Learning from country experiences in implementing a health systems response to VAW using WHO guidelines and tools: Implementation Research in India

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SVRI Forum 2019
Objectives and Methods

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Purpose, objectives

Aim: learn how to improve health systems response & quality of care (QOC) to survivors. Phase 1 pilot

1. validate implementation of WHO guidelines and tools
   • assess needs of HCP
   • adapt & implement training + service delivery readiness
   • assess improvements in KAP of HCP
   • assess relevance of training

2. understand perceptions of QOC of women who receive care

3. validate instruments for measuring HCP skills and health facility readiness
Research Context

Spousal violence: 16% urban, 26% rural

National Lifetime spousal violence: 29%
Overview of intervention & research activities

**Intervention**
- Adaptation of training
- ToT
- Training of HCP
- Refresher training
- SOP for privacy & confidentiality
- Referral directory
- IEC/job aids
- Registers to collect data on VAW cases

**Research**
- Stakeholder consultations
- Training fidelity documented
- KAP survey - Pre, Post & post 6 months
- IDI & FGDS with HCPs
- IDI with women
- Aggregation of VAW cases

**Sample**
- 26 administrators (Doctors, Nurses, Social Workers)
- 8 trainings/5 months
- 210 HCPs
- IDI HCP 28; FGD 4 - Ongoing
- IDI women 10 - Ongoing
- 531 VAW cases / 10 months
Innovations in training

Dr Prashant Bhingare
Associate professor, Dept of Gynecology and Obstetrics
Aurangabad Medical college
Reflections on trainings

Adaptations

• Mix of doctors, nurses, social workers trained together

• Critical reflection on sex, gender, power, & lack of respectful care in medical & nursing practices

• Inclusion of presenting signs and symptoms of VAW survivors in clinical case presentation meetings to orient other doctors

• Inviting Protection Officers, Child welfare Committee members, Police to be part of the trainings facilitates multi-sectoral coordination, referrals

• Refresher training 6 months later

Changes

• Increased ownership across cadres

• Interest in other depts → additional trainings including for nurses across all depts

• Development of formal referral system

• Increased ability to identify less obvious signs of DV/IPV
Innovations in creating health systems readiness

Dr Nandkishor Gaikwad
Associate professor, Dept of Gynecology and Obstetrics
Miraj Medical college
## Reflections on strengthening health facility readiness

<table>
<thead>
<tr>
<th>Adaptations</th>
<th>Changes</th>
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<tbody>
<tr>
<td>Development of SOP</td>
<td>Helped in reducing the trauma from recounting the incident multiple times.</td>
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<td>Strengthening health work force capacity</td>
<td>Mixed group training, ensuring participation with minimal disruption of routine hospital functioning &amp; improved multidisciplinary team approach</td>
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<td>Privacy and confidentiality</td>
<td>space in the form of “sukun kaksh (relief room) enabled providers to ask about violence in privacy</td>
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<td>Confidentiality SOP for maintaining documentation</td>
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<td>Accountability mechanisms</td>
<td>Monthly review meetings helped problem solve challenging cases &amp; improve quality of documentation.</td>
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<td>Registers to get survivor feedback motivated staff</td>
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<td>Creating visibility of services</td>
<td>IEC materials in local languages visible, leading to awareness among women attending facilities</td>
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<td>Documentation system established in HMIS</td>
<td>A one page documentation form facilitated ease of gathering administrative and program data</td>
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Findings from India + implementation in other countries + lessons learned

Avni Amin
Department of Reproductive Health and Research, WHO
India: Changes in Provider KAP

![Graph showing changes in total knowledge, attitude, and practice scores over pre-test, post-test, and post-6 months for providers in India.](image-url)
India: Data from 531 women disclosing violence

Type of violence disclosed

- Physical violence: 64.40%
- Sexual violence: 11.90%
- Emotional violence: 73.60%
- Financial violence: 21.80%

Primary health complaint

- Poisoning/Wrist cut: 32.2%
- Injuries: 25.6%
- Sexual violence: 4.9%
- Other complaints: 4.3%
- No information: 33%
Implementation in other countries

Botswana, Cambodia, Namibia, Pakistan, Uganda, Uruguay, and Zambia have adapted and implemented the clinical handbook.

Afghanistan is scaling up the health sector response to violence against women: it has developed a health protocol in line with WHO guidelines, translated the clinical handbook into local languages and is training 6000+ health workers across all 34 provinces.

Cambodia has implemented a national population-based prevalence survey using the WHO multi-country study methodology.

WHO is building the capacity of health care providers in humanitarian settings, through the health cluster, in Afghanistan, Bangladesh, Democratic Republic of Congo, Iraq, Nigeria, and the Syrian Arab Republic.
Progress in other countries

Uganda: MoH has piloted in 3 districts & has a plan for scaling up services

Cambodia: Trainings being scaled-up in 11 districts + pre-service

Afghanistan: training 6500 providers + service improvements in facilities in all 34 provinces
Lessons: sustained changes require

**Training**
- Peer led training strong acceptability
- Joint training across disciplines and cadres
- Train all HCPs in LIVES, but identify dedicated staff for additional psychosocial support.
- Senior management champions + mentoring & supervision
- Refreshers/repeat trainings

**Supportive systems readiness**
- Improving infrastructure
  - patient flow
  - Privacy
- SOP for confidentiality
- Documentation system
- IEC, job aids to increase visibility
- Strengthening referral linkages with other sectors
- Institutional change takes time