



TURNING COMPASSION INTO ACTION:

Reflections from
the Health Care
Provider Training

Chhatrapati Sambhajnagar
(Aurangabad)
District, Maharashtra, 2025

*What Works to Prevent Violence
Against Women and Girls*



BACKGROUND TO THE TRAINING

The training of health care providers (HCPs) was conducted under the Udaan project, supported by the 'What Works to Prevent Violence – Impact at Scale' Programme. This initiative aims to scale up the effective prevention of violence against women through the following approaches:

Expand

Building on the initial phase of training providers in three tertiary health care facilities, the initiative now extends training to encompass all primary and secondary health care facilities in the intervention area.

Deepen

The initiative enhances its impact on violence reduction by incorporating capacity-building for community health workers (ASHAs), thereby strengthening community-level prevention and response mechanisms.

Adapt

Drawing on lessons learned from tertiary health care facilities, the initiative tailors and adapts interventions to effectively address the contexts and challenges specific to primary and secondary health care settings.

This initiative is embedded within a randomized controlled trial using a randomized block design to rigorously evaluate both the effectiveness of the intervention aimed at reducing violence against women (VAW) and the implementation strategies necessary for its scale-up. The trial is being conducted in two randomly selected blocks of Chhatrapati Sambhajnagar district, Maharashtra, with Gangapur and Paithan designated as intervention blocks, and Kannad and Vaijapur serving as control blocks.

The intervention encompasses both health-system and community-level

components. The health-system package is designed to strengthen workforce capacity through competency-based training that enables healthcare providers to effectively recognize, manage, and refer survivors. At community level, the intervention trains ASHAs (community health workers) attached to primary health centres and sub-centres to integrate violence against women and domestic violence prevention messages into routine health promotion, act as trusted bridges between communities and facilities, and participate in strengthened referral networks. ASHAs are positioned to provide basic psychosocial support and facilitate referrals that connect survivors to health, social, and legal services.

The intervention was co-designed through a two-day consultation convening key stakeholders, including district health leadership (DHO, Civil Surgeon), CEO of the District Council (Zilla Parishad), master trainers from Phase 1 representing medical college departments, facility-level medical officers and senior nursing staff, MASUM as the implementation partner, CEHAT as the research partner, a WHO representative, and members of the research and implementation consortium of What Works to Prevent Violence. This consultative process ensured stakeholder buy-in, assessed local feasibility, and aligned the intervention with existing government structures to support potential scale-up. The training curriculum is primarily based on the WHO's 2021 revised guidelines, "Caring for Women Subjected to Violence," integrating adapted materials from the Phase-1 WHO-CEHAT curriculum, with a strong emphasis on the LIVES approach (Listen, Inquire, Validate, Enhance safety, Support). Through iterative consultations among MASUM, CEHAT and WHO, the content was tailored to accommodate the diverse backgrounds and roles of trainees across primary and secondary health facilities, with particular focus on facility readiness and clear delineation of roles among different cadres.

THE TRAINING PROGRAM

Forty-two HCPs participated in the 5-day Training of Trainers (ToT) program. The objective of the ToT was to equip healthcare providers with the knowledge, skills, and facilitation capacity to identify, respond to, and train others on healthcare system responses to VAW/domestic violence (DV) in a sensitive, ethical, and systemic manner. Once the ToT was over, a 14-batch two-day training was conducted between May to July 2025 and 278 HCPs attended the training from 17 health care facilities in the two intervention blocks. The training aimed to frame VAW/DV as a critical public health issue, strengthen survivor-centred practices, and build facility-level preparedness through institutional protocols, referrals, and coordinated support. Core skills taught were:

- Understanding VAW as a health issue: Participants identified various forms of violence and their health impacts through discussions, case studies, and reflections linking clinical and public health views.
- Reflecting on biases: Experiential tools helped explore personal biases and societal norms, promoting non-judgmental, empathetic responses toward survivors.
- Survivor-centered communication: Empathetic communication skills, including SOLER and trauma-informed care, were developed via listening exercises, role plays, and peer feedback.
- Identifying survivors: Skills to detect signs of abuse, even without disclosure, were honed through case studies and clinical simulations.
- Applying LIVES framework: Providers practiced first-line support via demonstrations and role plays, fostering sensitive communication.
- Documentation and confidentiality: Emphasis on safe, ethical documentation with practical exercises balancing detail and discretion.
- Legal knowledge and compliance: Clarity on healthcare providers' obligations under relevant laws and ethical documentation was gained through expert discussions.
- Referral systems: Survivor-focused referral pathways and multi-sectoral coordination were built through role plays and facility mapping.
- Facility preparedness: Participants assessed health facilities using a five-point framework to identify gaps and suggest practical improvements.
- Facilitation skills: Adult learning principles and group facilitation were practiced with feedback to improve engagement and clarity.
- Supervision and mentoring: Supportive supervision and team responsibility were strengthened through role assignments and reflection.
- Planning and implementation: Participants developed context-specific training schedules, SOP adaptations, and action plans through group work.

PARTICIPANTS' QUESTIONS THAT SPARKED DISCUSSION

Gender-based violence recognition

Participants sought clarity on recognizing various forms of violence, particularly exemplified by the query “Whether hysterectomies among cane-cutting women can be considered a form of violence?” This theme included understanding structural violence, identifying less obvious forms of violence, and recognizing workplace violence as suggested by a male participant.

Communication and disclosure

Practical communication challenges dominated this theme, including managing cases where family members accompany patients (preventing private disclosure), handling situations where women rush through check-ups due to fear of husbands' anger, and responding appropriately when violence is suspected but not disclosed.

Clinical documentation and privacy

Healthcare providers demonstrated significant concern about practical documentation challenges (in Udaan register), including managing situations when survivors refuse consent for documentation, maintaining confidentiality protocols, determining appropriate coding systems for domestic violence cases in registers, and establishing clear documentation standards.

Role clarity and professional boundaries

Healthcare providers expressed uncertainty about their specific roles and boundaries in responding to violence. Participants also sought clarification on the division of responsibilities between primary health centres (PHCs) and sub-centre levels, debating who should conduct initial screening, provide psychological first aid, and make referrals.

Service delivery and infrastructure

Participants raised several practical operational concerns about service delivery.

They inquired which referral services best match various survivor needs and how to ensure “warm referrals” are completed effectively. Follow-up protocols were questioned—specifically, how to verify that survivors accessed the support provided. Facility constraints also featured prominently; for instance, participants asked about securing private rooms for confidential conversations and managing situations when infrastructure or staffing shortages impede service delivery.

Legal and procedural concerns

During the training, participants asked many questions about legal requirements. They sought clarification on POCSO protocols for underage pregnancies, were unfamiliar with the PWDVA, and found the MTP Act provisions for sensitive cases confusing.

Community and systemic challenges

Participants highlighted substantial community and systemic challenges that impede effective service delivery. They asked how to navigate community backlash when families or local leaders push back against supporting survivors and how to mitigate political interference that can stall routine health services. Several noted the difficulty of operating in conservative settings where the norm is “*no one interferes*” in domestic matters, making it risky to engage with survivors.

Program implementation and effectiveness

A number of participants voiced scepticism about program impact, encapsulated by comments such as, “*It is useless to work on DV and we can do very little in this problem, and men are not going to change.*” Some sought guidance on setting realistic expectations, balancing program objectives with practical limitations, and measuring success beyond numerical targets.

ECHOES OF LEARNING - PARTICIPANT REFLECTIONS

Overcoming fears and commitment to deal with VAW survivors:

Participants moved from fear and uncertainty to empowerment, recognizing their essential role in supporting survivors. They transitioned from feeling helpless to being equipped with practical skills—knowing how to ask sensitive questions, navigate legal pathways, and provide empathetic, responsible care.

“Earlier, I felt helpless when I saw women suffering from violence; now I feel I can make a real difference.”

– HA, Paithan PHC

Consistent use of LIVES approach; providing first line support:

Participants highlighted how the LIVES approach transformed their interactions with survivors by emphasizing empathy, validation, and survivor-led care. They gained confidence to guide survivors and learned to listen without rushing to fix problems. Practical exercises underscored the importance of gentle inquiry, role-playing warm referrals, and respecting survivors' choices.

“Validation is powerful; survivors need to be heard and believed, not judged.” – CHO, Paithan PHC

Enhanced communication skills:

Participants significantly improved communication skills, especially active and non-verbal listening. Role-plays boosted confidence in handling sensitive disclosures, while enhancing sensitivity to privacy and confidentiality. By focusing on deep presence and unspoken pain, participants transformed interactions into empathetic, supportive encounters.

“Active listening can be life-saving. I feel more equipped now to provide emotional support with care.” – HA, Paithan PHC

Setting up private LIVES rooms to talk to VAW survivors:

Participants highlighted the need for dedicated, confidential spaces for LIVES consultations within health care facilities. They recommended a quiet, secure, and welcoming room with basic first aid and a calm, non-clinical atmosphere to ensure survivors feel safe and respected. Trainers also shared creative solutions to maintain confidentiality despite space constraints.

“Providing a private LIVES room will also send a message that we take violence seriously and survivors are valued here.” – ANM, Paithan PHC

Prioritizing safety and confidential documentation:

Providers recognize the need for creative solutions in constrained settings and stress that multi-sectoral support must also uphold confidentiality. They highlighted the need for secure record storage, clear role definitions for documentation tasks, and respecting survivors' choices—even when documentation is refused.

“We must always ensure privacy during consultations, even if it means bending rules occasionally to prioritize safety.” – MO, Paithan PHC

“Sometimes survivors refuse documentation, and that does not mean we deny care; respect for choice is key.” – ANM, Paithan PHC

Strengthening multisectoral coordination:

Effective collaboration with police, protection officers, and legal services was identified as essential to comprehensive survivor care. Participants emphasized that healthcare support must extend beyond the facility, involving timely coordination with law enforcement, legal aid, and social services. Regularly updated referral directories and personal relationships with officials ensure “warm referrals,” while multi-sectoral partnerships build trust and accountability across stakeholders. This integrated approach not only enhances survivor safety but also strengthens the health system’s capacity to prevent and respond to violence against women.

“Our role doesn’t end at the facility; coordination with legal, social, and police services is essential for survivor safety.” – LHV, Paithan PHC

“Building personal connections with officials helps ensure timely and warm referrals for survivors.” – LHV, Gangapur PHC

“Multi-sectoral collaboration builds trust in the health system and fosters accountability among all stakeholders.” – MO, Paithan PHC

Regular internal PHC review meetings:

Regular internal meetings were seen as vital for continuously refining response protocols, fostering accountability, and maintaining a survivor-centric approach. Participants recommended weekly discussions to identify challenges, monthly case-review meetings to share insights while upholding confidentiality, and broader team gatherings to clarify roles and ensure coordinated follow-up.

“Internal meetings will help clarify each one’s roles so our facility can respond as a unified team.” – LHV, Paithan PHC

Institutionalized team-based response to VAW:

The training fostered a truly interdisciplinary approach, bringing together doctors, ANMs, LHVs, counsellors, and support staff to learn collaboratively. This shared learning created a unified understanding of roles, ensuring that every cadre—from doctors to support personnel—knows its responsibilities in identifying, supporting, and following up with survivors. Participants emphasized that violence response must be a collective effort rather than the burden of a few individuals, leading to more comprehensive, timely, and survivor-centered care.

“This was a rare and valuable opportunity where all cadres, from doctors to support staff, learned together. It created a shared understanding, ensuring that everyone in the facility is on the same page, and that responding to violence against women becomes a collective responsibility, not just the job of a few.” – MO, Paithan PHC

Raising community awareness:

Ongoing awareness-raising is vital to empower women to seek help at primary health centres. When women understand available services and safety plans, they feel less isolated and more hopeful. Participants stressed that awareness efforts must be sustained, not one-off events, to shift deep-rooted societal norms and ensure women feel confident coming forward.

“Raising awareness empowers women to come forward and seek help at PHCs.” – MO, Gangapur PHC

GLIMPSES OF HCP ToT AND TRAININGS



