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RESEARCH ARTICLE

Experiences of domestic violence prevention interventions and gender equality promotion work: a qualitative study of *Nirdhar Groups* in rural India [version 1; peer review: awaiting peer review]

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Abstract

Domestic violence and abuse (DVA) against women in India is a serious concern. To address this, community-based interventions to facilitate sustained change at local levels have been implemented in 37 villages by the Halo Medical Foundation (an NGO working in the Maharashtra state of India). This qualitative study of community led alliances (known as *Nirdhar Groups)* evaluates the experiences of these 'community citizen groups'. Participants from 12 villages from the project area participated in qualitative focus group discussions. *Nirdhar Groups* used local interventions to address priorities such as safe and equal access to education and healthcare. They offered education to address financial oppression and used community pressure and 'Responsible Couples' as mechanisms for change, to instil 'fairness, gender equality, kind and compassionate community values' and a variety of techniques to reduce DVA. The drivers for change included role modelling, empowerment of women in communities and a focus on changing cultural practices for present and future generations. This paper reveals how local interventions empower communities to address gender disparities and DVA.

Open Peer Review

Approval Status *AWAITING PEER REVIEW*

Any reports and responses or comments on the article can be found at the end of the article.

Keywords
Gender equality, Domestic Violence and Abuse (DVA), Women, India, Community Intervention.

This article is included in the Gender and Violence collection.

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Competing interests: DEVELOP project has two components namely quantitative/survey and qualitative study. The qualitative component is focused on the gender equality programme, which is funded by the SWISSAID. SWISSAID is a lead partner in India to support DEVELOP research activities being one of the key collaborators. Ms Sneha Giridhari, who is involved in the DEVELOP project and also as one of the authors, is employed during this research project duration by the SWISSAID as a programme officer and was involved in monitoring DEVELOP research activities in India. Other authors do not have any competing interest relevant to this study/project to declare. Research findings are reported to the best of the abilities of members involved with no influence from any organisations such as HMF or SWISSAID or any other partners. All data analysis and reporting are prepared by independent research members who do not have any financial interests in the project implemented in India and approved for publication by all involved.

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Introduction

Gender inequality in India

Many Indian women face domestic violence and abuse (DVA) from their male partner (Jejeebhoy & Santhya, 2018; Borah *et al*., 2017). The causes of gender inequality and violence varies with local culture and norms, meaning local, community driven interventions play an important role (Desai *et al*., 2017) to reduce sufferings and promote change. In India, many rural communities face problems around women and girls' safety (Ghosh & Choudhuri, 2011). Cultural pressures and norms often lead men into gender discriminatory practices (Ram *et al*., 2019). This may result in financial, emotional, or physical gender-based violence and discrimination (Anitha, 2019). As such, gender inequality severely hampers progress towards the Sustainable Development Goals (SDGs), particularly towards the fifth SDG, Gender Equality, and it is also important to achieve several others SDGs where girls/women involvement in health, economic and sustainable progress are imperative (United Nations Statistics Division, 2017). Rural and remote areas across India have inadequate resources such as limited judicial infrastructure, poor policing and environmental problems like frequent drought affecting agricultural yield which is the primary source of livelihood for many (Mahapatro *et al*., 2012; Showalter *et al*., 2020; Stephenson *et al*., 2013). Alcoholism and poverty are prevalent in these communities (Ram *et al*., 2019; Mshweshwe, 2020; Gunjal *et al*., 2020), fuelling men to dominate and engage in DVA (Daruwalla *et al*., 2019). Top down (governmental or socially led) strategies lack the capacity to address such issues faced in rural areas, which have their own social structures, community cultures, and related challenges.

Community based gender equality interventions

There is evidence that the most effective gender equality work can be done within and with the cooperation of the community itself (Daruwalla *et al*., 2019). Policies and laws are only effective when enacted in the community setting (Freudberg *et al*., 2018). Furthermore, engaging influential community members and ensuring that both women and men are actively involved in community-based gender equality interventions are markers for impact (Mahapatro *et al*., 2012). Targeted and localised approaches are deemed effective means for change (Kalokhe *et al*., 2017). With engagement from local communities, NGOs and community, volunteers are more readily accepted and recognised by those who need it most (Nair *et al*., 2020).

In partnership with and support from the SWISSAID India, the Halo Medical Foundation (HMF) initiated the 'Responsible Couples' project. The project involved developing local community level groups called *Nirdhar Groups* to address and reduce gender inequality, DVA and provide village-based support structures for women affected by gender inequality. *Nirdhar* in a local language, Marathi, means determination. *Nirdhar Groups* consisted of male and female community health workers, village police representatives, teachers, and elders. The NGO (HMF) convened, trained, and empowered such *Nirdhar Groups* with information, support, and resources so that they could support women's rights within their own communities. The 'Responsible Couples' project involved the following key activities: (a) establishing village level gender equality groups known as *Nirdhar Groups*; (b) conducting training, education and media campaigns to educate people across project areas on the importance of gender equality; (c) motivating men (men's involvement & engagement) to participate in household chores which are often shouldered by women, helping them understand the importance of gender equality and improving relationships at family levels; (d) advocating and working towards equal rights for women, such as joint bank accounts, joint property registrations for house and agricultural land (including ownership rights & decision making); (e) providing access to gender equality and domestic violence counselling services through HMF's registered counselling centre (known as *SAVALI Kendra*, registered with the government authorities to provide support services & justice to victims of violence). The *SAVALI Kendra* receives referrals from village level *Nirdhar Groups* where specific support and expert advice are required to address DVA cases. *Nirdhar Groups* have now been in existence in 37 villages located in the Osmanabad district of the Maharashtra State of India since 2017. The overall project scope and objectives were focused on reducing any violence against women/girls and improve gender equality in rural communities, which is informed by SWISSAID and HMF's strategies and work priorities to improve wellbeing of marginalised groups, children, and women in local communities. HMF has been working in community health and development sectors since 1990's in rural areas of Maharashtra, particularly in Osmanabad district, which is one of the marginalised regions in the country.

All outlined project activities were designed and delivered by a dedicated team at HMF, through financial support from the SWISSAID. Team members had a range of backgrounds, primarily in social work with experience and interest to work on community development initiatives. The project structure offered each staff member an opportunity to work with a specific set of villages over time to conduct field-based meetings, training, educational tours, and also help communities develop village level groups (*Nirdhar Groups*) to improve gender equality and reduce domestic violence in communities. SWISSAID provided technical support through consultants and subject experts to train staff and village groups along with an intensive monitoring approach to track project progress. The support was also extended to design project activities such as initiatives to involve men in household activities, develop training manuals, and village/community

level activities. Village groups were involved on a voluntary basis, and all project staff were full-time (~10 members) or part-time (~37 members) employed by the HMF (funded by the SWISSAID).

Purpose of the study

The purpose of this research was to explore the experiences of village level 'gender equality' *Nirdhar Groups* and to: (a) reveal how they developed processes and structures which impacted gender discriminatory practices and domestic violence & abuse (DVA) prevention across their local communities; (b) identify the issues and challenges they faced; (c) identify interventions which they used to combat gender inequalities in rural communities. The paper is presented in line with the COREQ guidelines (Tong *et al.*, 2007).

Methods

Ethics

The study has been approved by the Faculty of Health Sciences Ethics Committee, University of Hull, UK (approval reference number- FHS125), and also by the ethics committee of the Ashwini Rural Medical College, Hospital and Research Centre, Solapur, Maharashtra, India (approval reference number- ARMCH/IECHR/03/2019).

Participants

The study involved 12 focus group discussions (FGDs) in 12 villages, which were part of the 'Responsible Couples' project. The groups were selected from a pool of 37 villages, where village groups were actively working in the 'Responsible Couples' project at the time of data collection. Each village had one group and each group had 15 and 20 members. The outlined 12 groups/villages were randomly selected from project area by members of the UK research team, Professor Mark Hayter and Dr Anand Ahankari, who were not aware about individual group level performance, to avoid any selection biases. All 12 village groups were provided information about the study in advance and once they agreed to participate in the study, then FGD (data collection) date and timings were confirmed. Based on our series of consultations with partners, field visits, interactions with beneficiaries, and literature evidence, the proposed 12 FGDs were deemed sufficient to achieve data saturation.

Study setting

A semi-structured discussion guide comprised of open-ended questions was used to collect qualitative data (see *Extended data* (Ahankari *et al.*, 2019). FGDs explored the following topics having several sub-questions; how the village level group was formed, what trainings the group attend, what they understand by gender equality, what work they undertake as a group in their communities, impact of their work and what should be done more to ensure replication and success of such work elsewhere in Maharashtra/India. FGDs were deemed suitable for this work considering village level issues related to gender inequalities and domestic violence were identified by one or more group members, who then discussed those within the group during monthly meetings, and then they decided on their strategy to address identified issues. As a result, identification, intervention, and delivery was agreed through group discussions involving several members along with necessary support and advice provided by project staff. Thus, the proposed FGD method was appropriate to capture relevant data to achieve study objectives. The interview guide (see *Extended data* (Ahankari *et al.*, 2019)) was prepared and reviewed several times by research team, partner agencies, and relevant staff to ensure its relevance and application.

Data collection

All 12 FGDs were conducted in community spaces such as a village/community hall, school, health centre, or other appropriate community location to ensure necessary meeting arrangements, where accessibility, confidentiality, and privacy were in place. Willing participants were requested to arrive at an agreed time to avoid disturbances or interruptions during the discussion. The village groups worked together to deliver 'Responsible Couples' project activities, thus members were aware of roles and work undertaken by others. While as a group participants knew each other, confidentiality was maintained about discussions undertaken during data collection session, where participants were requested not to discuss any sensitive topic(s) outside their *Nirdhar Group.* Participants were informed about research procedures to obtain a written group consent prior to the data collection session. The FGDs were conducted in local language (Marathi), audio recorded, transcribed, and translated into English for analysis. Time duration for FGDs varied between 90 and 120 minutes. Participants varied in each FGDs from eight to 12 and included both men and women members. The interviews were conducted by two qualitative researchers (Mrs Anuprita Dixit and Mr Sandeep Rasalpurkar), who were not involved in any capacity in the 'Responsible Couples' project in the past, and did not work previously in any capacity/role for organisations involved in delivering the 'Responsible Couples' project. Both qualitative researchers were bilingual (Marathi and English), and were native speakers of Marathi language with over 20 years of work experience in research and development sectors. They had backgrounds in health sciences (MSc), recruited as data collection consultants, and were given necessary resources to conduct in-depth FGDs. The combination of one male and one female data collector (gender balanced approach) was preferred considering the research topic,

scope, and study participants background to create a suitable environment for all participants to engage in data collection sessions. Both data collection team and participants were aware about the study aims and objectives. Two key members of the UK research team, Professor Mark Hayter and Dr Anand Ahankari, provided in-person trainings to these qualitative researchers in India to inform about study procedures and ethics (Ahankari *et al*., 2019). Staff members of the 'Responsible Couples' project, funding agency (SWISSAID) did not attend FGDs to ensure that participants and research team members will have necessary autonomy and privacy to conduct in-depth data collection. FGDs data files (in Marathi/English) were accessible to research team members only, and were not shared with study participants. Each FGD was conducted only once, and study findings were communicated with village and project representatives through three dissemination events, where participants had opportunities to provide verbal feedback. All field based research work was completed between January 2019 and July 2019. Further details on the study procedures are available online (Ahankari *et al*., 2019).

Analysis

Analysis was informed by Braun and Clarke's (2006) six phase deductive reasoning methodology, which was felt to reflect the linearity of this project. All FGDs data files were stored using Microsoft Office Word Software for analysis purposes. No other software tools were used. The thematic approach started with researchers identifying individual coded elements within the data and then iteratively developing explanatory themes to generate a final thematic overview of the phenomenon under investigation. Themes, therefore, were separated into: (1) how groups identified problems and worked together to prioritise interventions; (2) short-term interventions to inform and engage communities; and (3) long-term interventions which reflected an embedded transformation across communities. Table 1 lists major themes and sub-themes. No field notes were taken/used in the analysis. Data analysis was conducted by two researchers (Ms Heidi Fewings and Dr Amanda Lee), and was supervised by senior qualitative researcher (Prof Mark Hayter).

Results

Theme 1 - Understanding gender equality and identifying priorities

This theme captures how *Nirdhar Groups* identified and defined their boundaries – using the norms and customs within their communities to assert the discourse of gender equality, and set the social transformation priorities within their communities. Group members highlighted several priorities, including addressing unequal access to education and healthcare, male dominated legislation (used as means to financial oppression and control), misogynistic rituals (dowry, child marriage), and family power dynamics with potential to increase 'burden' and disempower women. *Nirdhar Groups* highlighted confounding factors towards DVA and gender inequalities, such as substance misuse and the practice of hysterectomy to improve work productivity.

Table 1. Major themes and sub-themes.

Themes	Sub themes
Understanding gender equality and identifying priorities	• Discourse of gender equality • Safe access to education and healthcare • Legislation and home ownership • Misogynistic rituals- power, community, and family dynamics • Domestic Violence and Abuse (DVA) • Substance misuse
Short-term interventions to inform and engage communities	• Ensuring safe and equitable access to education and healthcare • Creation and establishment of 'safe spaces' • Facilitating equal access to finance, grants, and home ownership • Addressing and challenging misogynistic rituals through family communication • Acts to reduce DVA
Long-term interventions- Creating a sustained environment of gender equality	• Role modelling • Empowerment (through access to information) • Empowering communities (by instilling kindness, care, and compassion) • A sustained change for future generations

Discourse of gender equality

All groups began by discussing what they meant by 'equality' and then identified common practices, which impacted women's rights and social status within communities. On defining gender equality, many of the groups acknowledged that men and women should be treated equally.

> "Gender equality means how a husband should behave with his wife" (FGD10).

> "Consider both of them similar" (FGD6).

> "Boys and girls are equal. Both have similar rights" (FGD7).

Some groups identified physical burden on women running households, and culture-based lack of knowledge on their rights as women.

> "Household work should be shared … Men and women should help each other in their work" (FGD9).

> "[Men] should not harass … women … not treat them as slaves… [or] think that they are lesser than us" (FGD6).

> "There is need to increase female participation. A female must be aware of her rights, her likings, or she should think how to increase her say in the family, what changes she should adopt. When she is aware of her rights, she will demand for it [rights]. We must increase this awareness through self-help group meetings" (FGD7).

Safe access to education and healthcare

Access to basic healthcare was identified as 'unequal' between men and women, where decision making power to access services remains with men. In our study area, women are known to neglect their personal healthcare issues and prioritise their children, husband, and family, especially in-laws.

> "A major issue is that the women don't go to the doctor because they are thinking of money. If the problem is simple, they take some tablet [medicines] and wait till the problem gets worse, besides no one from family tells them to go to the doctor. They themselves never talk about their health problems" (FGD6).

> "When we tried to take pregnant woman [to] hospital [for antenatal care] her mother in-laws used to say, 'I gave birth to 10 children but never saw [been to a] hospital'. Then we have to explain in-laws also about past and current situations" (FGD7).

Local cultures appeared to prevent women from accessing education. In particular, FGDs uncovered some practices that made women feel 'unsafe' when travelling to access education. These were mainly due to verbal harassments by young boys/men.

> "We used to blow whistle, to see the girls travelling on the bus or tease them in groups. Now we have stopped such things. Atmosphere is also changed" (FGD9).

> "Now since I joined this group, I am completely a different person. I can tell other boys not to do such things. I can tell them definitely that I used to do all these bad things and now stopped doing them. And of course, they listen to me" (FGD9).

Legislation and home ownership

Gender equality in legislation was raised, with a focus on home, or land ownership and after being widowed or divorced. In the past, home ownership and finances were registered in the husbands' name. New legislation has meant that women can now be placed on deeds for home ownership, financial institutes such as bank accounts, and such registration is also required to access government schemes and funding.

> "We never thought about our bank accounts. It was only in names of our in-laws and husband" (FGD9).

> "Women … had to sit behind and with dress code of saree … [they] never visited the bank" (FGD11).

> "In past, property belonged to men only" (FGD12).

Misogynistic rituals – power, community, and family dynamics

Misogynistic rituals and cultures were highlighted as critical reminders of the oppression of women in local communities. Thus, certain behaviours and practices were identified as priorities for intervention. These included addressing child marriage, gynaecological health, and female foeticide.

> "Child marriage should be banned. We should marry the girls after 18 years of the age" (FGD6).

The tradition of dowry was identified as problematic but noted to be reducing across societies.

> "[Dowry] is going on – but secretly" (FGD5).

> "A similar case that happened in [nearby village]. A girl was killed for dowry. I think this may be effect of this … this tradition of dowry… should be stopped. And most of the victims of these traditions are women" (FGD2).

One priority for *Nirdhar Groups* was identified as family planning. Smaller families were seen to decrease the burdens on women.

> "Now, they have started doing family planning following two children, even if they have two daughters" (FGD8).

> "I used to go to people those who have two children and tell them about the operation [family planning], but people used to say that you are not married and why you are telling this to us? Since *Nirdhar Group* is formed, these things are working out. Committee is influencing the villagers slowly. So we will do a good work. Even people from other villages … we inform them about our work" (FGD8).

Domestic Violence and Abuse (DVA – formerly known as 'intimate partner violence')

Reducing DVA and aggression was a priority across most *Nirdhar Groups.* Many groups identified a need to address DVA and offer interventions to reduce addiction amongst 'violent men', educate men about these issues and impacts on women, which may help improve equality and wellbeing of women. These were primary project objectives set by SWISSAID and HMF.

> "We have a law against domestic violence … [but] women are unaware about it" (FGD11).

There were many examples of incidences of DVA.

> "he [used to] beat his wife" (FGD7).

> "a boy [man] used to fight with his wife … then send her back to her maternal home" (FGD4).

> "One drunken husband was beating his wife with a stone" (FGD1).

Substance misuse

In some communities, substance misuse with alcohol and betel nut were often identified as a causative factor. Betel nut, also known as areca nut, is the seed of areca palm tree. It is widely cultivated in South Asian countries. It contains psychoactive ingredients, and has many harmful effects on humans due to its carcinogenic nature (Arora & Squier, 2019). In our study area, it is known as 'supari' in the local language.

> "I was vicious. I ate tobacco and used to harass girls" (FGD9).

> "The movement of prohibition of alcohol is the most important issue, while it [alcohol] rises, women don't get together because if they do, their drunkard male counterparts fight with them at home. The next day women came together and discussed about it. This is the biggest problem in our village" (FGD6).

> "If we say the violence is due to addictions, then we observed that addict beats only spouse [wife], doesn't beat sarpanch [village chief], if he sees sarpanch, then he salutes [shows respect to] him. He says, save me, I from your group only and the same person beats the spouse on reaching home or can do anything as he wishes, like abusing, so we understood that violence is not only due to addiction" (FGD5).

Theme 2 - Short term interventions to inform and engage communities

This theme contains examples of how *Nirdhar Groups* interacted with specific families and groups, to instil personal-level change in culture and behaviours. Through regular communication and involvement with their community citizens, the *Nirdhar Groups* were able to anchor themselves as agents of change. Their work involved a range of initiatives in line with priorities identified in their communities as explained in the theme 1.

Ensuring safe and equitable access to education and healthcare

Many *Nirdhar Groups* implemented strategies for equal access to education and healthcare for both daughters and daughter in-laws/wives. Education opportunities are limited in our study region due to school structure, where most of the villages have schools until 10 or 13 years of age, and for middle school many need to travel to nearby towns. Due to preference given to male children, females often drop out from the education system (Psaki *et al.,* 2022), therefore, access to education is important for young girls in our study area. Furthermore, such inequalities prevent women/girls from accessing healthcare where females/women do not prioritise their health and are often neglected by their families due to gender based discrimination.

> "What is the use of girl's education; ultimately, she has to get married and work for family only. She is not going to be a collector [high level civil service post in India] or do any grand work. She won't live at her mother's place, so what's the use of her success to us. This was our view. But after joining the *Nirdhar Group* we realised our mistake. We thought, what we were doing was correct. This is our culture, and it is right, nice. But now we came to know that we were misusing our good culture" (FGD9).

> "Some time ago we were also used to take permission [referring to permission from husband/in-laws]. Now as we are members of *Nirdhar Group,* we have all information. We come across all the points, so we don't take any permission and directly go to hospital and take treatment. This change is happened because we have much information now" (FGD6).

> This suggests that women are looking after their health after being empowered through education and project activities delivered through 'Responsible Couples' initiative.

Creation and establishment of 'safe spaces'

Girls and young women often discussed concerns about access to public transport facilities, so that they felt safe to attend education. The number of college-going girls increased over time in these communities. Women and girls received a platform and also a support system through *Nirdhar Groups* initiative to share their concerns with policy makers and influential people in their communities. This provided opportunities to voice their concerns/problems during village meetings and demand for necessary actions to improve safety and transport facilities. Females were present at village meetings, which used to be traditionally attended by men in the past. Village government office then formally requested district authorities to re-start public transport services, which will benefit young girls and women to access education institutes. This also improves their safety during travel.

> "Girls used to stay home and prepared for exams, the number [of college going girls] has now increased to 25-30. Girls are not only going to colleges where college bus is available, but [also] to colleges where bus facility is not available. Number is increased to such colleges also" (FGD1).

> "This year iron tablets were given to women for improving health. Almost 200 women received medicines. Those who have low Hb level [Haemoglobin], they were taken to the HMF at Andur for further check-up. Madam [doctor and social workers at the hospital] had called, we had sent many girls there [for medical consultation]"(FGD8).

> "Not even ladies' members were there before [on village government committees]. Now their seats are reserved, due to law. They get elected. Being members, they go with them [men]. They take their female friends with them. They understand work procedure, nowadays water supply is under their control …. women in bachat gat [self-help/ microfinance group] will fight for it" (FGD5).

Facilitating equal access to finance, grants, and home ownership

Nirdhar Groups used a variety of means to inform women of their rights and responsibilities and offered education sessions on legislation, so women could work towards a financial freedom. Groups were trained and equipped with resource by project staff, who also provide support during such activities. Previously, finances were in the male domain, with accounts held in the husband's name, however women are now participating in financial activities.

> "Every woman can spend money from her own account … .no more dependent on men for expenditure … [men] are not reliable, so [some] government grants or subsidy goes directly in [bank] accounts of women" (FGD9).

> "They [women] have names on lands, on houses, on ration cards [government document to access food and essential supplies], they have bank accounts, means we have upgraded women" (FGD10).

Addressing and challenging misogynistic rituals through family communication

Nirdhar Groups used a 'community presence' to access homes and communicate across family groups to instil change.

> "If a child marriage is taking place, we go to that home for convincing them to stop the marriage" (FGD8).

> "If we change ourselves, whole environment in family changes, once family environment changes, changes occur on our street [in our area], finally changes occur in our village" (FGD7).

> "It happened in a house. It was a matter between parents and son. We have *Nirdhar Group* in our village, so the mother came to us and told their problems. It is our system that if there is a complaint, we all, along with the president, secretary, and members [of *Nirdhar Group*] go and try to solve quarrels. If we go without complaint, there is always a risk of a question 'who told you'. We wait for the family members to come to us. In this case as per our procedure we brought about, face to face meeting. We listen to both sides, we asked for their opinions, and then tried to convince them [to resolve issues]. Now everything is solved, and they are living peacefully" (FGD6).

Acts to reduce DVA

Community pressure and communication also facilitated issues with gender-based violence and oppression. *Nirdhar Groups* played crucial role while working as a team to intervene and provide support to victims. Capacity building trainings and continuous support by project staff (HMF) was offered considering a range of project activities and varying requirements and complexity of issues across project areas.

> "Suppose there is violence at one place, we go there with some other reason. Have a talk with mother-in-law when daughter-in-law is not there. Similarly, talk with daughter-in-law when mother-in-law is not around" (FGD8).

> Group members spoke of "visiting again and again" (FGD7) and putting pressure on issues to enable change: "People are afraid of doing wrong things because *Nirdhar Group* is active in our village" (FGD6).

Theme 3 - Long-term interventions - creating a sustained environment of gender equality

This theme identifies how *Nirdhar Groups* worked towards a sustained, cultural agenda for change. It presents how people worked together, celebrating their successful outcomes, and ingraining the culture of gender equality across their communities. Thus, this theme presents higher level examples of cultural transformation, such as role modelling, empowerment, instilling kindness, care, and compassion, with a sustained power to change the next generation.

Role modelling

Groups modelled their work through a "willingness" and "responsibility" to have to work for the village (FGD7). Men took more responsibility for preparing meals and hosting visitors. *Nirdhar* members acknowledged that to present change, they had to act as role models. They acknowledged that, to instil change, they had to be a part of that change. Some *Nirdhar* members identified significant changes they had experienced, driven by a desire to be a social transformer, an activist in the '*Prabhodhan*' ethos (*Prabhodhankar* was an 'enlightened good citizen, working for the good of communities).

> "The villages worked together, role modelling gender equality." "Household work should be shared between both male and female" "Both male and female can go out of the house for work. Female should have equal rights" "Both can go to market for shopping", "Men and women should help each other in their work" (FGD9).

> "Before brining any change in society, we must change ourselves. In our village among the youngsters, I was the top drunkard, vicious since last year or two I have given up all vices. I used to eat supari [beetle-nut and tobacco preparation]. roam in the village; … I stopped riding bike and passing time uselessly. I stopped chewing supari, completed studies and joined a job. So others follow my footsteps. Now I am respected in the society. The people call me a good person now. You should change yourselves before telling people" (FGD11).

Role modelling was achieved through dissemination of knowledge received from education and training provided by the HMF. A *Nirdhar* member spoke of the impact of training on their motivation to disseminate the new knowledge.

> "If the *Samajdar Jodidar* ['Responsible Couples'] behaves like ideal couples then only other people will follow them. Sometimes when women come to my place and sit in our hall [living room]. He [her husband] prepares tea for them without saying anything. Then women start thinking her husband is doing such things then why not mine" (FGD9).

> "We are role model for them they observe us, how we will behave they will adapt it. This work is big [important], all groups should work together. Everyone must work for it" (FGD7).

Empowerment (through access to information)

Several *Nirdhar Groups* facilitated health related information exchange – empowering adolescent girls with health and vaccine related information through social media. *Nirdhar Groups* helped to organise 'health clinics' for women in their communities. These were used as *fora* and means to instigate vaccination strategies and engagement in health literacy activities, as adjuncts to basic medical and maternity care.

> "Use of WhatsApp" (FGD9) "Women came out and got further information. Information technology coupled with it. And so it has speed in this field" (FGD5).

> "On vaccination day, we conduct tests [medical check-up] for adolescent girls. On that day we share information with them" (FGD5).

Empowering communities (by instilling kindness, care, and compassion)

Some *Nirdhar Groups* used their forums to assert kindness, care, and compassion towards all members of the communities. This also shows a sense of responsibility group members developed towards individuals in their communities who needed help. The ability to provide help as well as intervene in such situations as a group is much more feasible in our study area rather than working individually.

> "We would neglect orphans … Now we take them to an orphanage…we told a few [neighbours] If we see any orphan, then we advise the neighbours to take care of that child … a farmer … early in the morning .. heard noise of a child crying. He found a small baby having soil on face.. He informed sir [director of HMF] and took that baby to his home, cleaned him, and afterwards took that baby to an orphanage" (FGD3).

> "We, the members of Youth Group started helping orphan children on the occasion of 15th August and 26th January from last year [Independence and Republic Day celebrations in India]. There are 24 such children in our village. We gave them educational material. We help them as per our capacity. We will continue doing this till it is possible for us. We collect whatever rupees we get-20, 30, 50 rupees, whatever people give. We do not give direct money to the children. Instead of that we give them material useful for school like bag, pencils, or notebooks" (FGD9).

A sustained change for future generations

The underlying ethos of any sustained cultural change is to offer guidance and support to the next generation. Many *Nirdhar Groups* highlighted exemplars of 'good citizenship' which also helped in building confidence in girls and women in their communities.

> "It is our duty to set good examples for them to follow, subjects like equality, child marriage prevention, education for girls, must be instilled in the minds of younger generation. Then they will automatically start working. They will come forward and take initiatives. The work will continue" (FGD2).

Discussion

This qualitative evaluation of *Nirdhar Groups'* experiences in community level interventions highlights the power of local citizens in embedding change within local areas. NGO leadership and community rural interventions have been proven as effective in previous studies (More *et al.*, 2017; Krishnan *et al.*, 2012; Jejeebhoy & Santhya, 2018). Involving residents who provide services within these communities (such as lawyers and police, healthcare professionals and other key stakeholders) is key to positive outcomes for addressing gender-based inequalities (Macdonald 2015; Daruwalla *et al.*, 2019; Nair *et al.*, 2020). The *Nirdhar Groups* within our study included multidisciplinary community citizens of

'high standing' such as ASHA workers (Accredited Social Health Activists), healthcare professionals and police representatives. The qualitative analysis for this study drew from the work of Braun and Clarke (2022) who propose that true thematic analysis develops themes as patterns of meaning' rather than descriptive summaries of the phenomena under investigation. This systematic approach provides a richer account of the phenomena and produces findings that provide a more detailed and conceptualised account of the data (Braun & Clarke, 2022). This approach enabled the study to capture the complexity of gender-based oppression and DVA in a rural Indian setting to understand how individuals, families and communities interact and engage with one another on issues related to gender inequalities and DVA. To capture the physical, social, cultural, and historical contexts as well as attributes and behaviours of both *Nirdhar Groups'* and their communities, an ecological perspective (providing a complete perspective of the factors that affect specific health behaviors, including the social determinants of health) offered a lens to present the collective values and perceptions of 'norms', and how these were challenged through reflection on 'stereotypes, roles, and attitudes' within the communities.

Thus, *Nirdhar* members used their own community 'norms' and identified the discourse of gender equality, so that they could shape and identify their own transformation priorities. These priorities were consistent across all *Nirdhar Groups* and focused on access to education and healthcare, misogynistic rituals (such as disproportionate burdening on women and hysterectomy as means to increase work productivity), internal family power dynamics, male dominated legislation, DVA and all confounding factors (such as substance misuse). Each of these foci have been cited in previous studies conducted in India (Daruwalla *et al*., 2019; Freudberg *et al*., 2018; Kalokhe *et al*., 2017). In creating 'safe spaces', women were able to access education and basic healthcare without victimisation. By informing women of their legal and economic rights, and ensuring communities engaged to a discourse which was unsupportive of physical and emotional violence, *Nirdhar Groups* were able to act as advocates. They worked with groups of women and individual families to assert the stance that DVA was not acceptable.

A recent Cochrane review has highlighted the power of advocacy as a key intervention managing and reducing DVA, revealing the potential mediating factor of education as means to empower (Vigurs *et al*., 2019). With education and knowledge, women could then set their own goals and become an 'expert' on their own 'life and self'. However, this review also noted limitations of 'advocacy interventions', and asserted that women's needs were interwoven by the complexities of coercion, control, power, and economic/emotional control (Vigurs *et al*., 2019). Thus, it must be assumed that any interventions by *Nirdhar Groups* should be sustained and effective.

Governmental driven initiatives – such as the legislation which allows females to open bank accounts, to have home ownership and to access public distribution funds were already in place. Yet rural and remote communities were neither aware nor willing and thus less engaged in such key national schemes. The *Nirdhar Groups* were used as a conduit to offer guidance and education, so that women had the prerequisite knowledge and understanding of their rights to finances. There are several studies which support economic empowerment of women and link increased control of finances with both a reduced risk of DVA, and also increased access to reproductive and maternal healthcare services (Raj *et al*., 2018; McDougal *et al*., 2019; Singh *et al*., 2019; Dhar *et al*., 2018). Our study found several *Nirdhar Groups* applied legal pressure to ban sales of liquor (alcohol) across their villages. Misuse of substances has been directly linked to higher incidences of DVA (Jeyaseelan *et al*., 2004; Ragavan *et al*., 2014; Wagman *et al*., 2018). Groups chose to mitigate risks by the banning of liquor sales in local areas and shops. This has the potential to drive sales of alcohol to backstreet illegal trade routes, which could be even worse for populations. America's prohibition period in the 1920s proved that blanket bans from senior leaders cannot replace personal responsibility, as they discovered 'top down' enforcement and censorship can cause disarray within social networks. Child marriages and dowry as means of gender-based oppression are reducing in India, perhaps due to the reduced number of females within the demographic population profile (United Nations Children's Fund and United Nations Population Fund, 2018). However, dowry and early marriage were still raised across the focus groups for prioritisation. There were several interventions highlighted, which illustrated how *Nirdhar Groups* applied peer pressure and in-home advice to prevent dowry and child marriage. There was also community interest to lead such work to avoid dowry and child marriages for the greater good of girls/women considering its wider societal benefits. Interventions were supported, and celebrated, by hailing individuals who were identified as '*samaj*' – or 'good citizens', (*Samajdar Jodidar* – Responsible Couples). The philosophy of *Samaj* – These 'Responsible Couples' and 'enlighteners of society' were reported amongst communities with pride. This role modelling shows a congruent relationship with *Nirdhar Groups* members and their communities. Changes are being made at personal levels as well as in the communities. These *'Samaj'* uphold principles of goodness and respect and act as 'pillars' within the communities.

The good citizens (*Samaj*) were able to exert peer pressure and uphold principles of care, compassion, and kindness. Some of the *Nirdhar Groups* reported community level changes aimed at helping those identified as less fortunate. Others identified mechanisms by which the men would show how they took responsibility for cooking, childcare and home

duties, demonstrating changes at individual and family levels breaking barriers to reduce discrimination, and also challenging existing social norms and misogynistic views. This philosophy was further entrenched as women in the communities could access 'outside' media influences. These included 'WhatsApp', Instagram, and Facebook (online forums) which enabled them to consider how women were viewed across the globe. As digital expansion has seen 'millennial India' adopt the second largest global internet use, the country is becoming democratized – and this is through a more geographically accessible public participation (Udupa *et al*., 2020). Thus, women are now more empowered with information on health, behaviours, politics, use and access to services, political participation and this has significant effects on their social mobility potential (Kumar *et al*., 2021). This movement is positively influencing women across rural India (Udupa *et al*., 2020).

Our research findings showcase a number of positive achievements of the 'Responsible Couples' project. It is possible that there may been positive impacts on communities due to other project activities outlined in the introduction such as campaigns, which may have created a suitable environment for *Nirdhar* groups to establish themselves in communities and engage in gender equality work. We also acknowledge that HMF's role is crucial considering their track record of over 30 years of work in Maharashtra state and their social influence may have helped to challenge existing 'social norms' while engaging men and communities in gender equality and DVA related discussions. However, our study design and data were not sufficient to analyse such effects or influences. The 'Responsible Couples' project has evolved over time through collaboration between HMF and SWISSAID, and their previous learning in Maharashtra, collaborations, and trainings from other NGOs. Their project design and delivery was more organic, which has undergone changes over time to identify and implement suitable activities to engage communities effectively. Therefore, our study approach is similar to process evaluation (Jejeebhoy & Santhya, 2018) to understand the core component- *Nirdhar groups*, which were crucial for their programme success. Nevertheless, we could not capture the entire process of development, training, and implementation of *Nirdhar Groups* initiatives (to achieve all objectives of the process evaluation), but rather conducted research once groups were active and well established. This prevented us from understanding fully what works, and what does not work in Indian rural communities. For example, HMF aimed to develop *Nirdhar Groups* in 40 villages, but managed to achieve that in 37 villages, which suggests possible resistance and lack of engagement from communities in three villages.

Conclusion

This study reveals the wide scope and influence that community gender equality groups can have. They provide a platform for women at the highest level in the villages and encourage dialogue confronting of a wide array of gender equality issues. The groups help raise awareness – particularly among men – but also help develop more practical and tangible change such as access to DVA prevention services and methods to address economic disparity. It also sheds light on the types of gender inequality women face in rural India and the types of challenges needing to be overcome. These groups are hopefully part of the solution – empowering women and educating men to provide safer and more equitable environments for women. They also perform the vital function of providing positive role models for the younger generation. Therefore, implementation of similar projects and its evaluation in other parts of the Maharashtra state as well as in other Indian states will provide valuable evidence. It is important to note that evidence from our research is from rural Indian communities, and considering constantly increasing migration to urban areas, further work is necessary to understand about its application in cities: how similar community groups could be formed in urban areas, which will be accessible to girls and women from all social classes and background. This will help design future community interventions to inform development work as well as policies to address DVA against women and girls in India and also in other similar settings.

Data availability statement

Underlying data

Data used in this study are confidential and are not available in the public domain. Ethics approvals provided permissions to use the dataset by specific individuals of the research team for stated purposes. Data from this project may be used further for future research by researchers/organisations involved in this work to conduct additional analyses.

If you wish to access this data, then please contact the corresponding author by email with the following information: a copy of your CV, research purpose/purpose for requesting data, and additional documents to support your request. Once these are reviewed by the researchers concerned, then you will receive a preliminary decision, and you will then be required to seek ethical approval from an ethical review board.

Extended data

Figshare: ADolescents GEnder SurVey, REsponsible CoupLes EvaluatiOn, and Capacity Building Project in India (DEVELOP): A study protocol https://f1000research.com/articles/8-958 (Ahankari *et al*., 2019).

This project contains the following extended data:

- Supplementary Files 1 to 5.pdf
- DEVELOP_Survey questionnaire Marathi.pdf
- DEVELOP_FGD Guide Marathi.pdf

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