Integration of GBV prevention into group perinatal care in Mali

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How did we get here?

Initial study of perinatal women’s mental health needs in Mali identified depression (*dusukasi*) and anxiety-like (*hamin*) syndromes

Midwives described as discuss mental health and a key contact point with women

Developed G-ANC+: built off an existing group antenatal care model and integrated perinatal depression prevention from the evidence-based Mothers and Babies Program

But! This program does not have the capacity at present to address ongoing social determinants of women’s health and wellbeing

Women described their relationship with their husbands as important factors related to their wellness
Project Setting and Context: Bamako, Mali

More than a 1/3 of women report IPV*

89% of girls are estimated to experience FGC*

IPV can threaten pregnancy outcomes; FGC decision making often occurs in postpartum period

Therefore, the perinatal period presents both risks and opportunities to mitigate risk

Group care provides opportunities for activities like safety planning & reflection on FGC intentions and plans

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Study Aims

Our goal is to create a GBV curriculum that is integrated into a group-antenatal care program for pregnant women in Bamako, extending care into the postnatal period.

1. Develop IPV response & FGC prevention content for integration into group perinatal care.

2. Pilot the "G-PNC+" and assess impact, feasibility, and acceptability.
Early learnings: Women’s perspectives on GBV

- 4 focus group discussions with 36 pregnant women or women who recently gave birth (6-8 per group)
- Drawn from the study of G-ANC+ at 4 CSComs in Bamako
- Guide drew on the WHO Violence Typology and the socioecological model
- Goal was to understand:
  - What actions are perceived as violence?
  - What family or community members may be supports in prevention?
  - How does violence or women’s related needs for support change during pregnancy

Garrison-Desany et al., (In preparation)
### Preliminary Findings: Women’s perspectives on GBV

<table>
<thead>
<tr>
<th>Type</th>
<th>Examples considered violence</th>
<th>Examples not considered violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>• Beating (in or outside of the home)</td>
<td>• Slapping during an argument</td>
</tr>
<tr>
<td>Psychological</td>
<td>• Yelling in public</td>
<td>• Yelling in the home</td>
</tr>
<tr>
<td></td>
<td>• Threatening in public</td>
<td>• Threatening in the home</td>
</tr>
<tr>
<td></td>
<td>• Insults and humiliation in public</td>
<td>• Insults and humiliation in the home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Neglect (“silent treatment”)</td>
</tr>
<tr>
<td>Sexual</td>
<td>• Forced sex, unprompted</td>
<td>• Forced sex, after a long period of no sex</td>
</tr>
<tr>
<td>Financial</td>
<td>• Women being forced to work due to men choosing not to work</td>
<td>• Husbands controlling all the household finances (e.g., taking wages)</td>
</tr>
<tr>
<td></td>
<td>• Not being given money to complete household shopping</td>
<td>• Women working outside the home and being in charge of all household tasks</td>
</tr>
<tr>
<td>In pregnancy</td>
<td>• Not paying for medical care</td>
<td>• Expecting household chores to continue to be completed</td>
</tr>
<tr>
<td></td>
<td>• Violence to harm the fetus</td>
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</tbody>
</table>

What I consider violence is when a man marries a woman and he refuses to take charge of her and does not have sex with them. There are men when they get married it's over, they don't do anything for their wives. I'm not talking about unnecessary expenses, like buying new clothes for ceremonies. I'm talking about illnesses and sexual intercourse and also prenatal follow-ups.
### Preliminary Findings: Addressing GBV

**Key concepts: Sabelie and Mugnu**

- Law enforcement involvement never discussed
- Norms against seeking legal separation or divorce
- Seeking medical support was rare

**Appropriate sources of support**

- Family members
- Close friends
- Community and religious leaders

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Here in Mali, one of the virtues of a woman is that she can put up with a lot without telling people. A woman must endure in silence. You wait until it is visible, otherwise people will say that the problem comes from you.

Religious leaders can help because they know the word of God and are able to strengthen both spouses. Some friends can help or mislead you, but religious leaders can never do anything to break up a marriage.
Preliminary Findings: Women’s perspectives on GBV

I suffer a lot because of my mother-in-law and my sisters-in-law. I have to put up with them all day. I don't know what I did to them but they tire me a lot. They don't love me, they want me to divorce my husband. While my husband doesn't want that. This is the problem I have. No one in the family speaks to me, even my mother-in-law, but I force myself to speak to them. She doesn't even want me to work for her. Nothing in particular can pass between us, they make my life as a couple difficult.
Building upon existing knowledge: Systematic review of FGC Interventions in West Africa

- Of the 15 articles, only 10 have a full text description of an empirical evaluation of an intervention
  - 1 qualitative
  - 2 post intervention mixed methods
  - 3 pre-post survey
  - 4 quasi experimental

- Types of intervention components evaluated
  - 3 policy (impact of legislation)
  - 8 include community education on the practice and its harmful effects via outreach, mobilization and/or media
  - 2 provide alternatives for individuals who perform FGC
  - 4 train providers or augment/support health response
  - 1 promotes integrational dialogue

PRISMA Diagram
Process: Community Advisory Board

- 10 individuals in Bamako with expertise in GBV including provision of services, advocacy, and legal assistance

- Working on collaborative design and expectations to share benefits

- Key considerations thus far
  - Midwives may not be prepared to recognize survivors
  - Women just may not be willing to openly discuss FGC and we should anticipate lots of support for the practice
  - New mothers are not the key FGC decision makers
Potential promise for impact, but also to misstep

The use of a group care model has potential to support prevention and respond to GBV

- Fosters social connection and support where women have few potential outlets for this
- Potential to go beyond screening and referral to consider ways to stay safe while meeting women where they are and supporting mental health
- Considers decision making time period for FGC

Despite the promise there are important considerations that require a slow adaptation process with multiple stopping points

- Unclear it is acceptable to talk about FGC and the degree to which primary decision makers can be engaged
- Supporting women’s safety and autonomy to decide best course of action for herself and her family
Next Steps: Taking it SLOW

Aim 1

• Conduct qualitative formative research (IDIs and FGDs) to explore how to adapt existing evidence-based strategies to improve safety and shape decision making regarding FGC for girl children.
• Develop initial draft of most promising strategies in a curriculum to be & pre-piloted with women
• Adapt existing group care manual through collaborative workshop

Potential Strategies

• Inclusion of men and mothers in laws in formative work and consider engagement of men and mothers-in-laws in safe ways
  • Dialogue and ways to facilitate discussion
• Supporting women’s safety within the home through context specific strategies and resources
• Training providers on non-judgmental, woman-centered and trauma informed care for women who may have experienced violence and who may have contrasting views on FGC
  • Include healthcare workers in formative work
Thank you!
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