

# 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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# **Objectives and Methods**

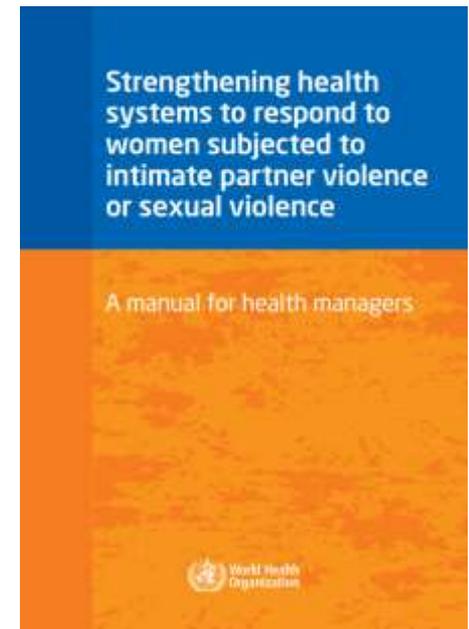
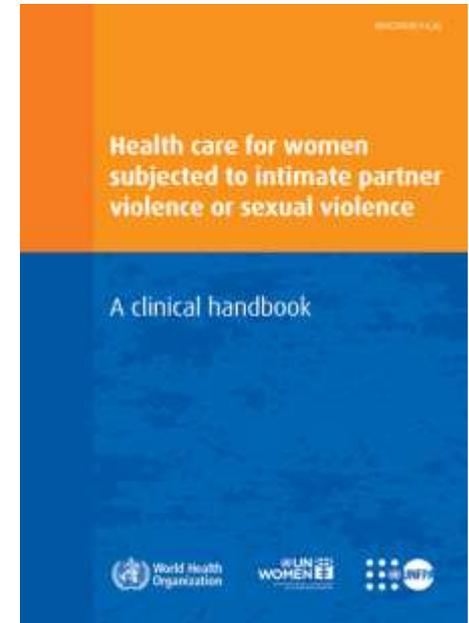
**Sangeeta Rege, CEHAT**

# 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

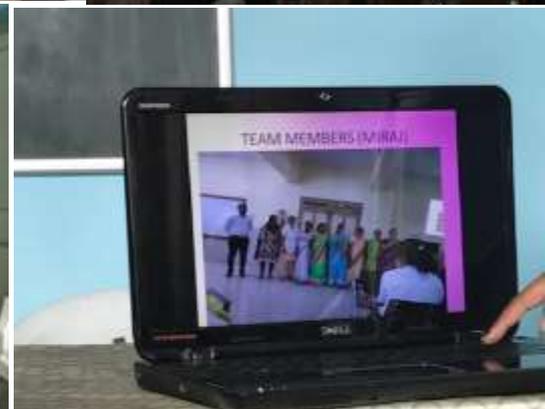
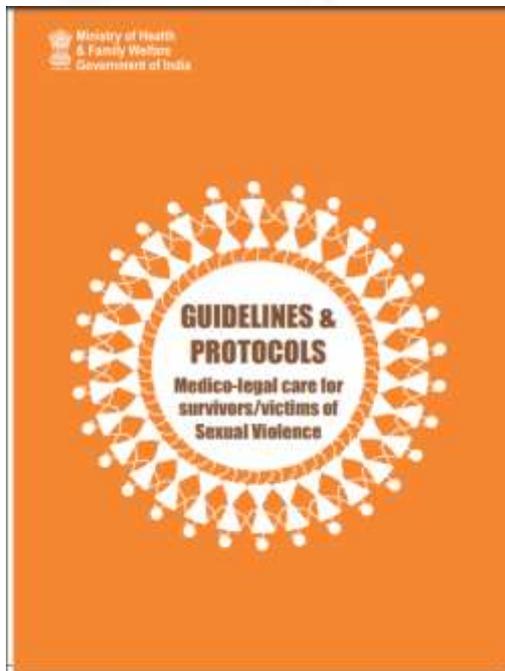


# Research Context

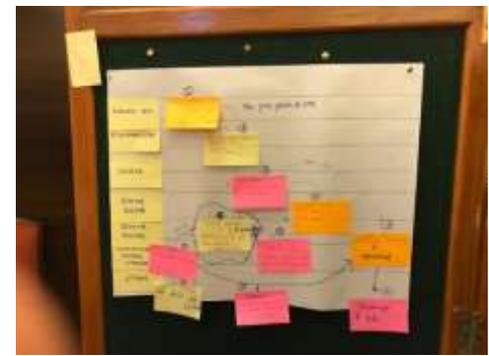
National Lifetime spousal violence: 29%



Spousal violence:  
16% urban  
26% rural



# 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**

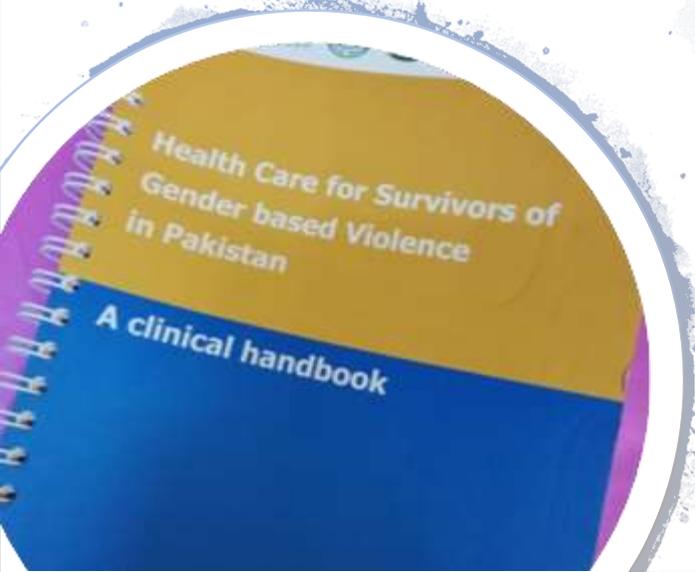


# Reflections on strengthening health facility readiness

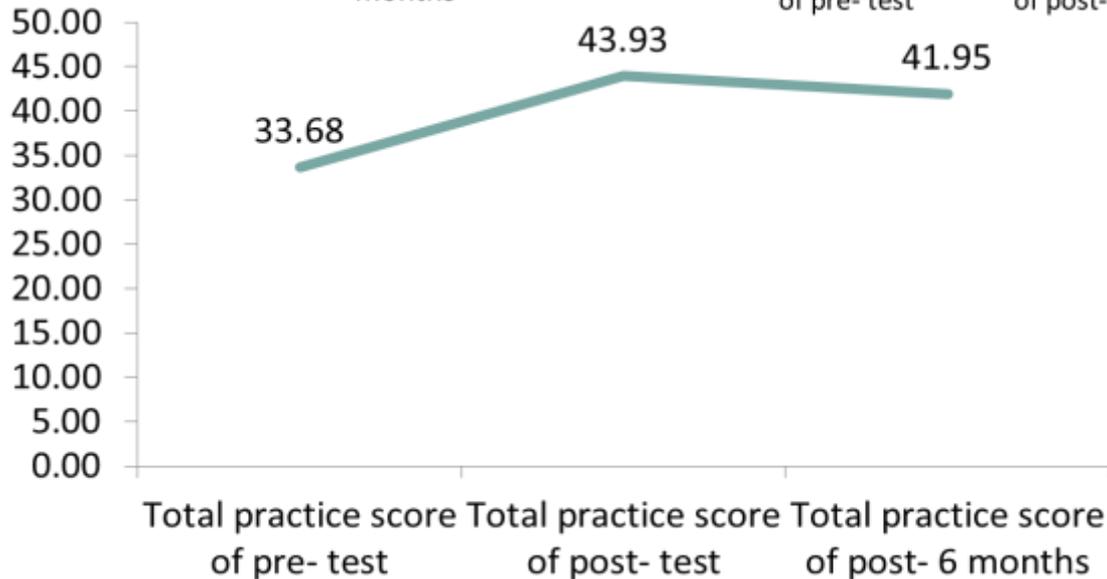
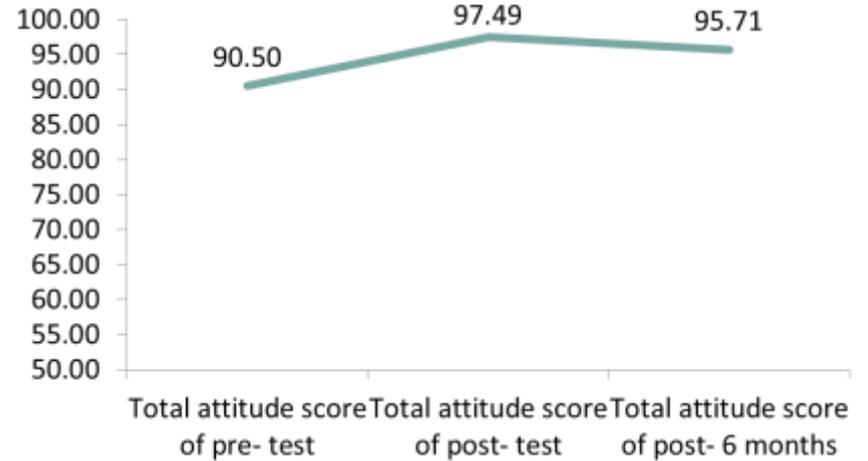
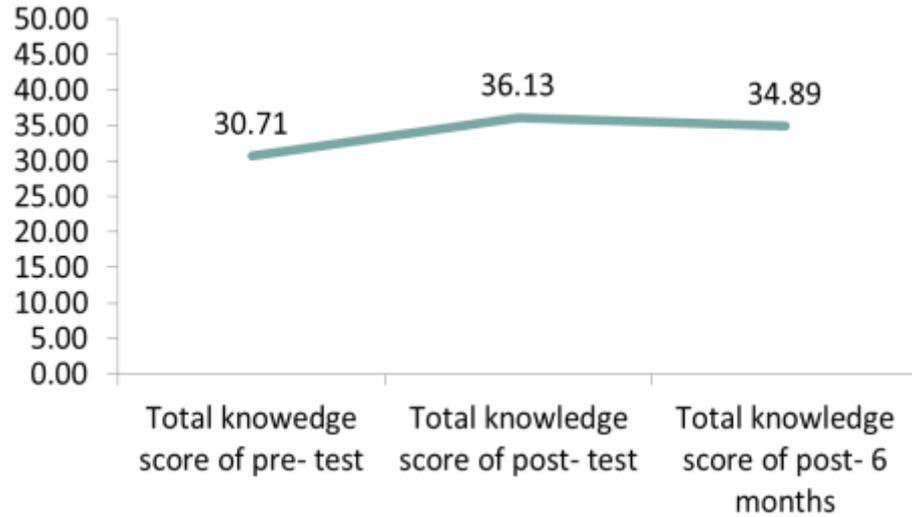
<b>Adaptations</b>	<b>Changes</b>
<b>Development of SOP</b>	Helped in reducing the trauma from recounting the incident multiple times.
<b>Strengthening health work force capacity</b>	Mixed group training, ensuring participation with minimal disruption of routine hospital functioning & improved multidisciplinary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

# Findings from India + implementation in other countries + lessons learned

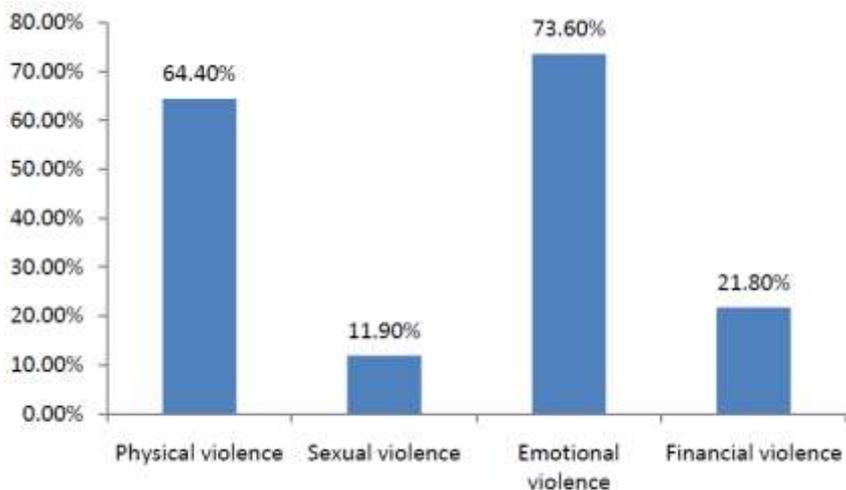
**Avni Amin**  
**Department of**  
**Reproductive Health**  
**and Research, WHO**



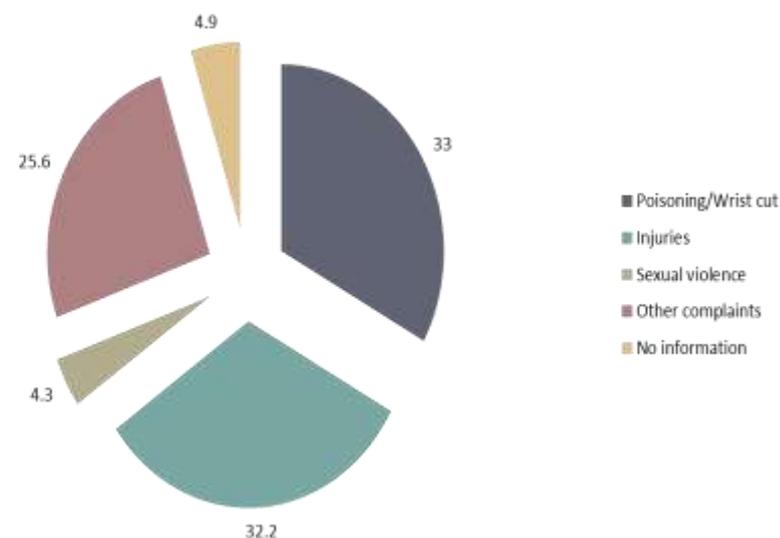
# India: Changes in Provider KAP



# India: Data from 531 women disclosing violence



Type of violence disclosed

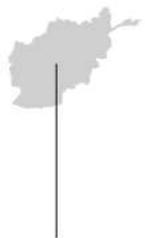


Primary health complaint

# Implementation in other countries



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

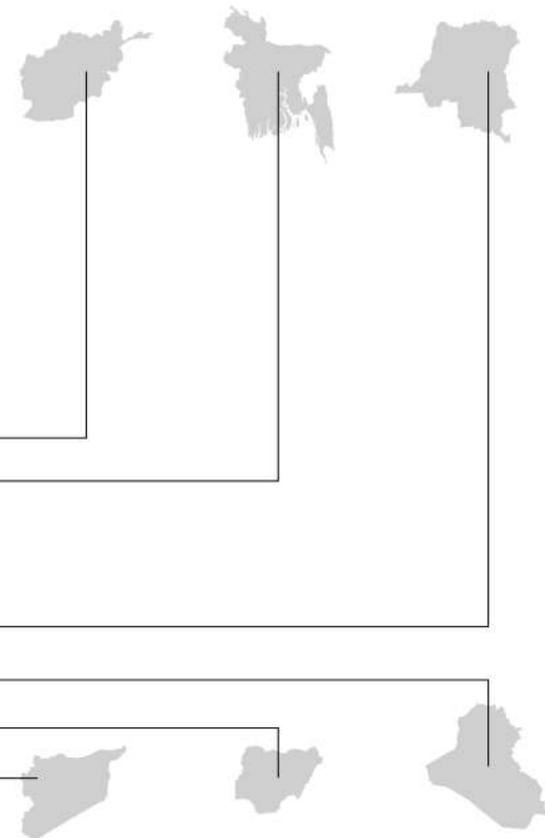


**Afghanistan** is scaling up the health sector response to violence against women: it has developed a health protocol in line with WHO guidelines, translated the clinical handbook into local languages and is training 6000+ health workers across all 34 provinces.



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

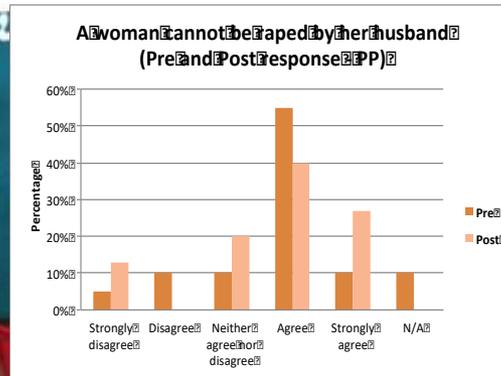
WHO is building the capacity of health care providers in humanitarian settings, through the health cluster, in **Afghanistan, Bangladesh, Democratic Republic of Congo, Iraq, Nigeria, and the Syrian Arab Republic.**



# 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**

