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FEEDBACK ON GENDER-BASED VIOLENCE TRAINING PROGRAM FOR HEALTHCARE PROVIDERS IN KARNATAKA, INDIA: A MIXED-METHODS PROCESS EVALUATION

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ABSTRACT

Background: Healthcare professionals (HCPs) are often the first point of contact for survivors of gender-based violence (GBV), which remains a significant public health issue and a violation of human rights in India. However, inadequate training frequently diminishes HCPs' confidence in managing GBV cases.

Objectives: This study assesses participants' feedback and perceptions on an organised training programme on GBV aimed at enhancing the skills, attitudes, and knowledge of healthcare providers affiliated with a medical college in Karnataka, India.

Methods: A mixed-methods approach was employed, combining qualitative insights from open-ended responses with quantitative data from a 7-item Likert-scale training evaluation form. Six batches of training sessions were conducted for urban and rural healthcare facilities, focusing on two groups: clinical PHC staff (ANMs, staff nurses, and medical officers) and other centre staff, as well as community-level workers (ASHAs, AWWs). The quantitative feedback was aggregated using descriptive statistics, while the qualitative data were analysed through thematic analysis.

Results: Feedback from 164 participants showed high satisfaction levels, with Median scores across all items were 4.0 (IQR = 1.0), indicating high agreement. Thematic findings highlighted increased GBV awareness, empowerment, community action readiness, and interest in participatory and culturally relevant training methods. Participants also stressed the importance of ongoing training and inclusive support to address bureaucratic and societal barriers.

Conclusion: Participants liked the training, finding it relevant for practical use and understanding GBV. The assessment emphasises the need for culturally appropriate, context-specific training and ongoing capacity-building to help HCPs manage GBV.

KEYWORDS: Domestic Violence, Violence Against Women, Community Health Workers, Program Evaluation, Health Education, Educational Measurement, Health Knowledge, Social Stigma, Women's Health, India.

INTRODUCTION

A public health concern and a significant global violation of human rights, gender-based violence (GBV) persists. Violence arising from gender inequality and structural power imbalances can take various forms, including physical, sexual, psychological, and economic [1, 2]. According to the NFHS-5, about 30% of married women in India have reported experiencing spousal violence; many of these cases go unreported due to stigma, fear, or lack of support [3]. Long-term psychological stress, reproductive health problems, and reduced health-seeking behaviour are all linked to GBV [4,5]. At the community level, frontline healthcare providers (HCPs) such as Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), and Anganwadi Workers (AWWs) are the initial point of contact for GBV survivors. They play a crucial role in identifying abuse, providing responsive care, documenting incidents, referring survivors, and ensuring their safety [6]. Formal training on GBV is not uniformly integrated into routine curricula for many frontline healthcare providers, and baseline knowledge, attitudes, and practices may vary across cadres, underscoring the need for structured training interventions.

Lack of training, societal norms, and fear of organisational or legal penalties, however, prevent many people from responding effectively [7, 8]. Efforts to enhance healthcare personnel's knowledge, attitudes, and skills concerning GBV are underway to address these challenges. These initiatives focus on survivor-centred care, confidentiality, ethical and legal issues, and intersectoral collaboration. Although significant, assessing their practical impact requires

context-sensitive approaches [9]. Feedback from participants provides valuable information for evaluating effectiveness and supporting ongoing development.

Feedback is a structured process in which participants express their opinions about the relevance, delivery, and impact of educational programmes [10]. According to educational theory, teaching efficacy is enhanced by tailoring methods to learners' needs, identifying gaps, and encouraging self-reflection [11]. To evaluate how training relates to professional duties, cultural understanding, and feasible approaches, feedback plays a vital role in the healthcare sector, particularly in the context of GBV. Feedback also functions as a diagnostic tool to measure how effectively training sessions foster knowledge and attitude development [12]. There are two primary feedback techniques: formative (for ongoing improvement) and summative (for post-program evaluation). Feedback can be delivered through various methods, such as focus groups, interviews, open-ended reflections, Likert-scale questions, and real-time comments [13]. Quantitative tools facilitate standardised evaluations, while qualitative insights provide deeper understanding of participant experiences, especially in sensitive areas like GBV [14]. Good feedback enhances education, promotes professional development, affirms experiences, and motivates responsibility [15]. However, receiving and assessing feedback can be challenging due to cultural taboos, fear of judgment, power dynamics, language barriers, or literacy issues. As GBV is a sensitive topic, these difficulties may become more acute during training. Preconceived notions, anxiety, or fear of repercussions can influence healthcare workers' perspectives and application of training. Emotional triggers and internalised social norms exacerbate these issues [16]. A comprehensive strategy is essential to overcome these barriers; thus, measures such as anonymous formats, safe feedback environments, and communication in local languages are important. Program implementers can identify these issues and adjust training to improve clinical responsiveness and community engagement through structured feedback [14].

This research is a component of a more extensive longitudinal interventional initiative designed to enhance the ability of healthcare providers to address gender-based violence in Karnataka, India. The current analysis evaluates participant feedback from a structured GBV training program. This method allows for a thorough understanding of participants' views on how relevant, clear, and useful the training was, as well as any problems, suggestions, or insights that may not be shown by quantitative measures alone. The results are meant to help make GBV training programs in primary healthcare settings more acceptable and better.

MATERIALS AND METHODS

Study Design

As part of a larger funded project titled "Catalysing Change: Enhancing the Capacity of Healthcare Workers to Address Violence Against Women - An Interventional Study in the Field Practice Area of KLE's JGMM Medical College, Hubballi, Karnataka," the feedback from participants in a gender-based violence (GBV) training programme was evaluated using a mixed-methods convergent parallel design. Both qualitative and quantitative data were collected concurrently and analysed to assess participants' perceptions of the training's relevance, delivery, and applicability to their roles as healthcare providers.

Study Setting and Duration

From January to December 2024, the study was conducted in the JGMM Medical College field practice area at KAHER University in Hubballi, Karnataka. The Urban Primary Health Centre (UPHC)-Ayodhya Nagar, the Primary Health Centre (PHC)-Adargunchi, and the PHC-Noolvi-three healthcare facilities in the Dharwad District-were the main focus of the study. In cohort 2, two additional healthcare facilities-UPHC Doddakeri and PHC Aralikatti- were included following instructions from the Dharwad District Health Authorities. This extension suggests improved the reach and effectiveness of the intervention by providing a broader representation of both urban and rural public health settings.

Primary Intervention Context

This study aimed to enhance the ability of frontline healthcare providers, including ASHAs, AWWs, ANMs, Staff Nurses, and Medical Officers, to identify, support, and assist survivors of GBV in primary health centres (PHCs) and the community. Capacity building for these HCPs is crucial as they often serve as the first point of contact for survivors.

The study used total population sampling, including all healthcare providers who met the inclusion criteria at the designated healthcare facilities, to ensure comprehensive coverage. A total of 179 healthcare providers were eligible across the selected facilities. Of these, 164 attended the training sessions (participation rate: 91.6%), and all attendees completed the feedback forms (response rate: 100%). ASHAs and AWWs involved in community-level identification and referral represented Cohort I, while PHC staff- such as ANMs, nurses, medical officers, and other personnel providing clinical care for GBV survivors- formed Cohort II. Training was conducted in six batches, with separate

sessions for ASHAs, AWWs, and PHC clinical staff. Each session lasted over six hours, combining interactive learning, scenario-based discussions, and guidance on legal and health systems related to GBV, aiming to enhance participants' Knowledge, Attitudes, and Practices (KAP).

The training formed part of a longitudinal interventional study with three phases: 1) Pre-training baseline KAP assessment, 2) Immediate post-training assessment for knowledge retention and practice readiness after intervention/training, and 3) A three-month follow-up to assess the sustainability and application of acquired knowledge.

Inclusion Exclusion Criteria

Inclusion Criteria

Healthcare providers affiliated with the selected primary healthcare facilities, including ASHAs, AWWs, ANMs, staff nurses, and medical officers, who attended the GBV training sessions and provided informed consent were included in the study.

Exclusion Criteria

Participants who did not attend the full training session or did not complete the feedback form were excluded from the analysis.

Feedback Evaluation Approach

Following each training session, the feedback was assessed using a mixed-methods approach, combining both quantitative and qualitative data to provide a thorough evaluation of the training's effectiveness. The feedback data presented in this manuscript were collected immediately after completion of each training session. Follow-up assessments at three months were conducted as part of the larger study but are not included in this analysis.

Quantitative Component

A structured feedback form with seven 5-point Likert-scale items (ranging from 1 = Strongly Disagree to 5 = Strongly Agree) was used to assess key aspects of the training. The specific domains evaluated were:

1. Relevance of the training content to participants' work
2. Clarity and organisation of content delivery
3. Effectiveness of trainer(s) in engaging and informing participants
4. Use of real-life examples and case discussions to contextualise content
5. Interactivity and participation during the session
6. Application of knowledge to real-world situations
7. Overall satisfaction with the training experience.

This quantitative data allowed for a clear, comparative analysis of participants' evaluations.

Qualitative Component

Participants could share their opinions on the training, identify any areas for improvement or difficulties, and propose modifications or additional topics beyond answering the Likert-scale questions on the feedback form. By capturing information that the structured questions could not fully address, this qualitative element provided deeper insights into the participants' experiences and perspectives.

The feedback evaluation, which combined quantitative and qualitative data, provided a comprehensive overview of the training's advantages, shortcomings, and impact on participants' educational experiences.

Data Collection and Management

At the end of each session, feedback forms were provided in the local language, Kannada for cohort 1 and in English for cohort 2, and they were completed anonymously. . Forms were checked for completeness and translated into English before being entered into an Excel database. Quantitative data were analysed using IBM SPSS Version 25, while qualitative comments were manually analysed thematically. The feedback questionnaire was self-administered and completed anonymously by participants at the end of each training session.

Data Analysis

To analyse participants' feedback on a 5-point Likert scale ranging from Responses ranged from Strongly Disagree (1) to Strongly Agree (5), non-parametric statistics were utilised, recognising the ordinal nature of the data. Medians and interquartile ranges (IQR) were employed instead of means and standard deviations, as Likert-scale responses do not assume equal intervals and may not follow a normal distribution.

All open-ended responses (n = 164) were analysed using an inductive thematic approach. Two reviewers independently coded the data and developed themes through discussion. Coding was done without a predefined framework, and themes were refined iteratively. Emerging themes included increased GBV knowledge, greater confidence and role clarity, practical application of training, training design and delivery, logistical considerations, and suggestions for scaling up. Discrepancies among reviewers were resolved through discussion.

Ethical Considerations

Ethical approval for the study was obtained from the Institutional Ethics Committee of JGMM Medical College, Hubballi (Reference No. JGMMMCIEC/058/2023; Protocol No. F-014/2023-V2; dated 26 October 2023). Written informed consent was obtained from all participants prior to their inclusion in the study. Participant confidentiality and anonymity were maintained throughout.

RESULTS

Quantitative Analysis

A total of 164 healthcare providers took part in the GBV training sessions and subsequently completed the structured feedback form. For all feedback items, the median score was 4.0, indicating a consistent central tendency across the assessed domains. The interquartile range (IQR) for all items was 1.0, suggesting low variability between the 25th and 75th percentile responses.

Alongside the ordinal data, a frequency-based analysis of response categories was carried out and is summarised in Figure 1. The percentage of respondents giving a rating of 4 or above (Agree or Strongly Agree) exceeded 85% across all items, reaching 94% for 'Clarity of GBV Knowledge' and 93% for 'Overall Satisfaction'. Among the highest-rated domains were "Relevance of Training" (92%), "Applicability in Practice" (91%), and "Engagement in Sessions" (90%). The proportion of participants selecting 'Strongly Agree' ranged from 68% to 76%, while the 'Agree' category accounted for 23% to 31% of responses. A small proportion (1%–3%) chose 'Neutral', and there were no responses in the 'Disagree' or 'Strongly Disagree' categories for any item.

Thematic Analysis of Participant Feedback

Thematic analysis of participant feedback identified key themes. Participants reported gaining increased knowledge of GBV, including different typologies, gender concepts, and legal provisions. Many also expressed greater confidences in addressing GBV and supporting survivors. There was strong interest in applying this knowledge within communities, with requests for more practical sessions and the integration of GBV topics into curricula. Feedback highlighted the effectiveness of interactive methods, culturally relevant language, and skilled facilitation. Logistics and hospitality also received positive remarks. Participants pointed out societal barriers to GBV response and prevention, such as stigma and institutional limitations, as shown in Table 1.

Feedback Parameter	% Responses ≥ 4	% Strongly Agree	% Agree	% Neutral	% Disagree	% Strongly Disagree
Relevance of Training	92%	75%	24%	1%	0%	0%
Clarity of GBV Knowledge	94%	76%	23%	1%	0%	0%
Applicability in Practice	91%	75%	24%	1%	0%	0%
Pacing of the Training	85%	70%	27%	3%	0%	0%
Effectiveness of Discussions	88%	68%	31%	1%	0%	0%
Engagement in Sessions	90%	75%	24%	1%	0%	0%
Overall Satisfaction	93%	75%	24%	1%	0%	0%

Figure 1: Distribution of Likert-scale responses across training domains (%) on a heat map

Table 1: Thematic Analysis of Participant Feedback from GBV Training

Theme	Description	Analytical Interpretation	Representative Quotations
Knowledge Acquisition on GBV	Participants demonstrated improved understanding of GBV	Participants demonstrated improved cognitive	"Gained good knowledge on GBV in detail" "Learnt about women's rights" "Got to know about the difference between sex and gender"

	typologies, gender concepts, and legal provisions.	understanding of GBV concepts, risk indicators, and response systems.	"Came to know about sex and gender, GBV, and signs, symptoms, and effects of GBV" "Got to know about mental harassment"
Empowerment and Attitudinal Shift	The training increased confidence to confront GBV and reinforced belief in gender equity.	The training fostered a shift from passive awareness to active engagement and advocacy roles in GBV contexts.	"It will give us the courage to talk about GBV." "Feeling grateful for the training" "Women have every right to stand against any wrong practice, and women are empowered to handle any designation or post." "I am always ready to stop mental and financial abuse that happens against a woman in society."
Practical Application and Community Action	Participants expressed readiness to provide survivor support and lead community awareness initiatives.	Indications of participants' intention to operationalize their training knowledge through community engagement.	"We will take the learned things forward and implement them in the community about GBV." "We can counsel regarding GBV to the survivors." "We will provide information about OSC / SAKHI to the survivors." "Understood how to create awareness and seek support regarding GBV in our vicinity of Anganwadi" "It will help me to work in the community."
Need for Continued and Broader Training	Recurrent sessions, more hands-on modules, and inclusion of GBV topics in academic curricula were suggested.	Participants advocated for systemic integration and continuity of GBV education for sustained capacity building.	"Expecting more pieces of training in the future" "Training should be extended for many days." "Arrange similar trainings for school and college students." "Consult with the education department and add it to the school syllabus / medical curricula." "Requesting more practical learning/training"
Training Design and Delivery	Interactive methods, culturally appropriate language, and skilled facilitation were highly appreciated.	Methodological effectiveness of the training was validated through participant engagement and comprehension.	"Sessions were nice with activities." "Explanation in the local language was satisfactory." "Faculty was very good." "All resource persons were exceptional." "Good response from the resource persons to any query."
Logistics and Hospitality	Logistical support (transport, food, venue) and respectful treatment enhanced the overall learning experience.	A well-organized, inclusive environment contributed positively to participant satisfaction and willingness to engage.	"Hygienic and tasty food" "We were given a lot of love and respect here." "Transport facilities were provided." "Venue was comfortable." "I liked how chocolates were given to keep us awake during sessions."
Reflections on Societal Barriers	Participants acknowledged persistent structural barriers and stigma as ongoing challenges to GBV response.	Participants demonstrated awareness of complex social dynamics that hinder effective GBV prevention and response.	"It would take a long time to stop GBV because of insecurity/stigma among the public." "Whatever is taught in the training is all happening today in society." "You have to understand the situation, respect the feelings and opinions of the survivors, and give them support and status in society."

DISCUSSION

The descriptive statistics from participant feedback show a very positive reception of the GBV training programme. A consistent median score of 4.0 across all seven items, along with a narrow interquartile range (IQR = 1.0), indicates that responses are closely grouped in the "Agree" to "Strongly Agree" range, reflecting high agreement among participants on the quality and relevance of the training (Table 1). This corresponds to Level 1 (Reaction) and Level 2 (Learning) in Kirkpatrick's Four-Level Training Evaluation Model, which assess how participants respond to and learn from a training intervention, respectively [17,18].

The consistently high median scores, narrow interquartile ranges, and the majority of responses in the "Agree" and "Strongly Agree" categories suggest that participants had very positive views of the training. The lack of negative responses and the concentration of responses at the upper end of the scale may indicate this generally favourable reception. However, this pattern may also be affected by response biases, such as the Hawthorne effect, which happens

when people change their answers because they know they are being watched, especially in structured training settings and socially sensitive situations like GBV [19].

This consistent pattern of high central tendency and low dispersion suggests that participants perceived the training as relevant and well delivered and aligns with the literature emphasising the importance of participant-centred content in capacity-building initiatives. Participants reported that the training was engaging and informative. Moreover, the data distribution characteristics (i.e., clustering and peakiness) suggest that the training received consistent positive feedback across diverse cadres of participants, such as ASHAs, AWWs, and PHC staff, with no substantial differences in perceived utility or relevance. This level of consensus in feedback is often hard to achieve in large-scale training programmes, which may inform the potential adaptation of similar training models in comparable settings.

These findings correlate with earlier research emphasising the effectiveness of structured, context-aware GBV training in boosting healthcare workers' confidence and skills. Baird et al. documented similar results in a five-year follow-up of the Bristol programme, noting increased provider confidence and lasting behaviour change after training [20]. Moreover, a WHO multi-country analysis indicated that the relevance and clarity of training materials significantly improve the health system's preparedness to tackle violence against women [21].

In our study, "Clarity of GBV Knowledge" and "Relevance of Training" received the strongest agreement, similar to the findings of Ramsay et al., who documented that well-structured, practical GBV content led to better clinical responses among UK healthcare providers [22-24]. The clustering of responses around high ratings is consistent with the results of Colarossi et al., where participants endorsed the usefulness and applicability of training in real-world settings [25].

Participants gained a comprehensive understanding of gender dynamics, forms of GBV, and legal frameworks, based on a thematic analysis of qualitative feedback. Reported changes included increased assertiveness and a stronger commitment to gender equality. This aligns with previous research indicating that culturally sensitive training improves healthcare providers' capacity to respond to GBV in Low- and Middle-Income Countries (LMICs) [23].

The willingness to participate in community outreach was a notable outcome. Many participants expressed their desire to bridge the gap between knowledge and practice by raising awareness and offering grassroots support for survivors. This self-reported willingness aligns with the Theory of Planned Behaviour, which suggests that behavioural intentions such as those mentioned here-are strong predictors of actual future actions, particularly in public health practice settings [26]. This demonstrates the effectiveness of the training's practical focus, which is crucial for frontline health workers who often serve as the initial point of contact for survivors. Moreover, participants highlighted the importance of ongoing learning and requested regular follow-ups and longer sessions. This underlines the need for continuous education to address new GBV challenges and ensure that providers have the most current information and skills.

The interactive elements of the training, such as scenarios and group discussions, were appreciated for enhancing understanding and engagement. A positive learning experience was also supported by the training environment's cultural sensitivity and logistical organisation. These points contrast with previous research from India that highlighted inadequate logistical support and poor GBV program implementation [6,7], suggesting that effective coordination can significantly boost training effectiveness. Participants identified societal barriers that hinder an effective response to GBV, such as organisational scepticism, resource limitations, and stigma, despite success stories. These challenges mirror those reported in rural South Asian areas, where contextual factors like privacy concerns, referral gaps, and a lack of institutional backing influence long-term outcomes [6, 27]. Language barriers, insufficient infrastructure, and limited community involvement exacerbate these issues in rural Karnataka, where over 20% of women who have ever married report experiencing spousal violence [3]. Improving accessibility and outcomes could be achieved by addressing these through partnerships with Panchayat leaders, involvement of ASHAs, and training in local languages. This approach aligns with broader recommendations for culturally and community-centric programming [28].

Buoyed by the enthusiasm and positive response of the participants, we aim to develop structured modules for training healthcare workers on GBV that can be utilised by other healthcare providers. The strong outcomes of the evaluation suggest that systematising these training strategies could support broader capacity-building initiatives in other healthcare settings.

Limitations

While the feedback evaluation shows promising results, several limitations should be considered. First, the findings are based on self-reported feedback and may be influenced by social desirability or courtesy bias, particularly given the sensitive nature of gender-based violence. Second, the training was delivered by faculty associated with the institution, which may have influenced participants' responses. Third, the absence of a control group limits the ability to draw causal inferences regarding the impact of the training. Fourth, feedback was collected immediately after the training sessions, and therefore does not capture long-term retention of knowledge, attitudinal changes, or actual behavioural practices. Finally, subgroup analyses by cadre (e.g., ASHAs, AWWs, ANMs, and PHC staff) were not conducted, which may mask variations in perceptions across different groups. Additionally, the study was conducted within a specific geographic and programmatic context, which may limit the generalisability of the findings to other settings.

Recommendations
Key strategies to enhance the impact of future GBV training programmes include modular training sessions spaced over time to improve pacing and retention; integrating GBV training into pre-service education for healthcare students; using technology, such as mobile learning platforms, to reach remote providers and provide continuous learning; and ensuring cultural relevance through local language delivery and context-specific case discussions. Periodic refresher training and mentorship programmes will reinforce learning, while strengthening partnerships with local governance bodies, community leaders, ASHAs, and Panchayat representatives can aid advocacy and survivor support. Lastly, linking training with clear referral and documentation pathways ensures a more systemic, survivor-centred response to GBV.

CONCLUSION

This evaluation highlights the effectiveness of a structured, culturally sensitive GBV training programme with participants reporting high satisfaction and perceived relevance. High satisfaction ratings and participants' readiness for community action suggest the programme was well received by healthcare providers. Thematic analysis indicates that the training not only enhanced cognitive knowledge but also prompted attitudinal changes, and participants expressed perceived improvements in understanding and motivation to apply learning.. Although aspects like training, pacing, and follow-up support require further development, the findings stress the importance of ongoing, contextually based capacity-building to strengthen health systems and deliver responsive care for GBV survivors.

Key Messages:
1. The GBV training received positive feedback from healthcare providers, as shown by consistently high median scores (4.0) and low variability (IQR = 1.0). This indicates strong agreement among participants regarding the training's clarity, relevance, and practical applicability.
2. Participants reported perceived increases in knowledge, empowerment, and preparedness for community-level GBV response, emphasising the effectiveness of culturally sensitive, interactive training methods and the need for ongoing capacity-building.

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