social norms at the community and district levels. Unfortunately, not all previous rigorous evaluations measured intervention effects at a level higher than individual.[1,2,15] One RCT measuring gender norms and economic empowerment of women in Cote d'Ivoire showed a positive impact on attitudes of female group members, but failed to show an effect in the community.[15] The Ugandan programme, SASA!, was the only programme that achieved a reduction in gender inequitable attitudes at the community level through community mobilisation.[3] However, this effect was found only among female community members; not male. SAFE is the first intervention to demonstrate a positive impact on these attitudes among females and males in the community. These results confirm that meaningful social norm change can be achieved through integrated intervention in low-income settings within a time-bound project.

The findings from quantitative analyses showed that the male group intervention, in addition to community mobilisation and the female group intervention, was absolutely critical for bringing about positive or relatively positive changes in

gender attitudes among both males and females compared to the control group. The female only group intervention had no overall impact on community level attitudes of males and females, and, it reduced men's gender equitable attitudes regarding male prerogatives. In a patriarchal society an intervention like SAFE may threaten men, and generate negative reactions, resulting in greater gender inequitable attitudes regarding male prerogative. Thus, in similar socio-cultural contexts, programmes aiming to positively change gender attitudes in the community must include men in addition to women.

Increased gender equitable attitudes in some domains the community created an improved environment for spousal VAWG response and prevention. Community mobilisation and activism on the part of the CCMs and the group members sensitised community people regarding gender, rights and VAWG. Mobilisation activities also helped in promoting knowledge about laws and legal provisions related to spousal VAWG. People in the local community became aware of the availability and access to legal services for addressing spousal VAWG. These changes led to an increase in female survivors' help seeking in the community. These changes in attitudes and behaviours resulted in an improved response to spousal VAWG and reduction in spousal VAWG. These findings lend support to the qualitative findings from SASA![4] that community-mobilisation contributes to spousal VAWG reduction in developing countries.

Intervention components reduced gender inequitable attitudes and spousal VAWG

It is very important to understand how different components of the SAFE intervention contribute to positive changes in spousal VAWG through multiple pathways. Group sessions played an important role in helping women and girls recognise spousal VAWG in their lives. In these sessions, women and girls became aware of their rights to live a violence free life. They interacted with others and gained confidence. As pointed out by Naved and Persson in a study in Bangladesh better spousal communication lowers the likelihood of violence by husband.[16]

The SAFE group members learned ways of addressing spousal VAWG and used new methods of communication strategically. The skills they acquired through SAFE in effective communication, negotiation and non-violent conflict resolution were very useful when females addressed spousal VAWG on their own. The female group members used SAFE advocacy materials effectively in the process of communication and negotiation for spousal VAWG reduction. When such strategies failed, women sought help from SAFE-created informal support systems, such as CCMs and SAFE group members. In extreme cases, they also sought support from the SAFE legal services.

Among the group members a combination of strategies such as (1) Sensitisation regarding gender, rights, and spousal VAWG; (2) Knowledge building regarding laws, legal provisions and available legal services; (3) Creation of a local platform for discussing spousal VAWG; (4) Skill building around communication and negotiation and non-violent ways of conflict resolution; and (5) Creation of new layers of informal support, achieved a reduction in spousal VAWG.

Reduction in spousal VAWG in the community was also achieved through community mobilisation, activism of the community members, NGO presence in the community and NGO support services. Presence of SAFE field workers seems necessary for achieving positive results in addressing spousal VAWG, which raises the question of sustainability of programme achievements. It is clear from the data that sensitisation of the law enforcing agencies, addressing their corruption and strengthening their accountability, was essential to properly respond to survivors' needs. In addition, NGO support for survivors will remain essential to ensure that women reach the services they need.

Intervention strategies underlying SAFE's success

The demonstrated impact of SAFE was the joint outcome of all intervention components and

approaches. Thus, it is important to point out the programme approaches or strategies that have also contributed to the impact. SAFE's success in achieving positive attitudinal and behavioural change is attributed to its integrated approach. The SAFE model was integrated in several ways. SAFE combined spousal VAWG prevention with response and services for survivors. The intervention was multi-sectoral as it integrated legal and health services. Moreover, in line with the idea of an ecological framework.[16] SAFE involved different tiers of urban slum, targeting young females and males as well as the slum community at large. Implementation modalities were also integrated, engaging grassroots efforts via community activism and NGO expertise. Finally, in contrast to other interventions where either group sessions[1,2] or community mobilisation[3] were introduced into communities, SAFE combined both types of engagement.

The importance of engaging women AND men, cannot be overstressed. When men were also engaged gender inequitable attitudes and spousal VAWG reduced more than when men were not included in the intervention. This finding is consistent with the literature.[17,18] Finally, following the lessons of Freire[19] and Stepping Stones,[2] SAFE developed interactive group sessions with females and males to promote changes in behaviours and attitudes. This approach worked. Using context specific scenarios and case studies to deliver messages, group sessions enhanced facilitated reflection and contributed to sensitisation, attitudinal and behavioural change.

Policy recommendations

SAFE's impact on gender equitable attitudes and spousal VAWG in the community has seven implications for policy. First, similar to SASA!,[3] SAFE demonstrated the feasibility of positively affecting gender attitudes and spousal VAWG by implementing an integrated and relatively short term project in a low-income setting. Second, it is clear that a combination of group sessions, community mobilisation and service provision was effective in achieving a positive impact at the community level compared to a standalone intervention. Third, an ecological approach in the intervention design was effective. Thus, working both with females and males and the community at large was essential. Fourth, it was important to facilitate and nurture community members' activism to diffuse the intervention's positive impact on group members to the broader community. Fifth, it was critical to combine spousal VAWG prevention with legal and other services for survivors, which ultimately enhances its reduction. Sixth, most survivors preferred support from informal sources to formal sources to address spousal VAWG and thus, it was important to strengthen both informal and formal support systems. Finally, the SAFE model needs to be widely implemented in urban slums of Bangladesh for addressing spousal VAWG.

Key policy recommendations for reducing spousal violence against women and girls in urban slums

- Use an integrated approach for interventions
- Combine interactive group sessions, community mobilisation and service provision
- Target both females and males, as well as the community as a whole
- Facilitate and nurture activism involving community members
- Combine prevention with services
- Strengthen both informal and formal support systems

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APPENDIX

A. Sample size calculation

Sample sizes for this study were calculated assuming that treatment effects could be estimated by measuring changes in key outcomes between baseline and endline surveys and by comparing change in these outcomes by treatment groups (arms). Keeping in mind the clustered nature of the intervention at the ward and community level, we followed design recommendations for cluster level trials.[1]

Sample sizes were calculated using Optimal Design[c] (OD) software, assuming 5% significance level, 80% power, intra-class correlation of 0.01, and a cluster size of 15 respondents, 153 female clusters of 15-19 years old (51 clusters per site), 81 female clusters of 20-29 years old (27 clusters per site); and 81 male clusters of 18-35 (27 clusters per site) were needed to detect a minimum detectable effect size (MDES) of 45% to 55% (Appendix-Table A1). Allowing for 20% over-sampling to group's size in order to address 5% non-response and 15% migration at the endline, the cluster size increased to 18 for which the sample size increased from 4,725 to 5,670 (4,212 females and 1,458 males).

B. Sample selection and recruitment procedures in baseline and endline surveys

As depicted in Appendix-Table A1, adolescent girls and women aged 15-29 and men aged 18-35 were included in the endline survey. The respondents were selected from slums[d] in the vicinity of three Marie Stopes clinics in Dhaka. Each of the clinic site slums were divided into 51, 27, and 27 non-contiguous clusters of 15-19 year old females; 20-29 year old females and 18-35 years males, respectively. These clusters were then randomly assigned to the three strategies. Male respondents were not selected from the same household to avoid any possibility of breach of confidentiality from selecting two respondents from the same household.

The slums in the Marie Stopes clinic catchment area varied in size. Since the size of slums may have impacted some of the variables of interest in the study, an attempt was made to ensure all sizes of slums were represented in the sample.

Appropriately trained same-sex interviewers recruited respondents after receiving guardians'/parents' permission and minors' assent, or informed consent from the adult and emancipated minor respondents. Influential leaders in the community gave their permission to researchers prior to entering slum communities. Parent's permission was received before contacting unmarried minor respondents less than 18 years of age. However, in the case of a married minor, the husband's permission was not obtained, because he was not considered a legal guardian. Married girls younger than 18 were considered emancipated minors,[e] and thus, gave consent themselves.

[1] Raudenbush SW. Statistical analysis and optimal design for cluster randomised trials. Psychol. Methods. 1997; 2(2): 173-185.

c OD holds three assumptions of balanced design; two available conditions for power calculation, which requires pair-wise comparisons for multiple groups; and the parameters are to be reasonable.

d For the study, we will use the "slum" definition of the Urban Slum Survey 2005, where slum has been defined as "settlements with a minimum of 10 households or "mess unit" with a minimum of 25 members and: predominantly very poor housing; very high population density and room crowding; very poor environmental services, especially water and sanitation; very low socio-economic status; and lack of security of tenure. To qualify as a slum, an urban community had to meet at least four of these criteria (CUS, NIPORT, MEASURE Evaluation. 2006).

e Emancipated minor is a legal status conferred upon persons who have not yet attained the age of legal competency as defined by state law (for such purposes as consenting to medical care), but who are entitled to treatment as if they had by virtue of assuming adult responsibilities such as being self-supporting and not living at home, marriage, or procreation (United States Department of Health & Human Services 1993). In Bangladesh, there is no legal definition of emancipated minor. However, icddr,b, an internationally reputed national research institution, considers married girls as emancipated minors.

Appendix-Table A1. Sample size requirements for survey with three-level multi-site cluster randomised trial

Age group	Marital status	Effect variable	MDES	Clusters for 2 arms (J1)	Clusters for 3 arms (J2)	No.of sites (K)	Total clusters (J2 x K)	Cluster size (N) [15 x 1.20 with 20% for over sampling =18]	Sample-3 arms [J2xKxN]
Female sample									
15-19	Married; Unmarried	Marriage*	45%	34	51	3	153	18	2,754
20-29	Married; Unmarried	Violence exposure	55%	18	27	3	81	18	1,458
Total female sample									4,212
Male sample									
18-35	Married; Unmarried	SRHR knowledge	55%	18	27	3	81	18	1,458
Total male sample									1,458
Total sample								5,670	

**The sample should be enough to measure changes in exposure to violence as well. J increased by 1 unit resulting in an even number cluster for sample size calculation with 50% effect level.*

C. Quantitative Analysis

Impact of the interventions on outcomes of interest was assessed using a difference-in-difference approach where change in outcomes in the intervention arms of the study was compared to change in the comparison arm. Difference-in-difference estimators may be represented as '$\hat{d}$':

$$\hat{d}=\left(\overline{Y}_{\text{Endline Intervention}}-\overline{Y}_{\text{Baseline Intervention}}\right)-\left(\overline{Y}_{\text{Endline Comparison}}-\overline{Y}_{\text{Baseline Comparison}}\right)$$

Difference '$\hat{d}$' is an accurate estimate of the impact of the SAFE study if there is covariate balance and baseline trends were parallel prior to the intervention. In other words, a measure of the relative change in intervention communities that took place between the baseline and the endline compared to the change in the comparison communities where the additional interventions that are of interest were not given can only be a valid measure of impact if the samples have not changed in significant ways during those two time periods in ways unrelated to the intervention.