CHAPTER-III

RESEARCH METHODOLOGY

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Having discussed all concepts relevant to the present study (domestic violence, health, women's health, violence as a determinant of women's health, health care and health care system as well as quality of care) and having established the need and rationale of the study (domestic violence and health care a syllogistic tie) in chapter-I, the literature related to different aspects of the problem under study has been reviewed in chapter-II. The review chapter highlights the prevalence of domestic violence in India and its impact on women's health. It underscores the urgent need for appropriate intervention from the health care delivery system to respond to this issue and women's needs considering the socio-cultural environmental (institutional environment) context of their lives.

This chapter explains the significance of the present study for the social work profession, describes the setting of the study and the research methodology used by the researcher.

Significance of the Present Study for Social Work Profession

Domestic violence is a major national and international human rights issue that has public health, economic and criminal justice consequences. There is a growing realization globally that domestic

violence is a substantial burden on health care (WHO, 1996). Considering the high prevalence of domestic violence in India and considering its impact on women's health, it is very important that the country's health care system respond to this social issue urgently.

The Social Work profession is concerned with social health, and empowering individuals, groups and communities to work for the socially desirable goals of society (Bajpai, 1998). Moreover the profession is committed to participating in the formulation of goals, working out broad strategies in developing programmes, implementing them and providing feedback to planning on the basis of research on implementation of such programmes. The broad objective is to meet the special needs of disadvantaged individuals and groups with a view to enable them to utilize services (Gore, 1985 cited in Patel, 1999).

The social work profession is also primarily concerned with the issue of power and powerlessness (Goyal, 1999).

"The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well being ... Principles of human rights and social justice are fundamental to social work" (IFSW and IASSW, 2004).

The mandate of the professional social worker is to fight against social injustice, disempowerment and disabling effects, and work towards positive change. Thus it is obvious that the issue of violence against

women having its root in the unequal gender power relations, and domestic violence being an important factor responsible for women's poor health, becomes an agenda for social work research and intervention. The ecological model of social work identifies oppression and discrimination issues based on ethnicity, gender, class, age and sexual orientation (Parsons and others cited in Desai, 2004).

The progressive social workers strive to alter oppressive institutions, systems, beliefs and practices fundamentally by initiating social changes targeted at public issues (Desai, 2004).

The human rights framework views health as a basic human right. It also considers violence against women as a violation of women's human rights.

Thus for social work professionals working with any framework, interventions in the field of health must address the issue of domestic violence impeding a large number of women's lives. Moreover, it must be an area of concern for social workers as it threatens to nullify all what social work stands for (Gandhi, 2001) i.e., human dignity, self worth, social justice, human rights and empowerment.

India has one of the largest and reasonably well-developed health care systems in the World (Jesani, 1998). It is necessary for social workers that are part of the health care system to address this issue in their work.

Researches on domestic violence in the country as described in the 'Review' chapter, have mainly been views / opinion based studies or studies focusing on the nature and prevalence of domestic violence experienced by women. Some studies have also been conducted viewing domestic violence as a crime against women focusing on the legal interventions.

There are very few Indian studies on domestic violence that have examined the issue from women's health point of view. A social work research in the field of health had viewed cases of burns, injuries on women as an issue of health and safety (Anjaria, 1987).

Barring the few studies carried out in Maharashtra (Jaswal, 1999; Ganatra, Personal Communication cited in Gopal, 2000) Delhi (Prasad, 1999) and in Gujarat (Barge et al., 2000) the response of the health care system to the issue of Domestic Violence has hardly been researched. Moreover, there are not many social work studies related to the subject of the present research.

In this context the present study is highly significant for the social work profession as it aims to study the health care delivery system's response to the issue of domestic violence in the state of Gujarat and prepare a social work intervention plan based on providers' as well as users' (women's) perspectives and experiences that are hardly heard of or paid attention to.

It is hoped that the findings of the study would be useful to policy makers; social work and health care professionals both academicians and practitioners, women's health and human rights activists and all those involved directly or indirectly in the process of improving the life situations of women. Since the study explores the uncovered dimensions of women's experiences and health care providers' response to the issue, its findings would be equally significant to the field of women's studies and health studies as well.

The empowerment model of social work calls for maximum involvement, participation of clients in assessment planning and action to meet goals (Johnson, 1998) as well as for policy making to bring about systematic change.

"Doing service evaluation is a key part of empowerment because it means that those who fund and manage services will be required to hear the voices of those who have been traditionally silenced" (Dullea and Mullender, 1999).

Setting of the Study

The state of Gujarat, the main setting of this study is one of the economically and industrially developed states of the country. While the state has done well on economic indicators its performance on social indicators has been slower, revealing a wide gap between the status of

women and men (Gujarat State Nari Gaurav Niti, 2006). The female literacy rate in the state is 58.6 percent, while for males is 80.5 percent. The male-female sex ratio in Gujarat has declined from 934 in 1991 to 921 (878 in the 0-6 years age group) in 2001, which is a matter of serious concern. The female work participation rate is 28.03 percent compared to 55.02 percent for males (Office of the Registrar General and Census Commissioner, 2001).

Another area of concern is the prevalence of domestic violence in the state. The incidences of Domestic Violence cases are very high in the state of Gujarat. During the year 2003, 1,438 women committed suicide in the state, whereas 77 women attempted to commit suicide, 31 women died due to dowry related causes and in all 3,185 women filed complaint against their husbands or in-laws for physical or mental harassment (Source: Additional Inspector General of Police, CID Crime and Railway, Gujarat, 2005). The empirical study conducted in the state by Sriram (2001), Pathak (2001, 1992), Mehta et al., (2000), Visaria (1999) have also reported that 22 to 79 percent of women interviewed in their studies admitted having experienced domestic violence sometime in their lives.

The public health care delivery system of the state is well developed and is divided for the administrative functioning into six zones namely Gandhinagar, Ahmedabad, Vadodara, Surat, Bhavnagar and Rajkot.

There are in all 1027 Primary Health Care Centers (PHCs), 241 Community Health Care Centers (CHCs), 58 Government Hospitals (including 25 district hospitals, 4 hospitals for mental health, 1 infectious diseases hospital, 22 taluka hospitals and 6 class II hospitals) and 6 teaching hospitals (Government of Gujarat, 2003-04). Though all these public health facilities by and large cater to women from low socio-economic strata, all the medico-legal cases of domestic violence or cases with fatal consequences, irrespective of socio-economic background, and cases from urban or rural areas visit or are brought to government hospitals for primary, secondary or tertiary care.

Teaching hospitals of the state are given more importance within the zone in which they are situated. Teaching hospitals play a pivotal role not only by imparting medical education and training to future generations of health care providers but also by providing advanced treatment and care to its patients. Since teaching hospitals are considered to be 'Big Hospital' ('Mota Dawakhana'), patients prefer to visit them on their own or cases requiring advanced care are referred there by other government hospitals of the zone after providing required primary care.

Moreover, if any intervention is to be planned on the basis of the findings of the study a teaching hospital would serve as the best platform for its implementation for it being an educational institution

instrumental in generating new innovative practices and sensitizing new generations of health professionals on gender issues.

Hence Government teaching hospitals of Gujarat were purposely selected as the setting of the present study.

Research Questions

1. What are the experiences of women seeking treatment and care from the public health care delivery system?

2. Do women seeking treatment and care from the public health care delivery system experience domestic violence in their marital lives? Is domestic violence a cause of women's current health problem? What is their perception of the cause of their current health problem?

3. What is the nature of help that women would like to seek from the health care system against domestic violence?

4. How do health care providers perceive their roles in reaching out to women survivors of domestic violence? What attempts do they make to help women survivors of domestic violence?

5. What are the factors that affect health care providers' response?

Methodology

Aim of the study

To prepare a Social Work Intervention plan for including domestic violence as an agenda in the public health care system of the state based on users' as well as providers' perspectives.

Objectives of the study

The study has two parts, each having its own set of objectives.

Part-I of the study is related to a Women Users' Perspective.

Part-II of the study deals with the Health Care Providers' Perspective.

Part-I A study of domestic violence and health care - women users' perspective

Objectives

1. To find out the nature of care sought by women from the health care providers, their experiences and perception of the quality of care provided to them.
2. To find out women users' perception of the reasons responsible for their health problem/s.
3. To ascertain women users' views on the issue of domestic violence.
4. To ascertain women's experiences of domestic violence in their marital lives.

5. To explore women's need to seek help for the problem of domestic violence in their lives.

6. To seek women user's suggestions on the ways they would like the health care delivery system to respond to women survivors of domestic violence.

Part-II A study of domestic violence and health care – health care providers' perspective

Objectives

1. To ascertain health care providers' perception of women's health care seeking behaviour.

2. To find out the extent and nature of domestic violence cases encountered by health care providers in their work.

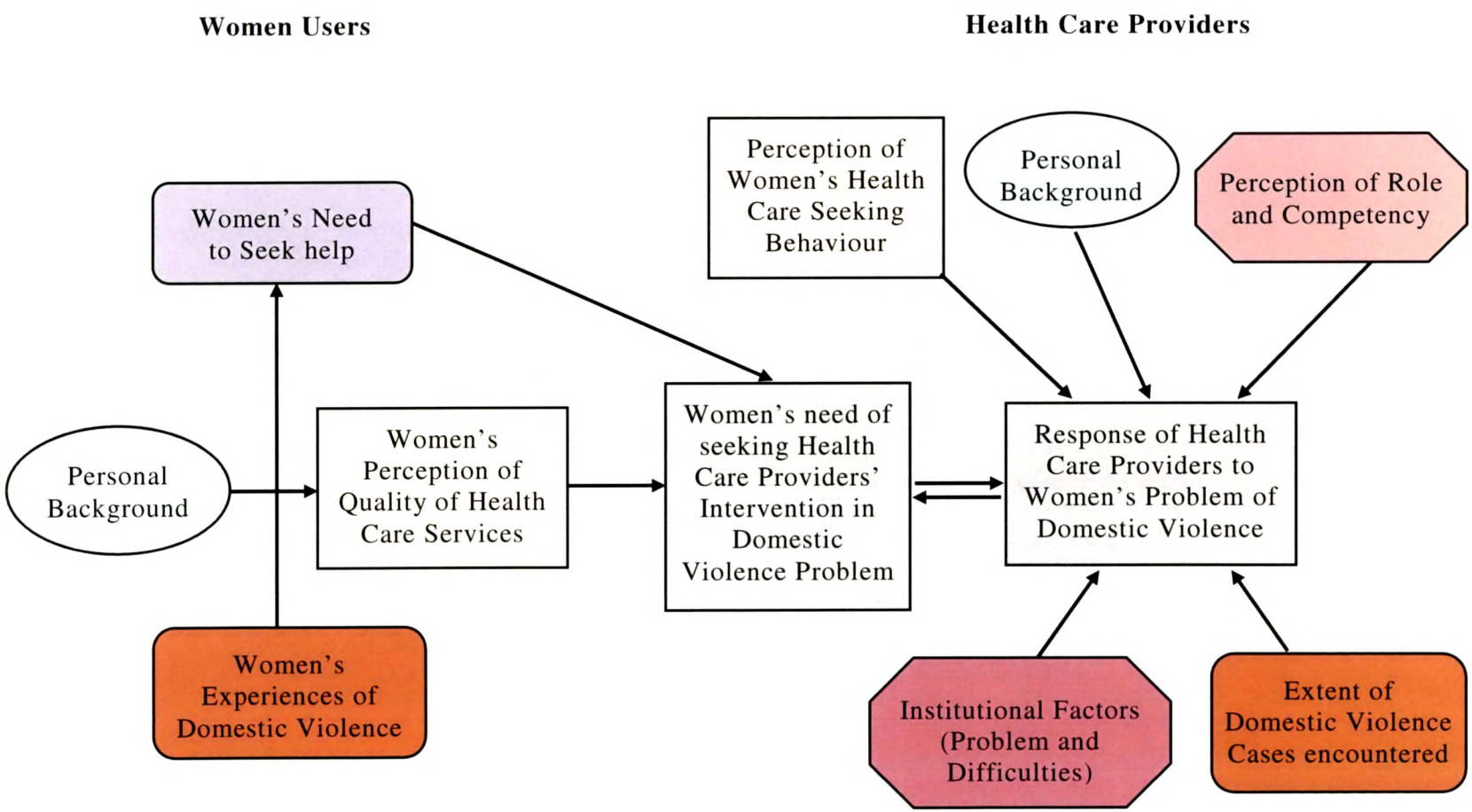
3. To understand health care providers' response to the survivors of domestic violence.

4. To ascertain health care providers' perception of any barriers experienced by them in addressing the issue of domestic violence in their work.

5. To find out health care providers' needs and wants for addressing the issue of domestic violence in their work.

The conceptual Framework that was developed for the study on the basis of literature review is presented below.

Figure-4: Conceptual Framework



Research design

The nature of the study is exploratory and a descriptive research design having quantitative and qualitative approach to data collection and analysis.

To supplement the quantitative data and to get more insight into the subject, in-depth interviews of women users were conducted for the purpose of collecting case studies

Operational definitions of the terms and variables examined in the study

Domestic violence

Domestic violence is defined as the processes by which women undergo subordination within marital relationship by their husbands, in-laws and/or other members of the marital family. It includes all acts of physical, verbal, sexual and/or psychological abuse that are experienced by a woman as threats, invasion or assault and that have the effect of hurting her (psychological, physical, sexual harm/suffering) or degrading her and/or taking away her ability to control contact with another individual.

Health care

For the purpose of this study, health care means a multidisciplinary team effort made by the health care system for caring and promoting women's health. It includes all the activities and services undertaken for the purpose of improving women's health.

Health care system

In this study health care system included distributive aspects of the system i.e., Delivery System. While delivery system includes all the three levels of Public Health Care delivery system (Primary, Secondary and Tertiary), for the purpose of this study, the government teaching hospitals of the state providing treatment and care to women survivors of domestic violence was considered as a health care system.

Health care provider

Health care provider means medical, paramedical and ancilliary staff viz. doctors, nurse, social worker, dresser, health worker or any other staff involved in providing treatment and care through the government hospital. In the following chapters, he/she is also referred as HCP or a Respondent.

Woman user

For the purpose of this study, a woman user is defined as any married woman currently seeking treatment and care from the government hospital. In the following chapters, she is also referred as a woman respondent or a respondent.

Response

This study defines response as the way health care providers behave with the survivors of domestic violence. It also includes why do they behave the way they do i.e., their views on domestic violence, their perception of

women's health care seeking behaviours, their own roles and competency and institutional factors perceived as barriers in addressing the issue.

Perception

For the purpose of this study, perception is defined as meanings given to the situation, experiences, behaviour and information. It is also the way women users and health care providers interpreted the situation, their experiences, attitude and behaviours of others and information provided to them.

Quality of care

For this study, it means the process of care giving to the way women care seekers are treated by the health care delivery system. It includes user-provider relationship as well as attitude and behaviour of health care providers towards women users.

Universe and sampling design

The study used multi stage sampling technique.

Stage-1: Selecting the hospitals

There are in all six government teaching hospitals in Gujarat. These hospitals are situated in 5 different zones of the state. Using the purposive sampling technique one government teaching hospital from each zone i.e., in all five hospitals were selected for the purpose of data collection.

Before finalizing the selection of the teaching hospital for the purpose of data collection, the researcher had looked at the data related to crime against women (2003): in Gujarat, available through the office of the Additional Inspector General of Police (CID, Crime and Railway, 2005). Crimes that were more specifically studied included those crime heads where domestic violence cases were more likely to be reported i.e., physical and mental cruelty, (Sec. 498A), Dowry Death (Sec. 304 B), Attempt to suicide (Sec.309), Suicide deaths (Cr. P.C. 174), Accidental deaths (Cr. P.C. 174), minor hurt (Sec. 324), and grievous hurt (Sec. 325, 326).

On the basis of the crimes that were reported under each of the above mentioned crime heads since the year 2001-03 at different cities / districts / units of the state (as given in the data), they were ranked from the highest to the lowest crime reporting city / district / unit. The top 5 cities / districts / units under each of the above mentioned crime heads were identified on the basis of the ranking i.e., where the selected crimes were reported higher in the state. When the ranking of each city / district / unit under different crime heads were done, the researcher observed that Ahmedabad city, Jamnagar district, Surat city, Bhavnagar district and Vadodara city emerged as the top 5 crime reporting cities / districts of the state. (Please refer Table-3)

Thus the teaching hospitals that were situated in these cities / districts that topped in the selected crimes rates and that were within separate administrative zones of the health care delivery system of the state were purposely selected for the data collection.

Table-3: Top Five City/District of Gujarat in Select Crime Against Women (2001-2003)

Sr. No.	Crime Heading	Ahmedabad City			Surat City			Baroda City			Jamnagar			Bhavnagar			Total Crime Committed in the State under the Crime Head		
		2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003
1.	Torture 498A IPC	530	413	595	118	85	116	76	67	129	163	172	129	118	100	113	3191	2866	3185
2.	Accidental Death Cr. P.C. 174	254	262	218	245	225	208	108	118	88	149	161	156	243	240	211	2750	2686	2545
3.	Suicide Death Cr. P.C. 174	144	133	112	142	141	137	70	57	67	93	98	110	107	113	119	1632	1455	1483
4.	Attempt to Commit Suicide 309 IPC	45	33	23	1	2	0	14	7	8	21	14	13	3	0	2	150	102	77
5.	Dowry Death 304B IPC	6	5	3	5	2	1	0	0	0	2	0	1	7	7	7	43	36	31
6.	Simple Hurt 324 IPC	43	55	45	17	21	24	29	21	28	44	50	28	57	47	53	817	708	591
7.	Grevious Hurt 325 IPC	19	17	10	10	7	11	24	15	19	16	19	7	9	15	14	237	209	189

Source: Additional Inspector General of Police (CID, Crime & Railway) Ahmedabad, Gujarat, 2005.

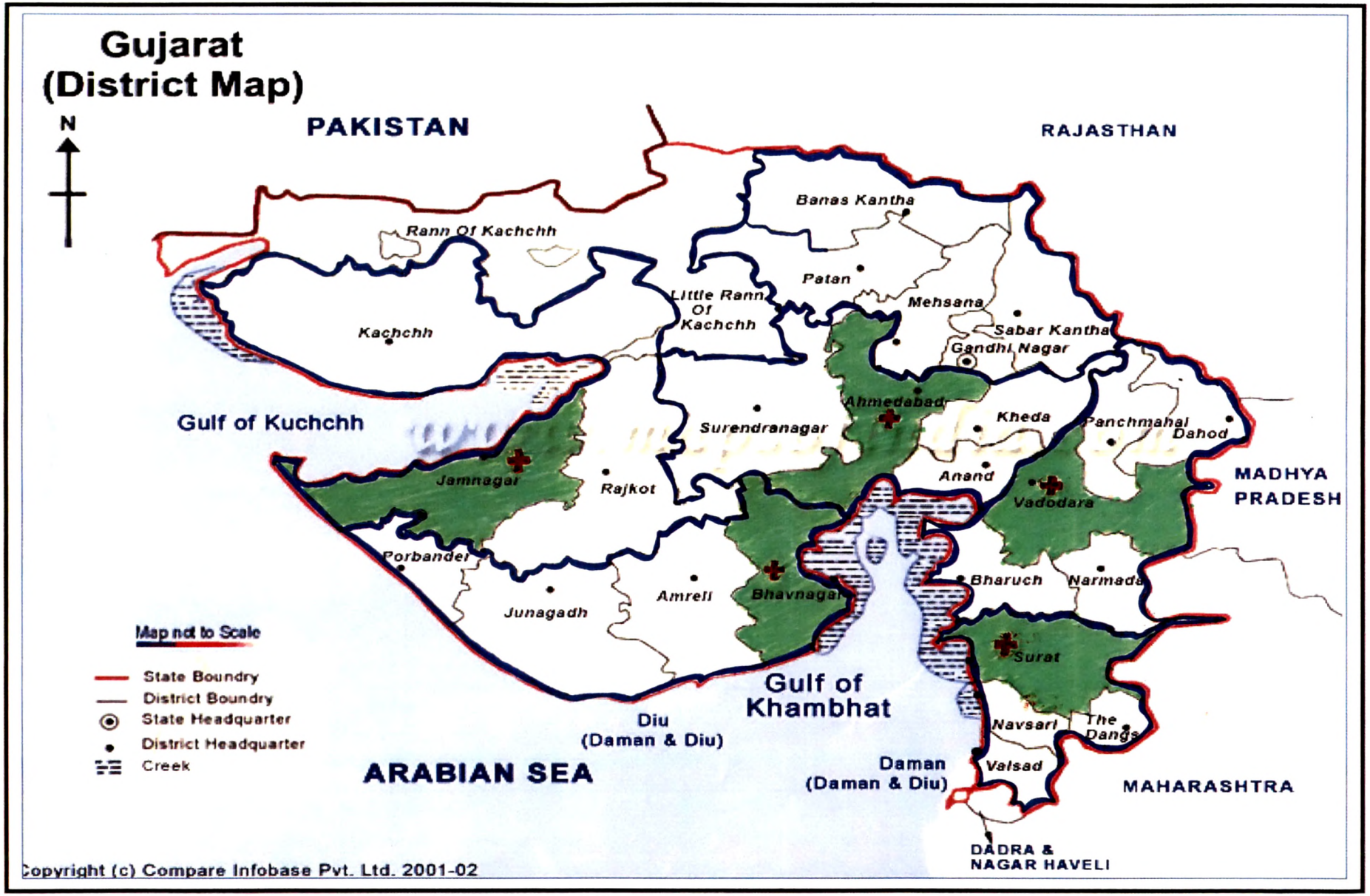


Figure 5 : Administrative Zone-wise Distribution of Select Teaching Hospitals

Following are the detail of the hospitals selected for the purpose of data collection.

Administrative Zone	Select Teaching Hospital
1. Ahmedabad	1. Civil hospital, Ahmedabad
2. Rajkot	2. G.G. Hospital, Jamnagar
3. Surat	3. New Civil Hospital, Surat
4. Bhavnagar	4. Sir, T. Hospital, Bhavnagar
5. Vadodara	5. S.S.G. Hospital, Vadodara

Women users approaching selected hospitals for treatment and care as well as health care providers working with the selected hospitals formed the universe for each part of the study.

A brief overview of the selected hospitals:

1. *Civil Hospital, Ahmedabad (CHA)* is one of the oldest, biggest and most modern hospitals of India. It is basically a tertiary hospitals situated at Ahmedabad, the largest industrial city in the state of Gujarat.Civil Hospital, Ahmedabad is attached to the B.J. Medical College housed within the same campus.

2. *Guru Govind Singh Hospital (G.G. Hospital) Jamnagar* still popularly known as Lady Irwin Hospital is situated in the new city of Jamnagar once an important princely state of Saurashtra. Today, Jamnagar is known for its coastline having industries like Essar, Reliance, Tata and numerous other industrial giants of the region. The M.P. Shah Medical College, affiliated to Saurashtra University, Rajkot, is attached to the hospital.

3. *The New Civil Hospital, Surat* is attached to the Government Medical College Surat. It is the largest public hospital of South Gujarat covering the tribal, rural, poor patients of South Gujarat. The hospital also receives patients from the neighbouring states of Maharashtra, Madhya Pradesh, Silvassa, Daman, Dadra and Nagar Haveli.

4. *Sir, Takhatsinhji Hospital (Sir, T. Hospital), Bhavnagar* is one of the recently recognized (1996) Teaching Hospitals of the state and is affiliated to Bhavnagar University. Bhavnagar is the second largest city in the Saurashtra pernnisula. It has the largest ship wrecking yard and is the center for gem cutting craft.

5. *Shree Sayaji General Hospital (S.S.G. Hospital), Vadodara* has been in operation since 1855. Vadodara, also known as Baroda, is the third most populated city in Gujarat after Ahmedabad and Surat. It is the administrative headquarters of the Vadodara district, and because of its strategic location it is called the 'Gateway to the Golden Corridor'. The S.S.G. Hospital is attached to the Medical College, Baroda which is affiliated to the Maharaja Sayajirao University of Baroda.

Stage-2: Selecting the departments

On the basis of field experiences of the researcher, review of available literature, preliminary visits of the selected hospitals and discussions with the experts from the field, ten departments of the selected hospitals were identified as the most likely departments providing treatment and care to survivors of domestic violence. Thus the study mainly includes but is not restricted only to these selected departments namely Department of Burns, Surgery, Plastic Surgery, Casualty, Medicine, Psychiatry, Orthapaedics, Obstetrics and Gynaecology, Ophthalmology and the Department of Ear Nose and Throat (E.N.T.).

Women users approaching the select department for treatment and care as well as health care providers of these departments further formed the universe of the study.

However if the researcher came across or learnt about a woman who could be a possible survivor of domestic violence seeking treatment at another department or about a health care provider involved in providing health care to the survivors of domestic violence, they too were included.

Since no gender desegregated data is available on the number of women that are provided treatment and care at the government teaching hospital in a year / month / day, it was difficult to estimate the size of the universe for the study of women user perspective. However, according to the Annual Administration Report of the Commissionerate of Health, Medical

Services and Medical Education, Government of Gujarat, 2003-04, on an average, per day 1634 out-patients and 211 in-patients are provided treatment and care by one government teaching hospital of the state. Another estimate stated in the Overview of Health Services of Government of Gujarat, 2000, is that everyday on an average a public hospital in Gujarat provides emergency care to 8 patients.

Similarly it was difficult to estimate the size of universe for the health care providers perspective study as no exact number of health care providers employed in each of the teaching hospitals was available. However, as per the Annual Administration Report of the Government of Gujarat, 2003-04, in all 1595 teaching posts of medical personnel existed at various departments in Medical Colleges / the teaching hospitals of the state. And as per the Overview of Health Services of Gujarat State, February 2000, there were 4361 and 651 filled up posts of nurse and other nursing staff respectively in the government hospitals of the state.

Stage-3: Selecting the respondents

Women users' perspective study: For the women users' perspective study, purposive sampling technique was used for the purpose of data collection. Following criteria were used to select women users from the selected departments for the purpose of study.

Criteria used for selection of women users

- Currently Married woman.
- Medico-legal case (MLC) of a woman except MLC due to vehicular accident or snake / insect / animal bite.

  And/OR

- A woman seeking treatment at the hospital due to some injury (fall, hit etc.) or Psychiatric problems.

  And/OR

- A women referred by the health care provider as a possible survivor of domestic violence.

The researcher spent 15 days in each hospital. Women users seeking the treatment from the selected departments of the hospital during this period were approached if they met the inclusion criteria. However, those women users who were grievously injured or not found in a condition to give an interview (i.e., women who were in pain, trauma, disturbed or stressed) were not approached.

Only those women users who appeared to be in a state to give an interview were approached and their consent was sought prior to interviewing them. The researcher could interview in all 143 women users. Interviews with 21 women users had to be discontinued half way due to ethical reasons as stated later in the chapter.

Health care providers' perspective study: For the health providers' perspective study stratified selection of health care providers on the basis of their occupation from the selected departments of each hospital were made using the purposive sampling technique. The criterion for inclusion was the willingness of the health care provider to spare time and to participate in the study.

While the quota size of a minimum two in case of doctors and one in case of nurses was initially designed, at the field level it could not be strictly followed due to the extremely busy schedules of the health care providers. However, it was ensured that each selected department was represented by at least one health care provider, irrespective of their occupation.

At the end, the researcher could interview 141 health care providers. Interviews with other 13 health care providers had to be discontinued half way either due to emergency calls or due to ethical reasons as given later in this chapter.

Stage-4: Selecting case studies

To get a deeper insight into the subject case studies were collected from 30 women survivors of domestic violence who were identified on the basis of interviews conducted at Stage-3. Again here the criteria for inclusion were women users' willingness to give indepth interview and those who shared about their experiences of domestic violence at Stage-3.

Tools for data collection

Two separate semi-structured interview schedules with open ended questions were prepared for the purpose of data collection; one tool for women users' perspective and another tool for the health care providers' perspective study (Please refer Appendices-A, B and C).

The tools were prepared on the basis of researcher's earlier field and research experiences on the issue of domestic violence and supported by an extensive review of available literature on the topic, and discussion with the experts in the field of study.

As the study required gaining insight into respondents' experiences, perceptions and needs, open-ended questions were included in both the tools so that respondents could express themselves freely and information gained would not be lost. However to get more specific responses on some of the parameters of the study, scales were also prepared. Thus the interview schedule consisted of open-ended questions as well as LIKERT scale types of items.

The tools were then validated for content and scales that were prepared were tested for clarity and relevance with the help from an interdisciplinary team of ten expert judges who had worked extensively in the field of social work, health and/or on the issue of violence against women. Other details of the scales are described at appropriate places in the following chapters.

Tools once prepared in English were translated into Gujarati language so that respondents could understand and express themselves in the language they were most fluent and comfortable with. Pre-testing of both the tools was done in order to test its efficacy in the field setting. Based on the experiences of pilot testing, changes were incorporated in the final interview schedule.

The major domains included in the interview schedule for the women users' perspective study were:

- Women's personal background information
- Current treatment related details (type of health problem, cause of the health problem)
- Health care seeking behaviour
- Experiences of current treatment
- Quality of care (experiences with health care providers at the time of intake, comfort with the sex of health care providers, experiences with health care providers, perception of health care providers' response and attitude and behaviour of providers)
- Views on domestic violence
- Experiences of domestic violence and
- Women's need to seek intervention in domestic violence problem affecting women's lives

The major domains included in the interview schedule for the health care providers' perspective study were:

- Health care providers' personal background information
- Perception of women's health care seeking behaviour
- Nature of interventions in domestic violence cases
- Perception of barriers in addressing domestic violence (reasons related to self role and competency, institutional factors, views on domestic violence)
- Personal experiences of domestic violence, and
- Needs and requirement to address the issue of domestic violence in work

Ethical considerations

Domestic Violence itself is a very sensitive topic. It tries to get into those 'personal' aspects of individuals lives that they may not like to recall or talk about. The entire study was conducted with due sensitivity and attention to the safety and confidentiality of all the respondents. Ethical considerations were revised and finalized on the basis of Ethical and Safety Recommendations of WHO for Research on Domestic Violence against Women (WHO, 1999b).

Women users' perspective study

- The focus of the study was framed as a study of women's experiences with the health care system to enable women respondents to explain their participation in the study to others safely.
- Interviews were conducted only when privacy was possible.
- Informed verbal consent was obtained from respondents after providing them with the due information about the study. They were interviewed only if they 'wanted to'.
- All the efforts were made to reduce any distress caused to the respondents. They were made comfortable by providing counseling, and extending possible support. However, this was not done as a condition for women to participate in a study.
- Interview was terminated or subject of discussion was changed if the researcher found the respondent to be in the state of physical, psychological pain during an interview or when an interviewee expressed her unwillingness to respond to any question or when an interview was interrupted by someone.
- Interviews with women users were concluded on a positive note. Each woman was thanked and appreciated for sharing important information, which would be used to help other women. Women respondents were informed of their rights under the law and that no one deserves to be abused.

Health care providers' perspective study

- They were assured that full confidentiality would be maintained and that no judgments would be passed on them or on their department or hospital's capacities or competency at any stage of the study.
- Interview was terminated when someone interrupted it or when the health care provider showed his/her discomfort or unwillingness to continue with the interview.

No pressures or compulsions were exercised on health care providers or women users to participate in the study.

Procedure of data collection

The data for the study was collected between May to October, 2005 after procuring the necessary permissions from various authorities.

Personal Interview technique was used to collect data from both the group of respondents namely, women users and health care providers. At the end, in-depth interviews of survivors of domestic violence were conducted. Two different procedures were adopted by the researcher for personal interviews for the Women Users' perspective study and for the Health Care Providers' perspective study. However these procedures as described below, were not mutually exclusive as the researcher was collecting data for both studies simultaneously.

Procedure adopted for the women users' perspective study

Step-1 : Identification of women users meeting the inclusion criteria for the study in different department of a large hospital was a challenge. Different techniques mentioned below were adopted by the researcher to meet with this challenge.

1. *Personal observations* : Visiting departments during OPD hours and sitting next to the health care providers. When women with injury or psychiatric problems were found, they were approached once they completed their discussion and/or treatment with the health care providers.

   Making daily visits to the inpatient wards of the selected departments during visiting hours and meeting women who could be meeting with inclusion criteria set for the study. These women were approached later to seek more details.

2. *Referral by health care providers* : Meeting health care providers of the selected departments with a request to refer any women who they have identified as a survivor of domestic violence.

3. *Referring the records* : Referring to medico-legal records of the hospital to identify if any medico-legal case of a woman was registered at the hospital when the researcher was not around the casualty department. If any such case registration was found and if the woman was admitted to the hospital then visit to the respective department was made.

Step-2: After identifying women users who could possibly meet with the inclusion criteria set for the purpose of study, these women were approached to seek more details. They were interviewed only if they met the criteria and were willing and able to participate in the study.

To facilitate the entire process of identifying and tracing women respondents in a big public hospital, the researcher had prepared a formatted register for each of the selected departments after pilot testing where in she noted down the details that helped her not only find her respondents but also plan daily schedules. (Please refer Appendix-D).

While most of the OPD women users who participated in the study were interviewed in one sitting, for inpatients/admitted women users' multiple visits (ranging from two to six) had to be made.

To ensure privacy and provide comfortable environment, women users admitted to the inpatient ward were interviewed when they were alone, whereas OPD women users were interviewed either in a room / cabin made available to the researcher in the selected department or at times in a secluded corner of the hospital. Everyday the researcher spent around 8-10 hours (sometimes stretching upto 12-15 hours) in one hospital and could interview 2 women respondents on an average. There were also days when no interview of women could be conducted.

Procedure adopted for health care providers' perspective study

Step-1 : On approaching each hospital, the researcher first tried to acquire the directory of the hospital where available. Information provided in the directory acquainted the researcher with the hospital set up, different departments, wards numbers, OPD days / timings, names and contact numbers of Heads of Departments, Heads of Units etc.

In the absence of such a directory, the researcher tried to gather this information from the display board or inquiry counter of the hospital or from the hospital's administrative office.

Step-2 : Preliminary visits to the selected department's OPD and In wards were made and first contact was established with the Head of the Department / Unit, Incharge Nurse etc. Health care providers from each of the selected departments were approached, beginning with the senior most health care provider in each occupation category, and appointment for interview was sought. Only those health care providers who were willing to participate and spare time for the study were interviewed.

To facilitate the process of data collection the researcher had developed a formatted register that included details of the hospital, departments and health care providers. This register also served as researchers' appointment diary. (Please refer Appendices-E and F).

Data analysis

Since the study had generated qualitative as well as quantitative data, its analysis also involved both the methods.

Qualitative data had been analysed using the following steps.

- Simplification of data into specific preliminary domains of the study.
- Forming of categories under the salient domain.
- Coding the interview schedules on the basis of categories formed under each qualitative domain.
- The coded interviews were compared in terms of the categories and the meanings attached to it. Discrepancies if found, were corrected.
- Culling out patterns of responses and the simple frequency analysis gave the needed information related to the major qualitative domains.

Computer aided analysis of Quantitative data was carried out using SPSS package. Frequencies and percentages were obtained to find major trends. Likert scales used in the schedule were analysed giving respondents positive scores to negative scores.

Simple bivariate and univariate tables with percentage analysis were prepared and Chi-Square test was applied to find the associations between variables, wherever found relevant.

Limitations of the study

1) The researcher's field experience with this study immediately made her realize that it was not possible (as well as ethical) to interview women users who had just reached the hospital with major injuries as they were not in a state to answer. Similarly, asking health care providers who were extremely busy attending a critical patient for an interview would not be an easy task. Thus the study do not include perspective of some of these women and health care providers.

2) One more limitation of this study is the restricted time spent at each hospital. Collecting data within the limited time available, demanded time management on the part of the researcher. While utmost care was taken to reach out to as many respondents as possible of both the groups, it is likely that the researcher would have missed out on meeting some of those who visited the hospital in her absence (at night) or when she was busy interviewing other respondents.

However, help from unexpected quarters came through. A friend who was also trained in the field of social work volunteered to provide administrative assistance in terms of seeking an appointment from health care providers because many times multiple visits (atleast 3 to 4) had to be made either to the OPD, ward or to their personal cabins to get an appointment of a single health care provider. There were some health care providers in all the hospitals who showed their interest and willingness to

extend help. They informed researcher about her possible respondent, when the researcher met them; some even called up the researcher on her cell phone to inform her "Ben, tamaro case avyo chae" (Sister, a case has come for you!).

3) Interviewing health care providers across different categories of occupations posed a problem. Our society being hierarchical, junior health care providers were not willing to participate without the permission of their seniors and some of the senior health care providers were not willing to participate as they did not have the time (nor any interest in the issue).

4) The present study was limited to public health care delivery system. Private health care sector shares a large part of India's total health care delivery system. The perspective of its 'users' and 'providers' can bring in more insight on the subject under study.

Presentation of the research report

This report is divided into seven chapters. The first chapter discusses the concepts related to domestic violence and health care, the links between the two, and establishes the rationale for the present study. The second chapter reviews relevant empirical researches and literature on domestic violence, its impact on women's health, the health care system's response to domestic violence, and women's experiences with the health care system, focusing on quality of care.

The third chapter describes the aims and objectives of the study, the research methodology adopted for the present study. Chapter four presents the findings of the study of women user's perspective of the health care system's response to domestic violence. It includes their perceptions about the quality of care. The fifth chapter contains the findings of the study of health care providers' perspective on the issue of domestic violence.

Chapter six presents the findings from the in-depth interviews with women survivors of domestic violence. The last chapter contains a summary of the results and discussion of the findings, and conclusions. It also presents a social work intervention plan for including domestic violence agenda in the health care system of Gujarat. It also provides suggestions for future research in the area of the present study.