How health workers perceive relevance of trainings to respond to violence against women using WHO guidelines: Findings from an implementation research in three tertiary hospitals of Maharashtra, India

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Introduction

• **Intervention**: Roll out of WHO clinical and policy Guidelines & Tools to strengthen health worker capacity & improve health systems readiness.

• **Research Aim**: To validate and revise the approaches to roll out the ‘Guidelines and Tools’, with a focus on intimate partner violence.
  
  • 3 overall objectives.
  
  • Focus here: Relevance of intervention to health workers & perceived barriers & enablers & women’s perceptions of care received
Background: Study settings

National Lifetime spousal violence: 29%

Spousal violence:
16% urban
26% rural
Methods: Intervention & research activities

**Intervention- Health systems’ building blocks**
- Strengthening health work force capacity
- Strengthening leadership
- Strengthening multi-sectoral coordination
- Promoting system level changes
- Improving service delivery
- Improving health infrastructure
- Improving information and evidence

**Research**
- Stakeholder consultations (N=26)
- Training of Trainers (N=26)
- KAP survey at Pre, Post & post 6 months (N=220 providers)
- Post training qual data collection with health workers - IDIs (N=21) & FGDs (N=2) with health care providers
- Post training interviews with women who received care IDIs (N=7) with women
- VAW data review / case aggregation (N=531)
Methods: Thematic analysis: Health workers perceptions

Perceptions of relevance of training

- Acceptability and feasibility
- Improved knowledge, attitude and skills

Barriers and enablers in responding to VAW

- Infrastructure: privacy and confidentiality
- Support to the health workforce
Findings: Acceptability & Feasibility

Relevant Content

“We learnt about types of violence and its health consequences. There were case scenarios and role plays to understand how to communicate with women and how to inform them about help. Protection officer madam also came and told us about laws and provisions under them for women. We had no idea that where women should go… that where should those women go? Then through this we came to know that there are ‘Protection officers’” (Doctor, 26- year-old, Female, OBGY)

• Peer-led trainings

“As our seniors were there, they told us how we can integrate it into our routine. This our seniors explained to us, how we must follow it in our routines.” (Doctor, 25- year-old, OBGY)
Improved knowledge, attitudes, skills

“The training made us understand why women reach us with the same health problems again and again. And we as doctors are not be able to identify any possible cause for the health problem because her health problems are related to domestic violence… they are having issues at home.” (Doctor, Female, 26-year-old, OBGY)

“Most women easily disclose it when we ask them politely. But there are also some women who hesitate to share anything. I think it is important to be receptive to such women, assure them that we are there to help her and validate her feelings.” (Doctor, Female, 26-year-old, OBGY)

“Now, whenever I examine a female patient and I have even a little doubt that the woman might be facing trouble… I don’t hesitate to ask her about her problems. This point always stay in my mind that we have to ask the woman.” (Doctor, Male, 27-year-old, Medicine)
Barriers & enablers

• Infrastructure in relation to privacy and confidentiality:

“In the outpatient department [OPD], there are 80 to 100 patients and in three to four hours we have to see all of them. This is the limitation in OPD. In the ward [in patient], we have multiple opportunities to interact with patients. There are nurses, junior residents and senior residents who interact with them on daily basis. So, in the in-patient department it is easier to do identification.” (Doctor, Male, 49-year-old, OBGY)

• Confidentiality during outpatient consultations:

“I just tell relatives that I was counseling patient 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.” (Doctor, Female, 26-year-old, Medicine)
Barriers & enablers

Health workforce shortages

“Lack of time is the biggest problem! So much work is there in the government hospitals! Patient load remains too high. But still providers who are interested will take out time for this. Therefore, it is important to change the way people look at this issue.” (Doctor, Male, 59-year-old, Medicine)

“There should be more staff members in the department…the medicine department is highly understaffed. We need more people…both doctors and nurses.” (Doctor, Male, 26-year-old, Medicine)

“If I identify any woman facing violence during OPD then I have my colleagues who can facilitate further procedures like contacting social worker and providing support services to woman. Also, if I feel that woman is not feeling comfortable in sharing her problems with a male doctor then also I call sister from our department…” (27- year- old, Male. Medicine, Miraj)
Women’s Data: Documentation Register

A total of 531 cases of violence were documented by trained providers across three departments in a period of 9-months from August 2018 to April 2019 across 3 facilities.

Disclosure of violence

Forms of violence

- Physical: 66.3%
- Sexual: 13.2%
- Emotional: 74.6%
- Financial: 21.8%
Women’s perceptions of quality of care

“Such services should be in hospital only. Otherwise, mother-in-law asks why you are going. What is the need to go? Mother-in-law says all such things. If we come to hospital, then such thing should be there for us! The only place we can go alone is hospital…” (20-year old woman)

“I felt nice. I told her (healthcare provider) about my problem… what is going on in my mind. When we share our problems with others, we feel nice.” (20-year old pregnant woman)

“Madam’s (HCP) suggestion about ignoring the behavior of husband and mother-in-law had actually helped me to stay calm and take care of my health during pregnancy. After talking to her (social worker), I can understand where I have to ignore and where I have to respond…” (21-year old woman)
Conclusions & Way forward

- Study reinforced need for a systems approach to health response to VAW.
  - Health workforce:
    - Training should be participatory and integrated in existing curricula
    - Refreshers & ongoing case reviews reinforce learning
    - Limited time requires teamwork, clear division of roles and creativity in optimising task sharing
  - Leadership:
    - Involve senior clinicians in supervision and mentoring and championing
  - Infrastructure:
    - Privacy and confidentiality require training and SOPs - more challenging in outpatient units
- Survivors see health services as a safe & accessible entry point for care, and value empathetic response and interest in their domestic problems.
Resources from the study


Strengthening health systems response to violence against women: protocol to test approaches to train health workers in India
Sarah R. Meyer, Sanjeeeta Rege, Prachi Avalasskar, Padma Deosthali, Claudia Garcia-Moreno, and Avni Amin

Knowledge, attitudes and practices of health care providers trained in responding to violence against women: a pre- and post-intervention study
Sanjida Arora, Saneeeta Rege, Padma Bhat-Decosthali, Soe Soe Thwin, Avni Amin

Innovations in implementing a health systems response to violence against women in 3 tertiary hospitals of Maharashtra India: Improving provider capacity and facility readiness
Srinivas Gadappa, Priya Prabhu, Sonali Deshpande, Nandkishor Gaikwad, Sanjida Arora, Sanjeeeta Rege, Sarah R. Meyer, Claudia Garcia-Moreno and Avni Amin