Improving the primary health care response to violence against women in low and middle income countries (HEalthcare Responding to violence and Abuse - HERA)

Background

Overall, 35% of women globally have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence, with a higher prevalence in most low and middle income countries (World Health Organization). In the Occupied Palestinian Territory, around 37% of married women have been exposed to at least one form of violence by their husbands (Palestinian Central Bureau of Statistics, 2011). This violence is associated with myriad adverse health consequences for women and children in the home that are exposed to it. HERA (**He**althcare **R**esponding to violence and **A**buse) is a multi-country study which emerged from the urgent need to improve the identification and response of primary health care services to violence against women. For the purpose of the HERA study we used the term domestic violence and abuse, drawing on two definitions of violence against women taken from the Violence Survey in the Palestinian Society (Palestinian Central Bureau of Statistics, 2011). This includes "*violence between spouses*" and "*domestic violence between household members*".

Aim of HERA

To strengthen the primary healthcare response to domestic violence in Palestine and pilot test an intervention, which includes training for providers and a referral pathway for women who are seeking help.

Objectives

1. To qualitatively explore barriers and facilitators to PHC response to VAW
2. To develop and implement a culturally appropriate intervention in two primary health care clinics (PHC)
3. To pilot test the feasibility and acceptability of the intervention using a mixed methods process and outcome evaluation

What did we do?
The study was conducted in three phases.

Phase1: Formative evaluation (assessing health systems readiness)
Between June 2017 and March 2018 a health systems readiness was conducted in two primary health care clinics based in Bethlehem and Hebron to identify barriers and facilitators to identification of women patients experiencing domestic violence and abuse, and to appropriate care and referral. Data was triangulated from the following sources.

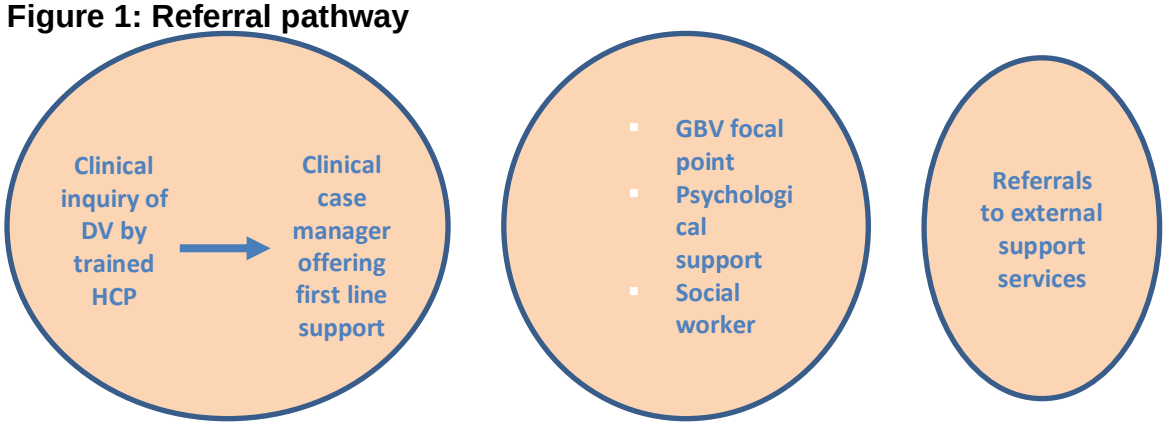
- Systematic review of prevalence of domestic violence and impact on health outcomes in clinical settings in Arab countries.
- Qualitative interviews were conducted with 20 women survivors of domestic violence and abuse who were identified by the Women's Centre for Legal Aid and Counselling (WCLAC), 12 health care providers from the two pilot clinics, and 11 officials from government Ministries and non-governmental organisations working in the area of gender based violence.
- Structured observations of the pilot clinics to explore service readiness to respond to violence against women.
- Review of key policy documents.

Phase II: Intervention development
Intervention development was informed by the results of Phase I and a key stakeholder workshop held in March 2018, which was attended by Ministry of Health officials, clinic managers, directorate level gender based violence focal points, representatives of family medicine and primary care physician organisations, and non-governmental organisations.

The research team presented key findings from Phase I and a draft of the intervention referral pathway. The aim of the workshop was to resolve key areas of uncertainty in the intervention (e.g. resource implications, role of different health care providers, logistical barriers for referral of survivors, locus of further support and counselling) and other issues before proceeding to the pilot. After the workshop, a detailed theory of change (ToC) was developed and sent to stakeholders for feedback before refinement.

Training materials for trainers and health care providers was developed by Juzoor for Health and Social Development in collaboration with An Najah National University and the UK research team. The intervention was piloted at the two clinics between April and September 2018.

Figure 1: Referral pathway



Phase III: Evaluation of pilot intervention using mixed methods

A mixed method process and outcome evaluation was conducted between April 2018 and March 2019. Data collected included:

- Semi-structured interviews with 11 health care providers, 2 trainers and 5 women who disclosed domestic violence to a provider in the clinics.
- Provider Intervention Measure (PIM) administered pre and 6 months post-training to clinic staff.
- Clinic registers on identification and referral of domestic violence cases
- Records of attendance at training

Key outcomes included number of women identified as experiencing domestic violence and referrals made and accepted, and change in health care providers' readiness and confidence to identify and respond to cases of domestic violence.

What we found?

- Identification of cases of domestic violence increased during the period of the pilot intervention. In the Bethlehem clinic 6 cases of domestic violence and abuse were identified and 15 in the Hebron clinic. However, not all cases identified were documented and this may be an underestimate. Documentation practices at the clinics was inconsistent.
- In general, women refused referrals to sources of help outside of the clinics.Womentended to associatereferral with negative consequencessuch as exposure, stigma, loss of the marriage and children. Limited mobility and freedom of movement further restricted women's access to external sources of support.
- Women described feeling relief after talking to the clinic case managers (i.e. nurses responsible for domestic violence cases)and theses clinical encounters became the intervention and a source of psychological support for women. As such, there was a containment of cases within the clinic settings and external referral to the GBV focal points and other professionals did not occur as anticipated. However, health care providers felt that this approach would be difficult to sustain in the long term due to staff shortages, lack of time and lack of appropriate training in counselling skills.

- Both in the Provider Intervention Measure and the semi-structured interviews, providers described a heightened awareness of the behavior cues and physical signs in women that raised their suspicion about domestic violence and abuse. They reported feeling more confident about asking women questions and referring them to the clinic case managers.
- Health care providers appreciated the practical elements of the training, particularly discussion of cases identified with the training team. Reinforcement training was essential to building the confidence of providers and developing their skills.
- Health care providers reported that the training was effective in clarifying the roles and responsibilities of clinic staff and of those in the Directorate health clinics, and appreciated the simple referral pathway.
- Although the Provider Intervention Measure showed an increase in providers' perceptions of personal safety when dealing with domestic violence and abuse, this was not confirmed by the semi-structured interviews. Provider's accounts show that HERA training did not enhance their feelings of safety when dealing with cases and it was felt that this was a much broader issue that needed to be addressed at a policy and legislative level.

What does this mean?

Whilst the HERA training resulted in increased identification of women experiencing violence, many challenges remain. Most importantly, 1) the need to alleviate the fears of providers supporting women patients, 2) having an appropriately trained provider to deliver first line support, advocacy and basic counseling, 3) increasing the clinics' capacity to support women who do not want external referral, 4) ensuring that private space is available in the clinics to discuss violence with women and that confidentiality of cases is maintained within the clinic. Before recommending up-scaling of the HERA model within Palestinian primary care, we will address these challenges in the next phase of the HERA programme.

Who was involved?

An-Najah National University
Ministry of Health
Juzoor for Health and Social Development
University of Bristol
London school of Hygiene & Tropical Medicine
University of Sao Paolo
World Health Organization

This study was funded by the Medical Research Council through a Global Research Challenges Foundation Award 2017 to 2019 (MR/P025102/1)