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ORIGINAL ARTICLE

Strengthening Health Systems' Response to Violence Against Women in Three Tertiary Health Facilities of Maharashtra

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Abstract

Background Domestic violence is known to have a significant impact on the health of women. Despite this, the health system in India is not equipped to respond to women facing violence. This can be attributed to limited information on how the evidence-based guidelines can be implemented in resource-constrained settings. To fill this gap, implementation research was carried out in three tertiary medical teaching hospitals in Maharashtra.

Methods The project was implemented in the OBGY, Medicine and Emergency department of a medical college and a district hospital in the state of Maharashtra. The intervention included consultation with key providers of three departments and a 5 day training of trainers on VAW. The trainers conducted 2 day onsite training for the health care providers. System-level interventions included the development of SOPs, IEC material, documentation format and identifying places for a private consultation. The research involved a pre- and post-test to assess change in KAP of providers after training, analysis of documentation register and interviews with trained providers and survivors.

Results Findings indicate a significant change in knowledge, attitude and practice of the providers. Documentation registers introduced in the facility departments showed 531 women facing violence were responded by providers in 9 months. In 59% of cases, the provider suspected violence based on presenting health complaints, indicating the success of the capacity building programmes in the development of skills to identify VAW signs and symptoms, as well as provide psychological support to women/girls. There was a high acceptability of intervention among providers. Survivors also recognised the usefulness of health care facility-based support services for violence.

Conclusion A multi-component intervention comprising of building capacity of providers and facility readiness is feasible to implement in low- and middle-income countries (LMIC) and can strengthen health systems' response to VAW.

Keywords Domestic violence · Health care providers · Training

Introduction

Domestic violence is widely prevalent and is often normalised by Indian society [1]. It affects every aspect of a woman's life including her health and well-being [2]. The initial data from the fifth round of the National Family Health survey (2019–20) indicate that more than 30% of women have ever faced violence from their husbands [3]. According to an estimate available from NFHS 4, about one-fourth of women, who ever faced spousal violence, experienced some form of injury. Further, only 1% of those who experienced any injury sought help from a health care provider [4]. The evidence from the literature suggests that women facing domestic violence can experience a range of sexual and reproductive health problems

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such as unwanted pregnancy, miscarriage, abortion, STIs, and HIV [5–7].

A public health approach with a significant role of health care providers has been recognised to address domestic violence [8]. Globally, there is strong evidence on the role that health care providers can play in early identification and response to survivors of domestic violence [9–12]. Additionally, the studies with women have reported high acceptance of doctors and nurses asking about abuse and providing support services [13–15]. Still, little efforts have been made in the Indian context to equip health systems and health care providers to respond to domestic violence [16]. This is despite enabling policy environment in the form of Protection of Women from Domestic violence Act, 2005 and National Health Policy, 2017 [17, 18]. A synthesis report on health systems' response to intimate partner violence in India found a lack of government directives to operationalize policy commitment. Further, there is limited evidence on the effectiveness and scalability of existing models of health systems' response to domestic violence in India [19].

WHO's Clinical and Policy Guidelines, 2013 provide evidence-based guidelines on how to implement a health system's response to intimate partner violence and sexual violence against women [20]. The guidelines highlight uncertainty for implementation of the majority of recommendations in low- and middle-income countries due to lack of evidence. To address this gap, a Mumbai-based non-government organisation (NGO) collaborated with WHO and three tertiary level teaching medical facilities for implementation research. The NGO has more than 2 decades of experience in engaging with the health system on the issue of violence against women. The project aimed to assess the feasibility of a series of interventions to strengthen the response of the health facilities to domestic violence.

Methodology

The project comprised of an intervention and research components to adopt a series of evidence-based recommendations and to assess their feasibility in terms of implementation and ability to bring a change in the existing response of the health system to the issue of domestic violence.

The project was implemented between July 2018 and April 2019 in three tertiary level teaching health facilities located in two districts of Maharashtra. These facilities serve as primary providers of health care in the districts and a referral point for the majority of the rural population. The project was implemented in the department of Obstetrics and Gynaecology, General Medicine and Casualty having a routine interface with women patients.

To adopt the intervention, a 2 day stakeholder meeting was organised with 30 key providers including both doctors and nurses from three departments across facilities. The meeting helped in the identification of providers' motivations and challenges in responding to VAW. The solutions to the challenges of HCPs were developed in a participatory manner along with providers. The stakeholder meeting helped in the development of standard operating protocols (SOPs), a plan for implementation of training, identification of opportunities for asking about abuse during routine clinical practice, and a format for documentation of cases of violence. The intervention was operationalised based on the health systems building block [21].

a Strengthening health workforce capacity: a 5 day training of trainers of 26 providers from three sites was carried on the issue of violence. These master trainers included both doctors and nurses from three departments having administrative responsibilities. The training included sessions like the difference between sex and gender, intersectionality, VAW as a public health issue, legal mandate for providers, skills on asking about abuse and providing first-line support. Participatory methods like case vignettes, role plays, and polls were used for the effective delivery of training. These trainers conducted 2 day onsite training for their colleagues in their respective health facilities. A total of 201 providers were trained by master trainers through eight trainings over a period of 4 months (Fig. 1).

b Strengthening leadership: master trainers were selected based on their existing supervisory and decision-making role in the department. This was done to increase the uptake of training activities and system-level changes.

c Strengthening multi-sectoral coordination: CEHAT—research partner to the project facilitated a meeting between health facilities and organisations providing additional support services outside the scope of a health facility. These services include shelter homes, legal aid and livelihood support. A referral directory was developed based on this meeting to equip providers to make referrals and connect women to various support services.

d Improving service delivery: the services to survivors of violence were improved by developing standard operating protocols. These protocols guided providers on providing support to survivors ensuring privacy and confidentiality. Job aids were developed for providers to recall the skills while providing care in out-patient and in-patient departments. In order to raise awareness among women about the availability of support services in the health facility, IEC material was developed and was made available in the local language.

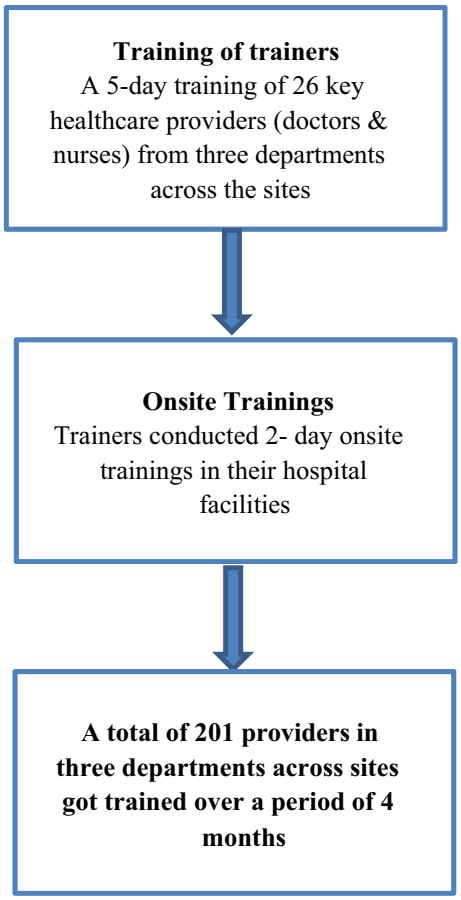

Fig. 1 Strengthening health workforce capacity

e Improving infrastructure: the stakeholder meeting helped in the identification of spaces for private and confidential consultations in the existing infrastructure of health facilities.

f Improving information and evidence: a format for documentation of cases of violence identified and responded by providers was developed in consultation with providers. The one-page format took into account the challenge of lack of time faced by providers. The format was introduced as registers in OPD and IPD of three departments and included information on presenting health complaints of women, forms of violence, and support provided by providers.

The research activities included administration of a survey before training, after training and 6 months after training to 201 providers. The purpose of the survey was to assess the change in knowledge, attitude and perceived preparedness of providers. The documentation registers were analysed to assess the change in the clinical practice of providers. In-depth interviews were also conducted with 21 trained providers to assess the acceptability and usefulness of intervention activities. Seven survivors supported by trained providers were also interviewed to understand their perceptions about the facility-based intervention to address VAW. The additional details of the project can be found in the published project protocol [22].

The KAP survey and documentation register data were analysed using SPSS version 20 [23]. Atlas Ti version 6 was used for the management and coding of qualitative data.

The project was reviewed and approved by Anusandhan Trust- Institutional Ethics Committee, an independent review panel of HRP (the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction) at the WHO, and the World Health Organization's Ethics Review Committee.

Findings

Training

The implementation of training involved various strategies like creating champions, training doctors and nurses together and including content on intersectionality, and inequality in training. The champions not only played an instrumental role in the training of providers but also in creating a supportive ecosystem for integrating enquiry about abuse in the routine clinical practice of providers. The involvement of champions also helped in increased acceptance of intervention among health care providers.

The training of doctors and nurses together contributed to building the understanding of shared responsibility among providers in addressing the issue of VAW. It gave the message that an effective health systems' response to violence requires a team effort.

The inclusion of concepts of inequality and intersectionality helped providers to understand the root causes of violence and bring a positive change in their attitude towards survivors.

The KAP survey results in a significant change in knowledge, attitude and perceived preparedness of providers after training. However, 6 months after training, a decline in a change in attitude score was found. This finding suggests that a change in attitude requires a loner engagement and reinforcement over time. Young providers were found to be more open to change in knowledge as compared to older ones thereby pointing to integration of training on VAW in pre-service training.

The in-depth interviews with trained providers found the usefulness of training in increased recognition of VAW as a public health issue, the importance of creating enabling environment for disclosure of violence and recognising covert signs of violence. Providers in interviews described

several health complaints based on which they suspected violence and asked about abuse.

Identification of Abuse and Provision of Care

KAP survey found a significant increase of 28% of providers who reported identifying and providing care to at least one survivor in the last 3 months. A total of 531 survivors were identified and responded by providers across three departments and sites over a period of 9 months.

About 59% of survivors were identified by providers based on their presenting health complaints, while the remaining survivors reported violence on their own. One-third of the cases were from the OBGY department, and out of these majority of them (81%) were identified in the Antenatal Care department. Providers suspected violence based on certain health complaints like neglect of the health of women, delayed antenatal care, repeated health complaints, no improvement in the health of women despite treatment and gynaecological problems like vaginal discharge, menstrual problems, repeated pregnancy and pain in the abdomen.

The first-line support in form of Listen, Enquire, Validate, Enhanced Safety and Support services (LIVES) was provided in 27% of cases. The first three steps of listening with empathy, inquiring about needs and offering validation were done by providers in all cases. Safety assessments and planning and referrals for other support services were less frequently listed, suggesting the need for more skill-building of providers and monitoring of response.

Improved Multi-stakeholder Coordination

The documentation register analysis indicated increased coordination with various stakeholders as an external referral was provided by providers in 44% of cases. However, the interviews with providers revealed a need to further strengthen the coordination with stakeholders. Providers voiced the need to have a dedicated person to do follow-up with external agencies regarding survivors referred by providers.

Experience of Survivors

Survivors reported a positive experience of receiving care from trained providers and recognised health facility as a safe space to seek services for violence. They identified empathetic listening and enabling environment by ensuring privacy and confidentiality as the pre-requisites to share the experience of violence with providers.

Challenges

a. Safety planning and support services: the finding from the analysis of documentation register on low proportion of safety planning and provision of additional support services corroborated with findings from interviews with providers. The majority of the providers reported that lack of time as a barrier to comprehensive first-line support to survivors.
b. Follow-up with referral agencies: providers informed difficulty in following up with referral agencies to know the status of the cases. Regular meetings between different stakeholders and a dedicated person to do regular follow-up with referral agencies were the recommendations given by providers to address this challenge.

Discussion

The findings of the project show feasibility of a set of interventions focused on building the capacity of providers and establishing enabling environment in the health system by introducing system-level changes. The system-level changes should address the challenges of providers in responding to VAW. The project generated important evidence on the adoptability of intervention activities and feasibility in bringing a change in the health system. The majority of studies with evidence on the assessment of interventions are based in North America [24]. Thus, the findings of this study help in establishing the elements of the intervention required to establish a health system's response to VAW. There are some key learning from the project based on the way intervention was implemented.

a. Involvement of providers with leadership roles is crucial for increasing the acceptance of training and system-level changes. Their participation in the conceptualisation and designing of intervention activities is important for the sustainability of health systems' response to VAW.
b. Training: training of trainers approach along with participatory methods of conducting training is effective in bringing a change in knowledge, attitude and perceived preparedness of providers. The training on the issue of VAW should be regular to sustain the change in the practice of providers.
c. The training on the issue of VAW should be integrated in medical education with ongoing in-service training.
d. A large proportion of cases identified by providers were from antenatal care, which builds a case for routine enquiry of VAW during ANC. Thus, obstetricians and gynaecologists are in a unique position to identify cov-

ert signs and symptoms related to the sexual and reproductive health of women indicating domestic violence. WHO also recommends routine enquiry of VAW only in antenatal care. This recommendation is drawn based on evidence on the high prevalence of violence during pregnancy and its detrimental impact on the health of pregnant women

e. The safety assessment and provision of additional services to survivors by providers require more skill-building of providers and establishment of effective linkages between the health system and other stakeholders.

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Declarations

Conflict of Interest The authors have no conflicts of interest to declare. The trainer (providers) were involved in implementation of the project. The research activities were carried out by CEHAT with support from WHO. None of the trainer was involved in analysis of the data.

Ethical Approval The project was reviewed and approved by Anusandhan Trust- Institutional Ethics Committee, an independent review panel of HRP (the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction) at the WHO, and the World Health Organization's Ethics Review Committee. Informed consent was obtained from all those who participated in the KAP survey, and qualitative data collection.

References

1. Anitha S, Yalamarty H, Roy A. Changing nature and emerging patterns of domestic violence in global contexts: dowry abuse and the transnational abandonment of wives in India. Women's Stud Int Forum. 2018;69:67–75.
2. Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women (2021) World Health Organization, Geneva. Licence: CC BY-NC-SA 3.0 IGO.
3. IIPS (2020) National family health survey (NFHS-5) 2019–2020 fact sheets: Key Indicators 22 States/UTs from phase I. International institute of population sciences, Ministry of Health and Family Welfare, Government of India.
4. IIPS(2018) National family health survey (NFHS-4) 2015–2016 International institute of population sciences, Ministry of Health and Family Welfare, Government of India.
5. Grose RG, Chen JS, Roof KA, et al. Sexual and reproductive health outcomes of violence against women and girls in lower-income countries: a review of reviews. J Sex Res. 2021;58:1–20.
6. Shrestha R, Copenhaver MM. Association between intimate partner violence against women and HIV-risk behaviors: findings from the NEPAL demographic health survey. Violence Against Women. 2016;22:1621–41.
7. Arora S, Deosthali P, Rege S. Effectiveness of a counselling intervention implemented in antenatal setting for pregnant women facing domestic violence: a pre-experimental study. BJOG: Int J Obstet Gynaecol. 2019;126:50–7. https://doi.org/10.1111/1471-0528.15846.
8. Rege S, Bhate-Deosthali P, Ravindran TKS. Violence against women and girls: understanding responses and approaches in the Indian health sector. Milton Park: Taylor & Francis; 2020.
9. Garcia-Moreno C, Amin A. Violence against women: where are we 25 years after ICPD and where do we need to go? Sex Reprod Health Matters. 2019;27:346–8.
10. Guedes A, Bott S, Garcia-Moreno C, et al. Bridging the gaps: a global review of intersections of violence against women and violence against children. Glob Health Action. 2016;9: 31516. https://doi.org/10.3402/gha.v9.31516 (**PMID: 28157027**).
11. Palani MS, Ramesh MM, Giftson MDBP. Violence against women and its implications to public health: human rights perspectives. Psychol Educ J. 2021;58:9170–8. https://doi.org/10.17762/pae.v58i2.3621.
12. Chandan JS, Taylor J, Bradbury-Jones C, et al. COVID-19: a public health approach to manage domestic violence is needed. Lancet Public Health. 2020;5: e309. https://doi.org/10.1016/S2468-2667(20)30112-2.
13. Hatcher AM, Woollett N, Pallitto CC, et al. Willing but not able: patient and provider receptiveness to addressing intimate partner violence in johannesburg antenatal clinics. J Interpers Violence. 2019;34:1331–56.
14. Colombini M, Alkaiyat A, Shaheen A, et al. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. Health Policy Plan. 2020;35:245–56.
15. Alvarez C, Fedock G, Grace KT, et al. Provider screening and counseling for intimate partner violence: a systematic review of practices and influencing factors. Trauma Violence Abuse. 2017;18:479–95.
16. Raj A. Public health impact of marital violence against women in India. Indian J Med Res. 2019;150:525–31.
17. The Protection of Women Against Domestic Violence Act (2005) (2015) Government of India
18. The National Health Policy (2017) Ministry of health and family welfare
19. Bhate-Deosthali P, Rege S, Pal P, et al. Role of the health sector in addressing intimate partner violence in india. A synthesis report.

New Delhi: International Center for Research on Women; 2018. p. 40.
20. World Health Organization, editor (2013) Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. World Health Organization, Geneva
21. García-Moreno C, Hegarty K, d'Oliveira AFL, et al. The health-systems response to violence against women. The Lancet. 2015;385:1567–79. https://doi.org/10.1016/S0140-6736(14)61837-7 (**PMID: 25467583**).
22. Meyer SR, Rege S, Avalaskar P, et al. Strengthening health systems response to violence against women: protocol to test approaches to train health workers in India. Pilot Feasibility Stud. 2020;6:63. https://doi.org/10.1186/s40814-020-00609-x (**PMID: 32426157**).
23. IBM Corp. IBM SPSS statistics for windows [Internet]. Armonk, NY: IBM Corp; 2017. Available from: https://hadoop.apache.org
24. Kalra N, Hooker L, Reisenhofer S, et al. Training healthcare providers to respond to intimate partner violence against women. Cochrane Database Syst Rev. 2021;5: CD012423. https://doi.org/10.1002/14651858.CD012423.pub2 (**PMID: 34057734**).

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