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**Scaling up the health system
response to**

Violence Against Women

**lessons from hospital interventions
in Maharashtra, India**

RESEARCH BRIEF



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Scaling up the health system response to violence against women: lessons from hospital interventions in Maharashtra, India. Research brief

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Acknowledgment



The research study which informs this brief was led by the Center for Health and Enquiry into Allied Themes (CEHAT) – a Mumbai, India-based non-governmental organization that has been actively involved in establishing a comprehensive health-sector response to gender-based violence. Partners who implemented the intervention component of the study were the Aurangabad Government Medical College and Hospital and the Miraj-Sangli Government Medical College and Hospital. The research was funded and technically supported by the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) through a grant made available by the Foreign, Commonwealth and Development Office (formerly Department for International Development), Government of the United Kingdom and Great Britain.

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Background

Violence against women (VAW) is a major public health concern, a manifestation of gender inequality and a human rights violation. Intimate partner violence¹ is the most common form of violence experienced by women (1). Violence has significant and long-lasting impacts on women's physical health, including sexual, reproductive and mental health (1). Women who have experienced violence are more likely to seek health care than non-abused women (2). Health-care providers (HCPs) are well-placed to identify women who have experienced violence and to provide appropriate clinical care and referrals.



In India, in the fifth round of the National Family Health Survey (2019–2020), physical and sexual violence declined in most states, compared to the fourth round (2015–2016) (3, 4). However, Maharashtra is one of the five states that registered an increase in such violence, from 21% to 25% between the two surveys (4). Among women who have experienced violence, only 14% explicitly sought any formal or informal help. Despite the significant health burden, the health system response to VAW in India remains ad hoc and fragmented, comprising of different models of service delivery on a small scale, delivered mostly by non-governmental organizations (NGOs). The training of HCPs is a common element of the different models (5). There is little documentation, however, of whether the training content and approaches are acceptable to HCPs, whether they are feasible, sustainable and effective, and of which models of service delivery can provide a woman-centred response in line with World Health Organization (WHO) recommendations (6).

¹ In India, intimate partner violence is referred to as spousal and included under domestic violence. Domestic violence also includes violence by other family members.

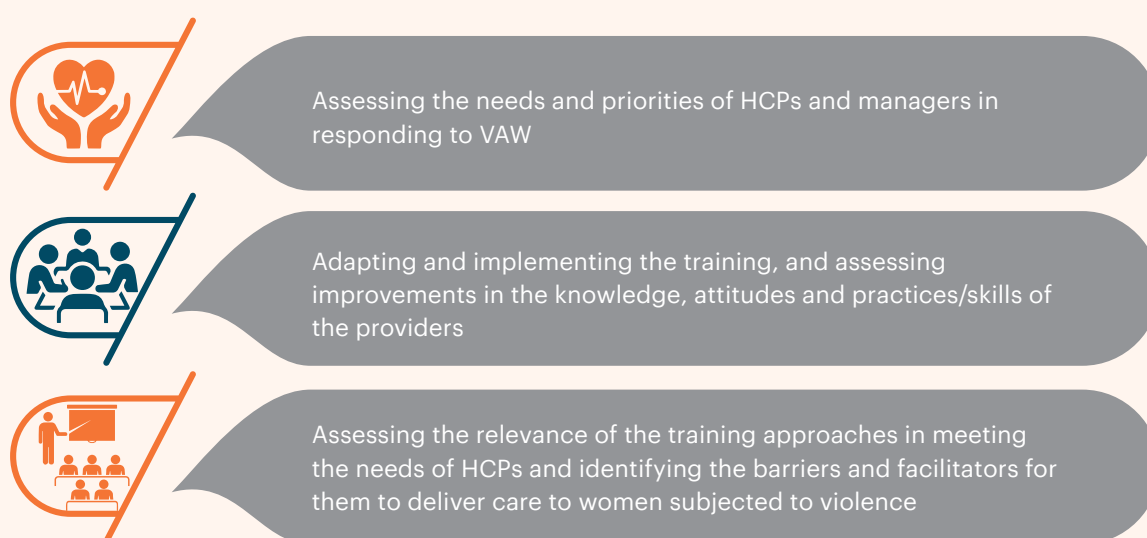
In an effort to address these gaps, the Centre for Health and Enquiry into Allied Themes [CEHAT],² the Government Medical College and Hospital, Miraj-Sangli, and the Government Medical College and Hospital, Aurangabad, worked with the WHO's Department of Sexual and Reproductive Health and Research and the Human Reproduction Programme (HRP) to run a mixed-methods pilot study of the implementation of WHO guidelines for responding to VAW (see below).

WHO clinical and policy guidelines and tools for responding to VAW

WHO published clinical and policy guidelines in 2013, with the aim to strengthen the capacity of health providers and improve health system readiness to respond to VAW (6). It subsequently developed two tools to translate the guidelines into concrete action, with practical instructions and job aids: a clinical handbook for HCPs (7) and a manual for health managers (8).

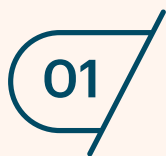




One of the aims of the study was to refine and validate approaches to roll out the WHO clinical and policy guidelines and tools, with a particular focus on domestic violence, including spousal or intimate partner violence. The specific objectives involved:



² CEHAT is a research NGO in Mumbai, India that has been actively involved in establishing a comprehensive health-sector response to gender-based violence. It has set up intervention models on domestic and sexual violence at the hospital level to provide crisis intervention services to women and to demonstrate the role of health professionals.

■ The findings of this study will contribute to:

-  01 operationalizing the health system response to VAW, as mandated by India's National Health Policy (2017), with respect to the feasibility, acceptability and sustainability of integrating the response into existing health services (9);
-  02 identifying the basic elements of a health system response to domestic violence, which can feed into the development of a national protocol or training materials for HCPs (currently missing) as a complement to the national guidelines on medico-legal care for survivors of sexual violence (10);
-  03 implementing a global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls, and against children (11), that has been endorsed by WHO Member States, including India.

02

CHAPTER

Intervention and study design and methods

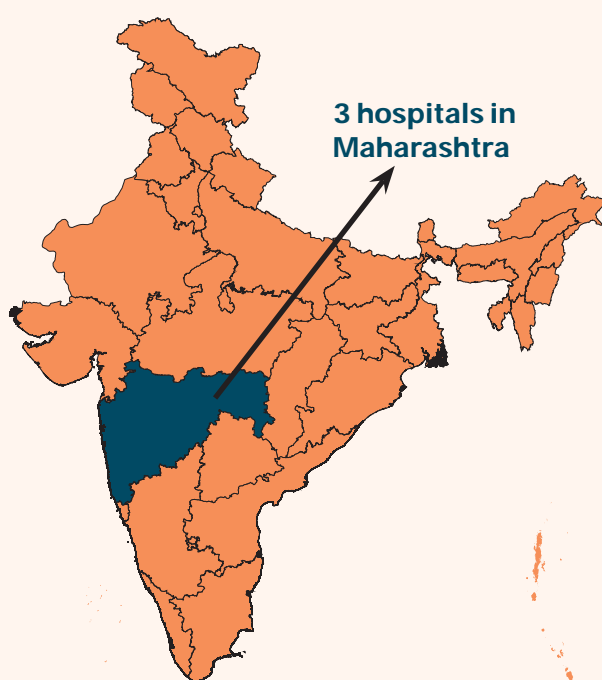
The pilot study used a pre-post intervention design with qualitative and quantitative methods of data collection to address the objectives (see Figure 1).

Figure 1: Study objectives and data-collection methods

GAPS IN EVIDENCE	OBJECTIVES	METHODS
Feasibility and sustainability of integrating a response to VAW in health systems	Assess needs and priorities of HCPs and managers in responding to VAW	Stakeholders' meeting with health administrators
Essential elements of quality response to VAW at the different levels of the health system	Adapt and implement the activities, and assess improvements in the knowledge, attitudes and practices/skills of the providers	Survey of knowledge, attitudes and practice of the HCPs before training, immediately after training and six months after training
How to implement/roll out the essential elements of a quality health system response to VAW	Assess the relevance of the intervention in meeting the needs and identifying the barriers and facilitators for HCPs to deliver care to women subjected to violence	In-depth interviews and focus group discussions with doctors and nurses

Study context

The study was conducted in three tertiary health facilities across two districts in the state of Maharashtra, India – namely, the Aurangabad Government Medical College and Hospital in the city and district of Aurangabad, the Miraj Government Medical College in the city of Miraj in the district of Sangli, and the Sangli District Hospital, which is in the neighbouring town of Sangli. In each hospital, the researchers selected the three departments that were most likely to receive women patients: obstetrics and gynaecology, general medicine, and the emergency department.



Disclaimer: Map is for design purposes only and not reflective of accurate territorial boundaries



Intervention

The intervention was co-designed with health managers and providers by adapting to the needs and barriers they identified. A two-day stakeholders' meeting was organized with 30 HCPs with managerial responsibilities, including doctors, nurses and social workers from all study sites. This meeting helped to generate an understanding of the training needs and gaps, facility infrastructure and procedures, and documentation mechanisms. Participatory methods were used to generate ownership, solicit inputs, develop a plan for rolling out the intervention activities, and identify participants' motivations for, or resistance to implementing a health system response to VAW. The selected intervention activities are presented in Table 1, organized according to the building blocks of a health system.

Table 1: Intervention activities

	 <p>Strengthening health workforce capacity</p> <p>Training of trainers and training of HCPs</p> <ul style="list-style-type: none"> • 26 HCPs with managerial/administrative responsibilities were trained as master trainers using the WHO curriculum (12) adapted to the Indian context by CEHAT • Over the course of four months, master trainers conducted eight distinct two-day training sessions for a total of 220 HCPs across three hospitals.
	 <p>Strengthening leadership</p> <p>Champions were selected from among health service administrative heads and senior clinicians based on the criteria of having a supervisory and mentoring role, decision-making responsibilities and a willingness to give time to mentor HCPs. They were given additional training on how to conduct training, mentor, and advocate a health system response to VAW.</p>
	 <p>Strengthening multisectoral coordination</p> <p>CEHAT staff conducted meetings with NGOs providing counselling services, shelters and livelihood support and with protection officers in each site, to seek their collaboration to receive referrals made by the hospitals. A referral directory was created, and copies were provided to the selected departments.</p>
	 <p>Improving service delivery</p> <ul style="list-style-type: none"> • Standard operating procedures (SOPs) were established to ensure the privacy and confidentiality of survivors. • Job aids in local languages were provided and placed on facility walls to aid provider skill recall. • Information, education and communication (IEC) materials were placed on facility walls to tell patients about on-site providers with whom they could speak to about domestic violence. • Documentation was improved through the creation of single-page facility register forms with information on symptoms, type of violence, perpetrator relationship, treatment given, and referrals provided.
	 <p>Improving health infrastructure</p> <p>There were discussions with managers to identify spaces, where consultations with women could take place with visual and auditory privacy. The champions and master trainers brainstormed ideas to create privacy in the challenging circumstances of overcrowding and limited space.</p>
	 <p>Improving information and evidence</p> <p>Facility registers with one-page intake forms were introduced to document cases of violence and facilitate aggregate reporting of a minimum number of indicators. These included presenting signs and symptoms, types of violence, relationship with the perpetrator, assessments conducted, and treatment, care, support and referrals provided.</p>

These findings are based on data from the survey of the knowledge, attitudes, and practices of the providers' before, immediately after and six months after training, an analysis of the facility registers to document cases of violence, and the qualitative in-depth interviews with trained HCPs.

Intervention was perceived to be acceptable, feasible and sustainable

The participatory approach to refining and validating the training approaches generated several innovations and had unexpected benefits and positive outcomes (Table 2).

Table 2: Innovations in training approaches and their outcomes

Innovation	Outputs
Training doctors, nurses and social workers together and articulating the roles and responsibilities of each cadre	<ul style="list-style-type: none"> Increased ownership for delivering care related to violence VAW across cadres The training broke down traditional siloes and hierarchies across professional cadres
Inclusion of concepts, such as understanding of sex and gender inequality, and intersectionality	<ul style="list-style-type: none"> The knowledge and practical application of these concepts helped providers to better understand the underlying reasons for VAW It also helped them to recognize their own biases towards women patients and towards survivors of violence It helped to create more empathy for patients and improved their communication with them
Training, mentoring and supervision by the master trainers drawn from administrators and senior clinicians	<ul style="list-style-type: none"> Increased acceptance due to the training sessions being led by peers/ health administrators, who were looked up to as role models Created champions within the hospital, contributing to a perception that this issue was important for HCPs to take more seriously

The involvement of health administrators in co-designing intervention activities, as master trainers and as champions, contributed to the acceptability of providing VAW care. HCPs reported receiving supportive supervision and mentoring by health managers during qualitative interviews.



So, we organize a discussion every month or whenever it is possible about the cases, any difficulties, challenges and doubts faced by staff members. These meetings are really helpful to appreciate and encourage staff members who are actively working on this issue.

– **Doctor (obstetrics and gynaecology), 48 years of age, male**



We approach our seniors if we find it difficult to ask women about certain things like sexual violence, cases of poisoning of young girls. They come with us and speak to women during ward rounds.

– **Nurse (emergency department), 32 years of age, female**

Qualitative interviews highlighted that the involvement of the health administrators as champions, contributed to the integration of domestic violence into the routine clinical practice of providers, facilitating the feasibility and sustainability of the intervention.



Champions within the health system

If you think about the feasibility of continuing this training, it is really possible. The only thing it requires is for people to be sensitized properly and regularly monitored. And they should have some programmes for changing their attitudes. So even if I am not there tomorrow, other people will take this over. So when you ask, whose mind has shifted, I think I am the first example.

Dr Shrinivas Gadappa, Head, Obstetrics and Gynaecology, Aurangabad Medical College and Hospital



“ Feasibility of the intervention and quality of service

I am not spending even a single extra minute than I was before, but the quality of service I am providing has improved dramatically. So I'd like to tell hospital administrators to call our personnel over to explain how this is absolutely quality addition without taking up more time...And the women have been encouraged to follow the legal procedure, so women have sought help and got redressals. So now they've brought in other women who come with their complaints because they are sure of support from our facility and their privacy being maintained, so that's wonderful.

Dr Pallavi Saple, Dean, Government Medical College, Miraj



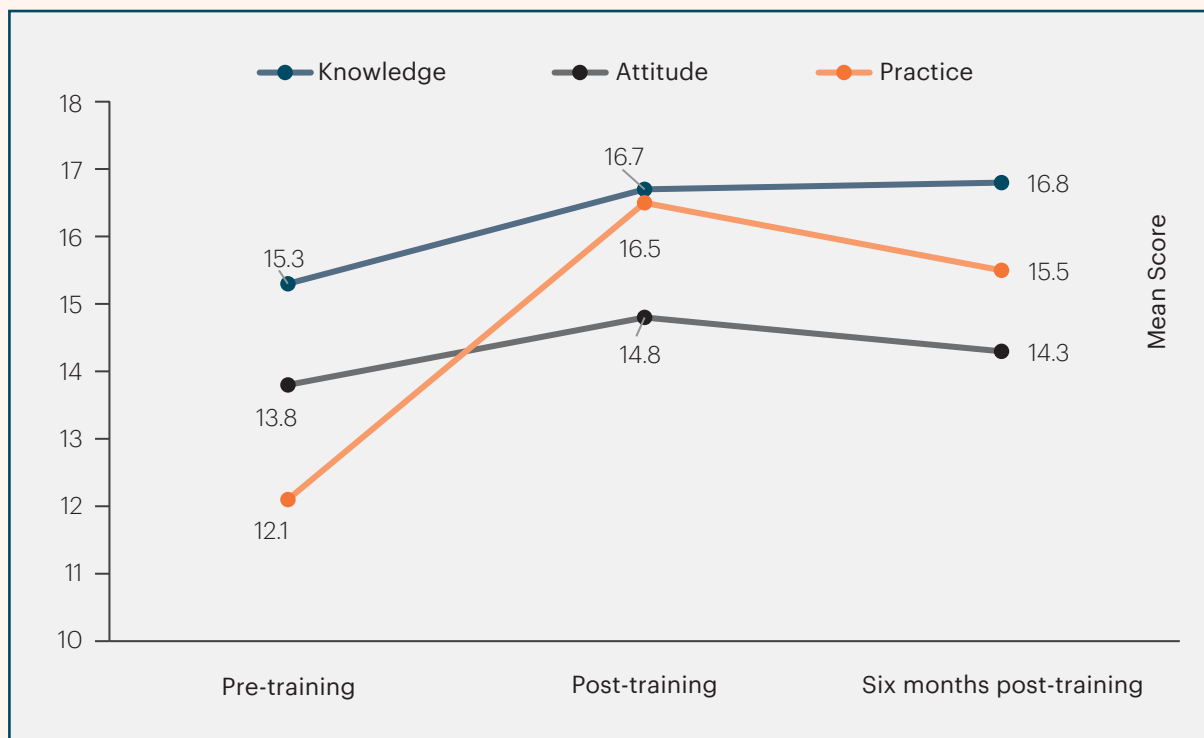
Training improved the knowledge, attitudes and practice of HCPs

Training activities significantly enhanced the knowledge, attitudes and practices of the providers, with respect to VAW, from baseline to post-training, with improvements sustained six months later in some domains.

Changes in the knowledge, attitudes and practices of HCPs were measured using a variety of questions/items, with subdomains for each category (e.g. knowledge about presenting signs and symptoms for domestic violence and knowledge about how to ask about violence; attitudes towards the acceptability of violence and towards asking about violence).

Figure 2 summarizes the overall mean scores for knowledge, attitudes and practices. The mean scores for overall knowledge increased significantly, from 15.3 at baseline to 16.7 ($p < 0.001$) post-training and to 16.8 ($p < 0.001$) at six months post-training. Mean scores on attitudes increased significantly from baseline to post-training (13.78 to 14.83, $p < 0.001$), but at six months post-baseline, the score was 14.31 and the change from baseline was not significant ($p < 0.103$). These results reflect the fact that attitudes are established over a long period of time and are difficult to change with a two-day training intervention; rather, they need reinforcement over time.

Figure 2: Change in knowledge, attitude and perceived preparedness



Note: All the scores were normalized and ranged from 1 to a maximum of 20. Wilcoxon signed rank tests were used to compare the mean scores of knowledge, attitudes and practices from baseline to post-training and to six months after the training

In-depth interviews with providers found that training and implementation of intervention activities increased the recognition of VAW as a health issue among providers.



Before this training, I never looked at health complaints of female patients in the context of violence. I had no understanding about this issue. Now, I know what I should do, what should I say so as to make women comfortable.

– Doctor (resident in medicine), 27 years of age, male

Providers were also able to develop an understanding about the significance of a hospital-based intervention for VAW.



The most important thing is that nobody from her family will come to know that she is seeking help from hospital for domestic violence. Also, I feel that a majority of patients have a lot of faith in doctors and nurses...especially patients who come from rural areas.

– Doctor (obstetrics and gynaecology), 42 years of age, female

Changes in the practices of HCPs were measured through two domains: the perception of preparedness to respond to VAW and the identification of at least one woman experiencing domestic violence in the three months prior to the survey. The mean score of perceived preparedness significantly increased from baseline to post-training (12.07 to 16.48, $p < 0.001$) and at six months (15.47, $p < 0.001$). However, perceived preparedness later also significantly declined between post-training and six months post-training (from 16.48 to 15.47, $p < 0.001$) (See figure 2). At six months post-training, there was a significant 28% increase in the percentage of providers who had identified at least one woman experiencing domestic violence in the previous three months. Interviews with providers also pointed towards the integration of identification of violence into their routine clinical practice.



We need to listen to her problems carefully and offer suggestions to her. By looking at the wound we can easily tell if it is accidental or assault. If a woman is saying it is assault, we should build rapport with her and encourage her to speak.

– Nurse (obstetrics and gynaecology), 29 years of age, female

The factors associated with changes in the knowledge, attitudes and practices of the providers' included age and providers' department.³ As compared with younger providers (under 25 years of age), the older age groups had lower mean scores of knowledge – and older age cohorts (over 25 years) were significantly less likely to show improvements in attitudes towards VAW compared with those younger than 25 years of age. The findings point to the need for integrating the training into pre-service training and into provider training, early in their careers to influence change. At the same, it also points to the fact that the uptake of in-service training is essential to address the attitudes of the middle- and senior-level cadres. Providers from the general medicine and emergency departments were significantly less likely to show improvements in attitudes towards VAW, compared with those from the obstetrics and gynaecology departments.

³ To identify what factors were associated with changes in the knowledge, attitudes and practice of providers, a multivariate generalized estimating equation was fitted with sex, age, site (i.e. hospital location) and type of department as independent variables.

“ Changes in attitudes

People say that short clothes are responsible. Actually that's a shortcoming of their perspective. There's nothing wrong with the clothes. Everyone is entitled to wear what they like. This is a democracy.

Resident, training participant at the Government Medical College and Hospital, Aurangabad



Intervention for improved service delivery and uptake

Identification and provision of care

Over nine months, 531 women were recorded in the facility register as survivors of domestic violence in the three departments of the health facilities hosting the training. In 60% of these cases, the provider suspected violence based on the presenting health complaints of the women, and asked women about abuse. A third of the women presented to the hospitals with attempted suicide and another third with injuries; 5% of cases of sexual violence were brought by the police (see Figure 3). A quarter of the women (26%) presented with other complaints but providers suspected violence based on a range of covert signs and symptoms, including health neglect, delayed antenatal care, repeated health complaints, no improvement in health despite treatment, vaginal discharge, menstrual problems, repeated pregnancy and abdominal pain. The high level of presentation with attempted suicide in the cases of violence is a significant concern. This highlights the importance of intervening earlier and at the primary health care level, including through mental health services.

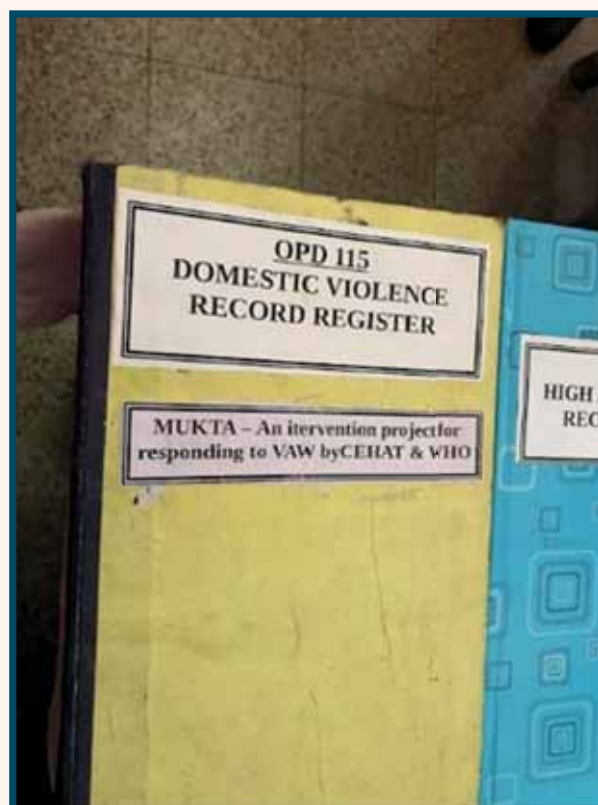
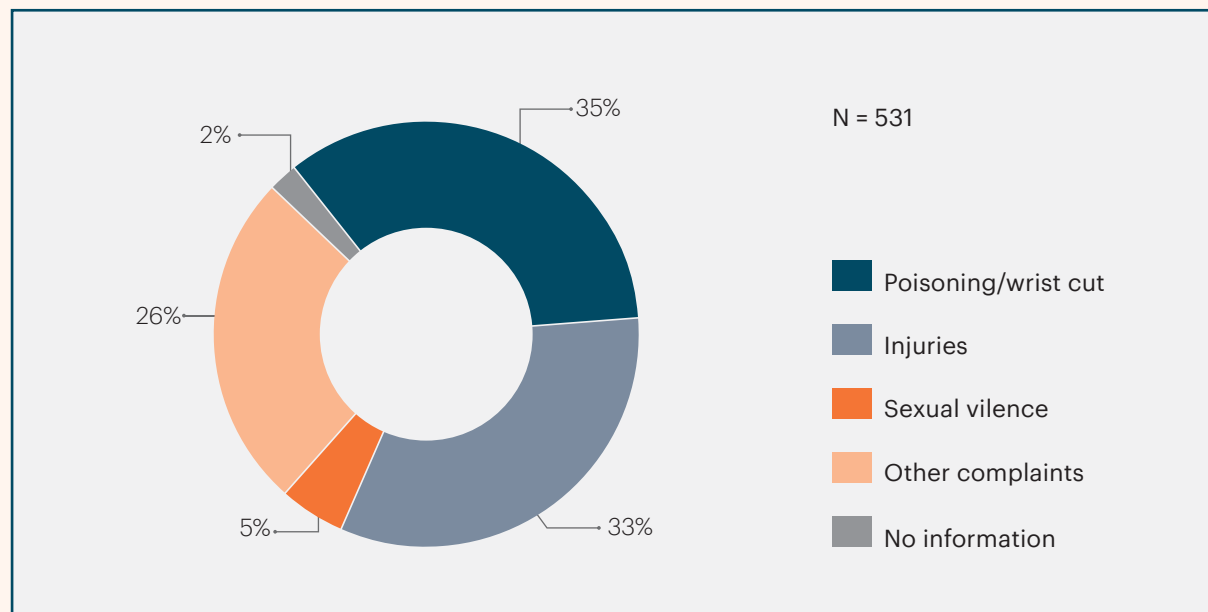


Figure 3: Presenting signs and symptoms of women who were documented as having experienced violence.



Self-reports by providers through the survey of knowledge, attitudes and practice suggested that, compared to the baseline, there was a significant increase in the provision of all five elements of first-line support.⁴ However, data from the documentation registers showed that only 27% of cases were listed as having completed all five steps.

Enhanced privacy and confidentiality

The development of an SOP on confidentiality and privacy, the training of providers to ask about violence in private consultation spaces, and the changes in patient flow led to improvements in privacy and confidentiality. In one hospital, to address concerns that rape survivors would experience the trauma of having to repeat their story of violence as they were shunted from one department to another for medico-legal examination and treatment, was resolved with a protocol to call doctors and nurses to a room in the obstetrics and gynaecology department. Known as *Sukun Kaksh* (i.e. peaceful room), examination and treatment could be provided in this one place.



Providers reported using various

⁴ The five steps of first-line support are defined by the mnemonic LIVES, which stands for Listening with empathy, Inquiring about needs, offering Validation, Enhancing safety and facilitating referrals to Support services.

strategies to protect the confidentiality of the women who disclosed violence:

Improved recall among providers



I just tell relatives that I was counselling patients about her health and diet. I don't tell them about actual conversation. Otherwise, they can harm the patient. So, I try my best to maintain confidentiality. This is important; otherwise the woman will never share her problems with anyone.

– Doctor (resident in medicine), 26 years of age, female

In qualitative interviews, providers spoke about the usefulness of job aids in recalling skills and also in spreading awareness among the staff members who were not trained:

Further, providers also reported the significance of materials in increasing awareness and help-



We can look at them in case we forget something. Also, for staff members who didn't get the chance to attend training, they can get information from these posters.

– Nurse (emergency department), 35 years of age, female

seeking among women:



Many women think that violence is a part of every woman's life, so if we have posters which give information that violence is not acceptable under any circumstances, then it also encourages woman to seek help.

– Doctor (resident in obstetrics and gynaecology), 26 years of age, female

Improved referrals to other services

An analysis of the facility registers showed that internal referrals to other hospital departments were made for 32% of women experiencing violence, and external referrals for 44% of women, with the most common referrals being made to a domestic violence protection officer. Unfortunately, while the qualitative interviews with providers highlighted that the establishment of referral linkages and the creation of a referral directory improved their capacity to make referrals, there was still a need to further strengthen coordination with other support services. To strengthen follow-up with women, HCPs from Aurangabad invited protection officers to participate in the training:



We had no idea [of] where women should go... where should those women go? Then through the resource directory, we came to know that there are protection officers, there are many services where women can get help. We can provide shelter to women who don't want to go back to their home.

– Doctor (medical officer, emergency department), 29 years of age, male

Policy implications

Table 3: Challenges and suggestions for improvements

Most of the women who identified as having experienced violence were not offered safety assessments and planning or referrals to other support services. This suggests the need for a dedicated cadre of HCPs (e.g. counsellors, social workers) to give more time to women in carrying out these tasks.



After training, doctors and nurses can easily identify cases of violence in [the outpatients department] and ward. Now, they have become experts in this. But the problem is that after identifying cases, they find it difficult to provide them help because they don't have that much time. We need to develop a system of referral and additional support services after identification.

– Nurse matron (emergency department), 43 years of age, female

The follow-up with referral agencies was reported as a challenge by providers, highlighting the need for joint cross-sector service training and regular meetings with providers from other sectors to improve referral follow-ups.

“

I feel something should be done for follow-up. I do refer her to [NGOs] or protection officers but what happens after that I don't know. If we can have some system for this, then it will definitely result in positive outcomes for women.

– Doctor (medical resident), 30 years of age, female

“

I think in every department a person should be assigned to do detailed counselling and follow-up. We don't know whether women get any help after leaving the hospital. If one person can call the woman and ask her about her well-being, then the response would be more effective. We don't have so much time to do detailed counselling and follow-up.

– Doctor (medical resident), 33 years of age, male

The frequent transfer of providers to other facilities was a challenge in sustaining a VAW response, highlighting the need for regular training, and for the response to be integrated in pre-service training and in the orientation training of new providers.

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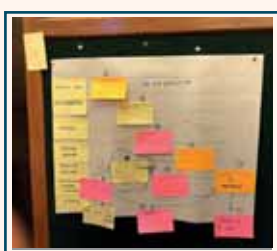
I think it is important to train everyone. If there are providers who are not trained and are not sympathetic towards women, then the efforts which trained doctors are putting in will be in vain. There is no point in telling a woman that we are there to help her. She will not believe us because of her experience with providers who are not trained.

– Doctor (resident in obstetrics and gynaecology),
26 years of age, male

Lessons learned



Creating ownership for the intervention activities requires the engagement of managers and administrators in planning, design and implementation. It requires the recognition of roles, responsibilities, constraints and barriers, and of providers' motivations to take on the tasks related to violence.



Training methods need to be based on adult learning principles and the need to be participatory. They should also enable critical reflection and foster a sense of collective responsibility and accountability.



Training content needs to focus not only on knowledge, but also on personal values and beliefs. It also needs to build competencies and skills – for example, in the identification of partner violence and the provision of first-line support.



The lack of sustained change, the decline in attitudes and in the perceived preparedness over time, reflect the need for ongoing reinforcement of training. A minimum of a two-day training session is required. Continual reinforcement, particularly of topics or skills that providers find more challenging to learn or retain, may be needed to sustain changes in practice and attitudes over time.



Young providers were found to be more receptive to changes in attitudes, as compared with older ones. This underscores the need to begin teaching about VAW in pre-service trainings, as students will be more receptive. The need for ongoing in-service training has also emerged strongly with the decrease in scores.



LIVES is the standard first-line care recommended by WHO guidelines, and this was provided to 27% of the survivors in this study. This is a new standard of care, and the findings indicate that it is possible for HCPs to deliver it. However, the low number of cases offered all five steps of LIVES indicates the need for further skill training of the providers and for the monitoring of interventions.



Training alone is not sufficient to bring about sustained changes. Additional intervention activities need to be implemented, including the training of senior-level master trainers; the provision of IEC materials for patients; job aids for providers to support the recall of skills learned; the creation of SOPs for confidentiality and privacy; the identification of private spaces for consultation; the creation of documentation registers; and the establishment of linkages with other sectors. These activities enabled trained HCPs to apply and put into practice the skills that they had learned.

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