RESPONDING TO DOMESTIC VIOLENCE IN PREGNANCY

Sanjida Arora, Padma Bhate-Deosthali and Sangeeta Rege

Intervention Team : CEHAT: Sujata Ayarkar, Rajeeta Chavan and Aarthi Chandrasekhar
MCGM: Chitra Joshi and Mrudula Sawant

Cehat

RESPONDING TO DOMESTIC VIOLENCE FOR IMPROVING MATERNAL HEALTH OUTCOMES: AN EVALUATION OF A COUNSELLING INTERVENTION FOR PREGNANT WOMEN IN MUMBAI

Sanjida Arora, Padma Bhate Deosthali and Sangeeta Rege

Intervention Team
CEHAT: Sujata Ayarkar, Rajeeta Chavan and Aarthi Chandrasekhar
MCGM: Chitra Joshi and Mrudula Sawant

Cehat

Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

Published in 2018

For additional copies of this report, please contact:

Centre for Enquiry into Health and Allied Themes (CEHAT)
Survey No. 2804 & 2805
Aaram Society Road
Vakola, Santacruz (E)
Mumbai - 400055
Tel.: (91) (22) 26673154, 26673571
Fax: (91) (22) 26673156
Email: cehat@vsnl.com
Website: www.cehat.org

Citation: Arora, Sanjida, Bhate-Deosthali, Padma and Rege, Sangeeta (2018). Responding to Domestic Violence for Improving Maternal Health Outcomes: An Evaluation of a Counselling Intervention for Pregnant Women in Mumbai, CEHAT and MCGM, Mumbai, India.

ISBN : 978-81-89042-82-0

Cover design by: Isha Deosthali

Layout designing: Pradeep Kapdekar

Printed at:
Satam Udyog
Parel, Mumbai-400 012.

FOREWORD

The world over, pregnancy usually conjures up images of joy and celebration, and of increased care and support for the woman who is bringing forth a new life. Unfortunately, not all women share this experience. Studies show that between 4-9% of all pregnant women experience emotional, sexual or physical violence from their intimate partner during their pregnancy. Society pays a high price for such violence. Intimate partner violence (IPV) contributes to poor care-seeking behaviour, higher risk of pregnancy-related morbidity and negative pregnancy outcomes. What can be done to mitigate these adverse consequences of IPV during pregnancy? This report describes a successful health facility-based intervention with pregnant women experiencing IPV.

I have had the pleasure of knowing about and learning from CEHAT's successful Dilaasa initiative, which was the first-ever health facility-based IPV intervention tailor-made for Indian settings. The present report describes yet another successful initiative by the CEHAT Team. The intervention requires skilled personnel but is feasible and replicable as part of routine antenatal care provided in public or private health facilities and calls for relatively modest resources. More importantly, the intervention is comprehensive and is based on feminist principles of responding to women's practical needs. The significance of the intervention would be appreciated when we note that the prevalence of IPV in pregnancy (16%) among women was much higher than pre-eclampsia (8-10%), HIV (0.8%) and Hepatitis B (1-9%). A brief counselling intervention delivered as part of routine ANC to women helped women to recognise IPV as an issue of power and imparted skills to remain safe and manage the violence. Several months after the intervention, physical, emotional and financial violence were found to have reduced and physical and emotional health had improved. The study provides much-needed evidence on the need for integrating routine screening and response to IPV in all maternal health care programmes.Presented in detail and in simple language that makes for absorbing reading, this report is essential reading for everyone concerned with mitigating the consequences of IPV on women. I congratulate the the CEHAT team for this report and trust that the report will inspire many others to implement similar interventions.

Sundari T.K.

TK Sundari Ravindran
Former Professor
Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum , Kerala

ACKNOWLEDGEMENTS

At the outset we would like to acknowledge the participation, cooperation and support of all individuals and organisations whose participation, cooperation, and support made this study possible. We are immensely grateful to the administrators, doctors, nurses, aayabais, and technicians of the hospitals for supporting us in the implementation of the project.

We extend our sincere gratitude to the members of the Programme Development Committee: Dr. Padmini Swaminathan, Dr. Vibhuti Patel, Dr. Padma Prakash and Dr. U. Vindhya for their rigorous review of the study at different stages. We thank members of the Institutional Ethics Committee: Dr. Anant Bhan, Dr. Nilangi Sardeshpande, Dr. Surinder Jaiswal, and IEC Secretariat for the ethics review of this study. We are also thankful to Dr. Shireen Jeejobhoy and Dr. Seema Malik for their review comments.

We are thankful to MacArthur Foundation and Dipa Nag Chowdhury, Deputy Director, India Office for supporting the implementation of this action research project financially.

We sincerely acknowledge the contributions of all the researchers and the interventionists who contributed to this project at various stages; Lakshmi Priya Menon contributed to data collection, Sujata Shirsat helped in data entry and management, and Nilam Khare, Sujata Taralkar (MCGM) and Archana Mali (MCGM) supported the project by providing crisis intervention services to women during different stages of project.

We thank Dr. Padma Prakash for editing the study report. A special thanks to Pramila Naik and Vijay Sawant for their support in printing of the report.

We are extremely grateful to the women who agreed to participate in the study and shared their stories with us.

CONTENTS

ABBREVATIONS

ANC : Antenatal Care
CuT : Copper-T
DHS : District household survey
HCPs : Healthcare Providers
ICTC : Integrated Counselling and Testing Centre
MS : Medical Superintendent
PWDVA : Protection of Women from Domestic Violence Act, 2005
VAW : Violence Against Women
WHO : World Health Organization

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

The last two decades have witnessed a phenomenal growth in public health interventions to combat gender-based violence and maternal mortality. There is a growing body of literature on the link between domestic violence and maternal morbidity, mortality and poor pregnancy outcomes. Studies conducted around the globe have stressed the need to intervene with pregnant women facing violence especially in a healthcare setting in order to ensure safe motherhood. The studies unanimously concluded that HCPs are in a unique position to provide a safe, secure and confidential environment for the disclosure of abuse.

Building on the evidence of the need to implement and the effectiveness of such interventions in other settings, this study by CEHAT attempted to assess the effectiveness of a counselling intervention in an antenatal care setting for pregnant women facing domestic violence. A group of women was followed for six weeks after delivery to assess the impact of intervention. The study was carried out in two public hospitals in Mumbai that provide both primary and secondary healthcare services. Women who came for their antenatal care registration were screened for violence using a screening tool. Since the tool was being implemented for the first time, the screening was carried out by trained counsellors. The women who were found to face violence were provided a counselling intervention and were followed for six weeks after delivery. Healthcare providers of the gynecological department in both the hospitals were trained to identify women facing violence based on certain standard signs and symptoms, and to refer them to counsellors for support services.

The study provides valuable information on the feasibility of an intervention in a healthcare setting. The various aspects of feasibility included were: willingness of women to disclose violence in healthcare setting; support from the health system, and the experience of counsellors in implementing the intervention. Further, the study also assessed the impact of the counselling intervention on the health of women, and their coping and safety behaviors.

Key Findings

- The overall prevalence of violence during pregnancy was found to be 16 per cent. This includes women who faced violence in the past and who normalized the violence and those who disclosed having faced violence during screening.

- The prevalence and pervasiveness of violence, established during this study, is found to be comparable to the prevalence of several common conditions like gestational diabetes and pre-eclampsia for which screening is routinely carried out during antenatal care. This builds a strong case for the inclusion of an intervention for violence in maternal healthcare services.

- A large proportion of pregnant women in the study were young or in the early years of marriage, which reiterates the significance of positioning an intervention in antenatal care setting for early identification of women facing violence.

- For the majority of women, violence was present in the marital relationship for many years of marriage. Evidently violence does not cease during pregnancy. In other words, pregnancy does not provide protection to women from abuse.

- Emotional violence was found to be the most common form of abuse faced by women during pregnancy followed by financial and physical violence. The various forms of emotional abuse include verbal abuse, threats to remarry, extra-marital relationship of the husband, and restricting mobility.

- Violence during pregnancy was found to have a detrimental impact on the health of women. About 72 per cent of women who were less than 54 kg at the time of ANC registration were in their second and third trimester. Further, about 61 per cent of the women were found to be anemic. The prevalence of anemia was found to be higher than in other hospital-based studies, indicating the consequence of violence for women.

- All the women in the study talked about emotional health consequences like feeling unhappy, worthless and nervous due to violence during pregnancy. Significantly, 29 per cent of women reported having suicidal thoughts during pregnancy.

- For 22 per cent of the women the unwanted pregnancy was a consequence of violence. The pregnancy was the result of forced sex and the husband's refusal to use a contraceptive.

- About 29 per cent of women registered for antenatal care in the second and third trimesters due to violence. Various forms of violence prevented these women from accessing maternal healthcare. These included a restriction in mobility, excessive burden of household chores, and the lack of physical and financial support.

- The healthcare providers trained as a part of this study played a crucial role in referring women to counsellors for psychosocial support. There were 14 women who were identified and referred to counsellors by HCPs.
- The experience of counsellors involved in screening women reflected the comfort level of women while talking about violence. Women found the hospital setting to be a safe and accessible place for seeking support services.
- The participation rate in the study was around 91 per cent, which is much higher than in other studies on violence against women. This again highlights the readiness of women to talk about violence in a healthcare setting.
- In their narratives, women strongly articulated the helpfulness of the intervention in the form of emotional support and information about their rights.
- The study recorded several cognitive changes among women about the understanding of violence as a result of the intervention. Importantly, women began to recognize the impact of violence on health, and the need to raise their voices against violence.
- Almost all women adopted a safety strategy in the event of an episode of violence. Some women also implemented strategies like keeping valuables in a safe place in order to ensure safety in the future.
- About half the women, who had not taken any action at the individual level before the intervention, reported employing a safety strategy after the intervention. Actions taken at the individual level include taking up a job, moving out of the matrimonial house and opting to medically terminate the pregnancy.
- About 84 per cent of the women said that their health status got better after intervention. The study found a significant decrease in negative emotional health consequences due to violence among women after the intervention.

Learnings and Recommendations

- The findings of the present study on the prevalence of violence during pregnancy and its health consequences warrant a routine enquiry of domestic violence by healthcare providers during antenatal care.

- The health system provides the first opportunity for intervention, since antenatal care is a necessary and unavoidable contact for women and in developing countries, likely to be the only point of contact with the health setting.
- Antenatal care also provides the opportunity for repeated contact with healthcare providers, which helps in rapport building and routine enquiry of violence.
- Training of healthcare providers and institutional support play an important role in sustainable implementation of such interventions at the level of the health system.
- Healthcare providers of different cadres involved in providing antenatal care are in a unique position to screen women for violence, provide psychological first aid and refer them for support services.

1. INTRODUCTION

Over the last three decades, violence against women has been recognized as a public health issue of global significance. Violence has far reaching consequences for physical and mental health of women. It is known as the leading preventable cause of morbidity and mortality of women (Sharma, 2015). Although, research studies have documented variation in the extent and forms of violence in different settings, women are universally more likely to face violence from their intimate partners (Heise, 1994). Intimate partner violence has been defined as the behaviour within an intimate relationship that causes physical, sexual or psychological harm including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours (WHO & London School of Hygiene and Tropical Medicine, 2010). The landmark study by WHO on women's health and domestic violence in 10 countries found that the prevalence of physical or sexual violence from an intimate partner varies from 15 to 71 per cent (Garcia-Moreno et.al., 2005). In Indian context, the fourth round of the National Family Health Survey, which is a representative household survey, found that 29 per cent of ever married women in the age group of 15 to 49 years faced spousal violence (IIPS & ICF, 2017).

Pregnancy is a vulnerable period for women during which the health consequences due to violence are intensified. The issue of violence during pregnancy has been researched widely in recent times owing to its public health implications. Various aspects of the phenomena have been explored by researchers, with main emphasis on its prevalence and health consequences. A growing body of literature has identified violence during pregnancy as one of the risk factors for poor maternal health and adverse pregnancy outcomes (Espinoza & Camacho, 2005; Islam et.al., 2017).

Further, violence during pregnancy has been found to be a contributing factor to homicide and suicide among pregnant women in developed countries (Campbell, 1999, Granja et.al., 2002; Palladino et.al., 2011). Despite this established role of violence during pregnancy in causing maternal mortality, its role has been neglected while estimating maternal mortality. The definition used for calculating maternal mortality excludes deaths during pregnancy due to homicides, suicides and accidents and consider them as "pregnancy related deaths". There are limited research studies on suicide that have distinctively looked at pregnant women. The literature based on maternal mortality has mostly focused on bleeding, pre-eclampsia, unsafe abortion and other obstetric complications. Also, the issue of accessibility to maternal health services has not been studied in the context of

gender relations. Hence, IPV has been termed as the hidden component of maternal mortality. The burgeoning knowledge on violence during pregnancy is advocating for an inclusive definition of maternal mortality which encompasses the role of violencE in pregnancy (Alves et.al., 2013; Espinoza & Camacho, 2005).

The following sections present the information available in literature about violence during pregnancy. These sections also attempt to identify the gaps in literature to draw upon the need to conduct a research study with an intervention for addressing violence during pregnancy in the context of maternal health. It is a comprehensive review of published literature on violence during pregnancy. The studies mentioned below in different sections are the ones that are published in English, are based on primary and/or secondary data, and present the diverse findings of different themes.

1.1 Prevalence

There is a huge body of literature suggesting a high prevalence of violence during pregnancy and its impact on women and pregnancy outcomes. These studies providing information on prevalence have used different methodologies. Table 1.1 illustrates the research designs used by study its which have estimates of the violence during pregnancy.

The evidence for the occurrence of violence during pregnancy on a large scale comes from a WHO multi-country study. This study, which was carried out in the form of population-based surveys, found that the prevalence of violence during pregnancy varies from 1 to 28 per cent, with most of the countries in the range of 4 to 12 per cent (Garcia-Moreno et.al., 2005). These findings are reinforced by another international study based on analysis of DHS data from 15 countries which found that the prevalence ranges from 2 per cent of ever pregnant women (in Australia, Denmark, Cambodia and Philippines), to 13.5 per cent (in Uganda) and is usually between 3.8 to 8.8 per cent. (Devries et.al., 2010). These large surveys are only representative and included behaviourally specific questions about violence which prevents underreporting as compared to studies which used global screening questions (Ellsberg et.al., 2001). Varying prevalence of intimate partner violence during pregnancy has been reported from different parts of the world due to difference in socio-cultural norms and the methodologies used for estimation.

Table 1.1
Prevalence studies with research designs

RESEARCH DESIGN	CHARACTERISTICS
Population based survey	Large scale, representative and use behaviourally specific questions
Community based research studies	Small scale, use direct questions on violence
Facility based studies	Cross sectional and longitudinal studies
Meta-analysis	Based on secondary data from different sources

The evidence on the prevalence of violence during pregnancy is mostly limited to physical violence, and is generally facility-based. The small scale population based studies on violence are limited in number. A study carried out in central America in 50 geographical clusters found that 17 per cent of women experienced physical, sexual and emotional violence during pregnancy (Valladares et.al., 2005). The prevalence of physical violence during pregnancy was found to be 1 per cent by a longitudinal prospective study in England (Bowen, Heron, Waylen & Wolke, 2005). Similar prevalence rate (1.2 per cent) of physical violence during pregnancy was noted in a study conducted among residents of Vancouver (Janssen et.al., 2003).

Apart from population-based studies, there are numerous others conducted in hospital settings. The findings from a longitudinal cohort study based in a clinical setting in Sweden found the prevalence of violence during pregnancy as 2 per cent (Finnbogadottir, Dykes & Wann- Hansson, 2016). Parys and colleagues (2014) in their facility-based study conducted at multiple sites found that 10.6 per cent of pregnant women attending antenatal care faced violence during pregnancy.

The information about the nature and the prevalence of violence during pregnancy is limited in developing countries (Islam et.al., 2017). A recently published study based on combining data from 12 studies through meta- analysis found that on an average 8 per cent of women experience violence during pregnancy (Wang et.al., 2017). The prevalence was found to be very high (66 per cent) by a study conducted in Bangladesh using population based data (Islam et.al., 2017).

The meta-analysis of hospital based studies carried out in Africa found the prevalence varying from 2 to 57 per cent (Shamu et.al., 2011). A study carried out among women attending antenatal care in Kenya found an overall prevalence of 37 per cent with psychological

violence as most common, followed by sexual and physical violence (Makayoto et.al., 2014). Similar findings were reported by another study carried out in Malaysia with emotional abuse as the most common form of violence (Khaironisak et.al., 2016).

In the Indian context, the majority of research has focused on women of reproductive age without distinctly looking at pregnant women. The National Family Health Survey (2016) included the questions on violence during pregnancy for the first time in its fourth round. The prevalence of violence during pregnancy was found to range from 0.2 to 6.5 per cent (IIPS & ICF International, 2011). These findings need to be interpreted carefully by considering the fact that questions asked in survey captured the physical violence only which is usually reported less during pregnancy. A population-based study carried out in seven cities of six Indian states found a 13 per cent preponderance of violence among pregnant women (Peedicayil et.al., 2004). Another large-scale population based study in three states of India reported that 31 per cent of women faced violence during their recent pregnancy (Babu & Kar, 2012). On the other hand, some clinic-based studies stated prevalence of physical violence during pregnancy, to range from 22 to 48 per cent (Purwar et.al., 1999; Khosla et.al., 2005; Chhabra, 2007).

In general, the prevalence of violence during pregnancy was found to be higher in clinical studies than in the population-based studies. This may be because women in healthcare setting are likely to accept the enquiry about violence, which is widely evident globally as well as in India (Boyle & Jones, 2006; Swailes, Lehman & McCall- Hosenfeld, 2017 ; Decker et.al., 2013; Suryavanshi et.al., 2018).

1.2 Dynamics and Associated Risk Factors

The other dimension that has been explored is the dynamics of violence during pregnancy. Information on this aspect is important to design interventions for women facing violence during pregnancy. Some studies have found that pregnancy may provide protection from abuse (Taylor & Nabors, 2009), while others have shown contradictory findings that violence may escalate during the pregnancy (Jasinski, 2004 ; Castro et.al., 2014).

In addition to this, researchers around the globe have also focused on understanding the evolution of violence before, during and after the pregnancy. A study among antenatal care attendees in Rwanda reported that pregnancy does not provide any protection from violence, but only a decrease in physical violence; the reduction in physical violence was attributed to cultural norms which consider assaulting a pregnant woman as unacceptable

(Rurangirwa et.al., 2017). Similarly, a study carried out in 11 antenatal clinics of Belgium found a decrease in physical violence during pregnancy (Parys et.al., 2014).

Also, there are studies focusing on the risk factors associated with the experience of violence during pregnancy. These factors delineated by literature for violence during pregnancy are not different from those that are associated with violence against of in general. The presence of abuse before pregnancy has been found to be a definitive predictor of violence during pregnancy (James et.al., 2013). The other risk factors for violence during pregnancy documented in the literature based on secondary data include the lower educational status of women, young age, and unwanted pregnancy (Devries et.al., 2010; Goodwin et.al., 2000). Studies from Western countries have established the greater propensity of single women to face violence during pregnancy as compared to married women (Anderson et.al., 2002; Saltzman et.al., 2003).

1.3 Health Consequences

Violence during pregnancy can have fatal as well as non-fatal health consequences for pregnant women and the child (WHO, 2011). Fatal outcomes include suicide and homicide, and non-fatal outcomes take into account physical, mental, reproductive health and negative health behaviour. Physical and mental health consequences include injuries, physical impairment, physical complaints, depression and lack of attachment to the child. Reproductive health consequences comprise miscarriage, unsafe abortion, low birth weight, pre-term delivery and STIs. Negative health behaviours include delayed antenatal care, smoking, drinking alcohol and drug abuse.

There are abundant research studies in developed countries that have examined the health consequences due to violence during pregnancy. Campbell and colleagues (2003) in their study based in 11 US cities analysed pregnancy as a risk factor for homicide of women by the intimate partner. A study based on CDC's surveillance system in 17 US states found that deaths due to suicides and homicides during pregnancy outnumber the traditional causes of maternal mortality (Palladino et.al., 2011).

A study among women attending antenatal care found that 19 per cent were HIV positive while 17 per cent had STIs who were facing physical violence during pregnancy (Matseke et.al., 2012). As it was antenatal care a cross-sectional study, it could not establish the temporality between violence and health consequences. Furthermore, it has been recorded that violence during pregnancy may result in adverse health outcomes such as miscarriage, stillbirth, preterm labor and low birth-weight babies (Devries et.al., 2010). A study in Ghana

on physical violence during pregnancy and pregnancy outcomes found violence to be significantly associated with perinatal and neonatal mortality (Pool et.al., 2014). Several mental health effects of violence are also known to complicate pregnancies. For instance, depression and PTSD, which are both known to be higher among women facing domestic violence, are likely to lead to C-sections, instrumental vaginal deliveries, spontaneous abortions, hyperemesis, preterm contractions and postpartum depression (PPD) (Kendall-Tackett, 2007). A systematic review of studies exploring the correlation between violence during pregnancy and postnatal depression found violence to be an important factor in the development of postnatal depression (Antoniou et.al., 2008).

Studies in the advanced countries have emphasized on violence during pregnancy and risky health behaviour. Amaro and colleagues (1990) in their study reported that the women facing violence during pregnancy were found to be heavy users of alcohol and illicit drugs. A US-based study on secondary analysis of data reported that the women who were physically abused during pregnancy were less likely to stop smoking during pregnancy (Cheng et.al., 2016). There are also studies citing strong relationships between violence and maternal health seeking behaviour (Taggart & Mattson, 1996; McCloskey et.al., 2007). These studies concluded that IPV was an obstacle to healthcare access during pregnancy.

In India, studies quantifying the impact of violence during pregnancy on women's health are less in number. With regard to the fatal consequences of violence during pregnancy, Indian studies point to a correlation between violence, and childhood mortality (Ahmed et.al., 2006; Jejeebhoy, 1998). Ahmed and colleagues (2006) assessed that the women who faced violence during pregnancy were 2.5 times more likely to have perinatal and neonatal mortality. One study on maternal deaths in Maharashtra found that deaths due to domestic violence were the second-largest cause of deaths in pregnancy accounted for 15.7 per cent of all deaths in pregnancy, exceeded only by postpartum hemorrhage (Ganatra, 1998). The correlations between postpartum (PPD) and domestic violence have also been documented in literature from India. For example, one community based study on PPD in rural Tamil Nadu found the incidence of PPD to be 11 per cent (Chandran, 2002). This study attributed PPD to the birth of a daughter when a son was desired, relationship difficulties with in-laws and parents, and lack of physical help available to a pregnant woman. Another study from Goa found that the gender of the infant were some of the risk factors associated with developing PPD, among other economic factors such as poverty and hunger. They also found that depressed women were unable to complete their daily activities than non-depressed ones, suggesting that violence also has an impact on women's ability to function

as new mothers (Patel et.al., 2002). The evidence on limiting impact of violence on antenatal care seeking comes from a study carried out in rural India. This study found that women who faced violence during their recent pregnancy are more likely to receive their first ANC during third trimester of pregnancy (Koski et.al., 2011).

1.4 Interventions

The research conducted on the different aspects of violence during pregnancy has emphasized the need to address the same issue of violence during pregnancy. These studies have recognized and recommended the role of the health system and professionals in responding to pregnant women facing violence. This has resulted in the rise of research studies aimed at assessing the potential of the health system. The health system based interventions for women facing violence during pregnancy can be defined as the efforts to meet the needs of survivors of violence and to prevent the recurrence of violence (Kirk et.al., 2017). These interventions largely encompass violence among pregnant women in healthcare setting, referral to the services, safety planning, cognitive behavioural therapy, home visits by nurses, and offering empowerment counselling to pregnant women. Substantial evidence on these interventions, which may be useful in the Indian context can be drawn from studies implemented in healthcare settings in countries like the United States, Australia, Hong Kong, Peru. An assessment of acceptability of a gender-based violence screening programme that was implemented in Kenya looked at client experiences with the programme and provides insights into what women want from ANC services, and what would make it possible for them to disclose violence to the health care provider. Clients stated that they were more likely to seek assistance for the abuse from a hospital setting than from family and friends. Respect for confidentiality, positive provider attitudes and convenient location of services (close to the ANC) were cited as factors that would facilitate disclosure to the health care provider. Clients also stated that they wanted the provider to respect their choices and provide concrete services (Undie et.al., 2013). This sentiment is echoed in another study from Sweden, which sought to understand women's experiences of facing violence during pregnancy and also explored their interaction with the midwife (Edin et.al., 2010). The study found several reasons for why women did not disclose the violence to the midwife. Women considered midwives to be associated with the somatic aspects of pregnancy, not as a resource to access help, and hence their expectations regarding psychosocial support were quite low. Judgmental attitudes of midwives too were cited as a reason for non-disclosure; for example, one woman felt belittled by her midwife and she interpreted this as being due to the fact that she was a single mother, she always came alone, and the baby's father was not Swedish. The midwives

were described by some women as representing some kind of authority, and disclosing violence to them was threatening, as it revealed the shame of agreeing to remain in a situation considered to be so bad. Further, women who had confided in the midwife did not get much help - they received only a contact to an agency which did not help them. However there were also positive experiences with the health system that were reported by the women. One woman for instance, felt that even just the fact that the midwife listened to her was therapeutic. These experiences provide invaluable insights for training of providers in screening women for abuse. They suggest that merely implementing a routine screening programme in ANC clinics will be insufficient if the services so provided are not in keeping with women's expectations.

The content of interventions to be provided to women too has been studied and evaluated particularly in the United States and China (Parker et.al., 1999; Tiwari et.al., 2005). In both locations, the empowerment model of intervention has shown to be useful, which is also recommended by the WHO (2013) guidelines. Parker et.al. (1999) state that because violence is characterized by coercive control by the abuser, the empowerment intervention is directed towards increasing the woman's independence and control. It consists of two components - increasing the woman's safety and enhancing her choice making and problem solving. This intervention study from China added another aspect of 'empathetic understanding' to the model. The purpose was to help women positively value themselves and their own feelings, as abusive experiences are likely to be ignored particularly if they involve psychological abuse. The intervention was evaluated through a randomized control trial in an antenatal clinic in a public hospital in Hong Kong. Women in the intervention arm received a 30-minute counselling session by a midwife with counselling skills. The woman was also given a brochure reinforcing the information that was provided. Those in the control arm received a wallet sized card with information on community resources such as shelters, law enforcement, social services and NGOs. The study found that women in the intervention group had significantly improved role limitation due to fewer physical and emotional health problems and lower postnatal depression scores than those in the control group. They also reported less psychological and minor physical abuse, but no sexual and severe physical abuse.

A systematic review of interventions done by O'Reilly and colleagues (2010) found five screening studies and four intervention studies. All the five screening studies reported increased identification of domestic violence. Also, it was evident from screening studies that repeated enquiry throughout pregnancy increases identification of women facing violence. The review concluded that there is limited evidence on the effectiveness of

interventions and more research is required to establish their usefulness for women facing violence during pregnancy.

Another comprehensive review included 10 studies implementing different interventions involving health system and providers (Jahanfar et.al., 2014). The review pointed that the results on outcomes like decrease in violence and improved health of women were inconsistent across the studies and there was no significant difference found in the study and control group. Further, the information on pregnancy outcomes like miscarriage, stillbirth and abortion was inadequate. The reasons for inconsistent results were methodological issues, small sample size, and difference in measured outcomes.

The literature provides us an understanding of the expectations of women from health facilities and providers. However, there is no published research study on the effectiveness of health facility-based intervention for pregnant women facing violence in Indian context. The above interventions can be tailored and implemented in the Indian context in order to see their effectiveness for pregnant women facing violence.

1.5 Problem Statement

There is extensive empirical evidence suggesting high magnitude of violence during pregnancy, intersection of violence with adverse health outcomes, and constraining effect of violence on maternal healthcare seeking behaviour. The need to implement an intervention for pregnant women facing violence and that too in a healthcare setting has also emerged from a study based on case records of 10 years of a hospital-based crisis centre, Dilaasa[1] which provides psychosocial support to survivors of violence. Of the 2,146 women who registered at the centre during the period 2001 to 2010, there were 1,730 ever pregnant women. Amongst the ever pregnant women, 1,249 reported that they had faced some form of violence during pregnancy. 72 per cent (1249) of the 1,730 ever pregnant women reported having faced violence during pregnancy, of which 178 came to the centre when they were pregnant. What was striking is the large number of survivors reported violence during pregnancy as part of their narration of history of violence that they have faced from their husband and/or marital family. The women's experience of violence during pregnancy was not an isolated event and occurred along with other forms of severe violence, such as attempt to kill, physical assault with use of

[1] Dilaasa is a hospital based crisis centre, a joint initiative of the MCGM and CEHAT, established to sensitise Health care providers and train them to understand domestic violence as a health issue.

instruments, isolation and, forced sexual intercourse amongst others. Women reported miscarriages, stillbirths and delivery complications as a result of the violence.

The women who were found facing violence were mainly in their first two years of marriage and therefore, pregnancy provides an early point of contact as well as an opportunity to seek help. The findings of this study also indicate that the majority of women had not sought any formal support before coming to the centre. This suggests that the health system may provide the first opportunity for intervention, since antenatal care is an inevitable contact for women and likely to be the only point of contact with health setting in developing countries. In addition to this, the ongoing relationship with a healthcare provider during ANC helps to build trust, which is essential to reveal the violence faced by women.

Given the need to address the issue of violence during pregnancy, and learning from the interventions implemented in other countries, a research study was conceptualized in two public hospitals in Mumbai. The study implemented an intervention consisting of routine enquiry about violence from women coming for their antenatal care and providing counselling to women facing violence during pregnancy. The data emerging from the implementation of this intervention was analysed to assess its feasibility and effectiveness. The study was envisaged to build a case for a response to gender-based violence into maternal health services by implementing an intervention model. In this study, we have focused on domestic violence and it is defined as conduct against a woman by any male or female relative living in or has lived in a shared household, which harms, injures, harasses, threatens or endangers the woman (PWDVA Act, 2005).

The broad objective of this intervention-based research study was to assess the effectiveness of a counselling intervention for pregnant women in mitigating violence faced by women, improving self-reported health of women, coping and safety behaviour of women. The specific objectives of the study included:

1. To ascertain the number of women facing domestic violence during pregnancy.
2. To improve self-reported coping, safety behaviour and physical and mental health of women facing domestic violence during pregnancy.
3. To assess efficacy and feasibility of counselling intervention in a hospital setting for pregnant women experiencing domestic violence.

1.6 Structure of the Report

This report is divided into ten chapters. The first chapter provides evidence from the literature on violence during pregnancy and establishes the context of the study. This chapter identifies the high prevalence of violence during pregnancy, health consequences due to violence and health system based interventions that have been implemented in other countries but their effectiveness has not been established. The second chapter is on the methodology adopted by the study, which include the details of the procedures undertaken for the implementation of the research study. The intervention and conceptual framework of the study is explained in the third chapter along with the operational definition of expected outcomes. Chapters four to seven provide information of prevalence of violence, socio- economic profile of women facing violence, history of violence and health consequences due to violence respectively. The feasibility of implementing an intervention is explained in chapter eight while the expected outcomes due to intervention are presented in chapter ninth. The last chapter of this report discusses the main findings and the implications for practice that emerged out of this study.

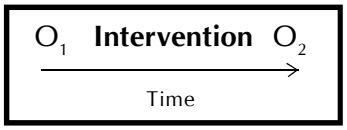
2. METHODOLOGY

This chapter provides information about the research design, study setting, and procedures undertaken for the implementation of the study. Further, it describes the development of tools for data collection and ethical considerations.

2.1 Research Design

As the primary objective of the study was to assess the feasibility and effectiveness of counselling intervention, a pre- and post research design was adopted. This means that there was no equivalent control group in the study. In this study, the same group of pregnant women was followed for 6 weeks after delivery to measure the effectiveness of intervention. The study used a pre- experimental research design instead of RCT as an RCT is highly resource intensive.

Figure 2.1
Pre- Experimental research design



* O_1 & O_2 are observations before and after intervention respectively

The research design employed in this study closely resembles a similar study carried out in South Africa among pregnant women attending ANC (Matseke et al., 2013). This study also looked at the effectiveness of a counselling intervention for women facing violence during pregnancy in health setting. The post-intervention assessment was done at three months after providing intervention, and the study captured the impact on the decrease in violence, and improved safety.

2.2. Study Setting

The study was carried out in two public hospitals in Mumbai. Both these hospitals are managed by Municipal Corporation of Greater Mumbai. Hospital A is a 436-bedded hospital with 139 male beds and 267 female beds. Hospital B is 259 bedded, with the number of male beds at 100 while female beds are 159. Both these hospitals are secondary peripheral hospitals and are located in westerns suburbs of Mumbai. These hospitals provide primary as well as secondary healthcare services in the fields of medicine,

pediatrics, surgery, gynecology, orthopedics, skin, psychiatry, ENT and dental. Under maternal and child health, the hospitals provide ANC, natal, postnatal, family welfare and immunization services. Hospital A also provides emergency services and plays an important role in treating mass casualties in the event of disasters.

Hospital A has a crisis intervention department, which was set up in 2001 as a joint initiative of public health department of MCGM and CEHAT. Since its inception, the centre is involved with providing counselling, support and referral services to women facing domestic and sexual violence.

Hospital B has no crisis centre and it was selected so that the feasibility of intervention could be tested in a hospital without a designated crisis intervention department by drawing from the existing hospital staff.

2.3 Study Participants, Sampling Size and Technique

In this study, participants were currently pregnant women attending their first antenatal appointment in hospital A and hospital B irrespective of their age, marital status, number of children, residency status and gestational age.

The results of the pilot study carried in one of the study hospitals produced a prevalence rate of 15.7 per cent of violence during pregnancy. This gave us an estimated 2700 women to screen to get a sample size of 250 women. The follow-up rate of domestic violence survivors at the crisis centre located in hospital A was 60 per cent, and based on this we drew a final sample of about 150. It was decided that 150 women would participate in both pre and post intervention assessment.

2.4. Practical Issues and Activities Undertaken

i. Who should screen the women?

One of the methodological issues we faced was about who should screen the women and at what point the screening should be carried out. This was a critical concern keeping in mind the replicability of this model in other healthcare settings. A rigorous review of existing literature and observation in hospital settings was carried out to engage with this issue.

The second activity undertaken was the observation of the proposed study settings. Researchers spent considerable time to develop a seamless identification and referral service in order to ensure that all pregnant women get screened. A detailed observation

enabled us to understand the departments with which pregnant women come in contact during their ANC.

We found that hospital A offers ANC to newly registered pregnant women for two days, Mondays and Thursdays while it is Mondays and Tuesdays in hospital B. Both these hospitals have specified timings for providing ANC services to women who come for the first time and those who come for their subsequent ANC visits. The ANC outpatient department in hospital A is located on the ground floor while in hospital B it is on the first floor. The other departments like ICTC and sonography are on the same floor as the ANC out-patient department in both the hospitals, which makes it convenient for the patient to seek services and helps proper patient flow from one department to other during ANC visit.

In both the hospitals, patients are given ANC case papers by 12.00 pm from the registration department in the order of their arrival. The procedure starts at integrated counselling testing centre (ICTC) where pregnant women are given group counselling on HIV testing, mode of transmission, diet during pregnancy and further procedures in the hospital. It takes almost an hour for a woman to complete this procedure and move to the injection OPD, which is on the same floor. Here the women need to wait around 45 minutes till the nurse comes from the general OPD.

The screening in the present study was carried out by counsellors and not health providers. Health providers of the ANC departments in both hospitals were trained to identify women facing domestic violence based on sign and symptoms. In hospital A, the counsellors of the crisis centre carried out the screening while in hospital B it was the counsellor at the family planning department. The counsellor was rigourously trained using role plays and mock sessions on how to ask about violence by the experts in the field of VAW. This is similar to other comparable intervention studies in healthcare settings that included screening for violence among pregnant women in healthcare setting, referral to the services and offering empowerment counselling to pregnant women. Except one study, screening was primarily carried out by trained professionals of the research team.

Table 2.1
Intervention studies with screening component

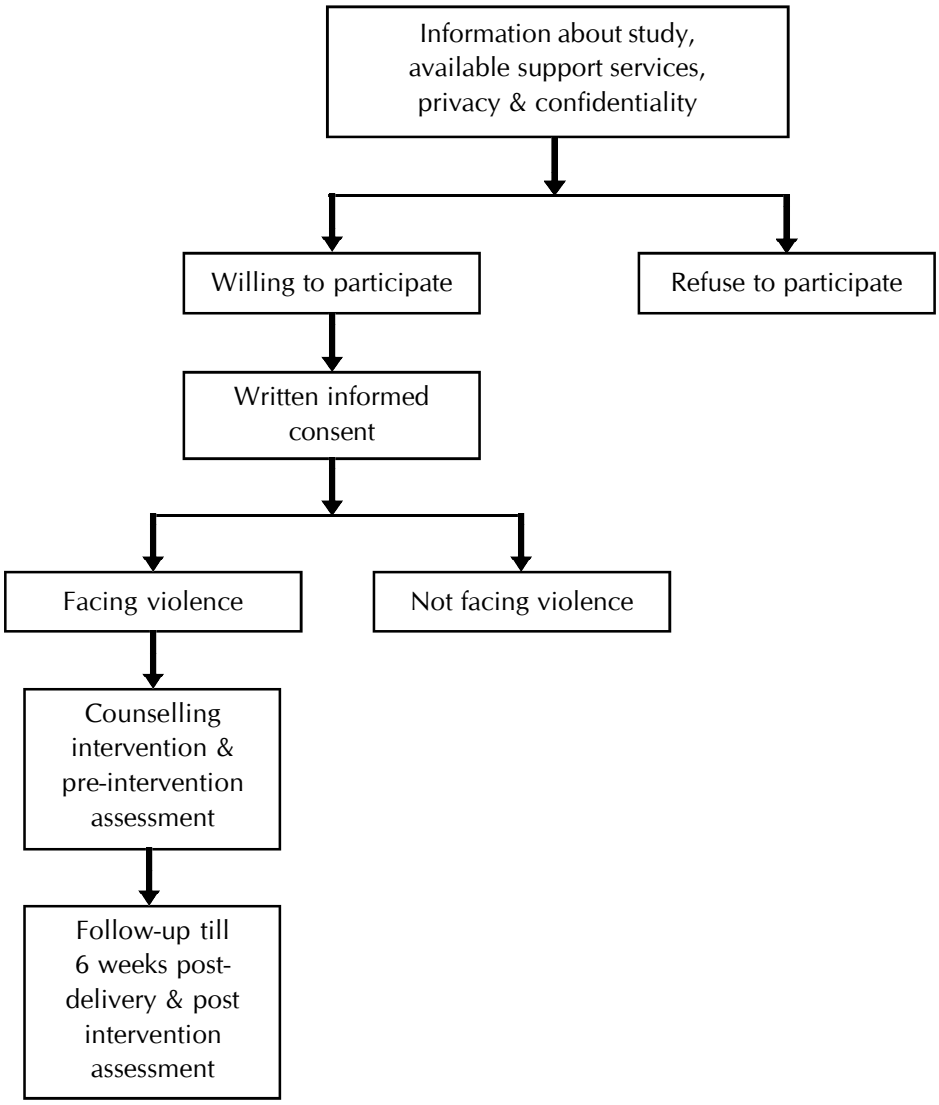
STUDY	COUNTRY	SCREENED BY
Parker et. al.(1999)	USA	Trained professionals from research team
McFarlane et. al. (2000)	USA	Trained domestic violence counsellor
Tiwari et. al.(2005)	HONG KONG	Trained professional with masters degree in counselling
Kiely et. al. (2010)	USA	Computer assisted self-interview
Taft et. al. (2011)	AUSTRALIA	Maternal/child health nurses

ii. Place for screening

The screening was done during the waiting time at the ANC department. The screening was carried out during the time when the women moved through the different departments. All departments involved in the antenatal care were trained and sensitized to the study protocol so that no woman was missed.

The counsellors opened the dialogue with women by providing information about the study, the available support services, and stressed the fact that the information would be kept confidential. The entire process was carried out in privacy. Informed consent was taken orally from every woman before the screening. For those women who agreed to participate in the study, a written consent was sought. Women who declined to participate in the study were thanked for their time and encouraged to contact the counsellors in case they changed their mind later. Women who were screened positive for domestic violence were offered counselling intervention. They were given the option of taking the intervention on the same day or on a day when she followed up for her 'blood report', which was usually two days later. However, women whose safety was a concern were advised to accept the counselling intervention on the same day.

Figure 2.2
Procedure for screening and providing intervention



iii. Screening Instrument and Tools for Data Collection

Various screening tools used in earlier studies were referred to such as Women Abuse Screening Tool (WAST), Hurt, Insult, Threaten and Scream (HITS) and Abuse Assessment Screen (AAS).

WAST is an 8-item screening tool that identifies the tension in intimate relationships in addition to physical, sexual and emotional abuse. HITS is a 4 item on a 5 point likert scale

which helps in identifying physical violence only. AAS is the most common tool used by researchers for identifying violence during pregnancy. It is a five item screening tool covering the aspects of physical, emotional and sexual abuse in addition to threats and fear.

Table 2.2
Different types of scales reviewed

SCALE REVIEWED	CHARACTERISTICS	REASONS FOR NOT USING IN PRESENT STUDY
WAST	8 item, captures physical, emotional and sexual abuse from intimate partner, response are on likert scale.	Too long, doesn't capture violence from marital family members, likert scale was not found to be suitable.
HITS	4 item, captures physical violence, response are on likert scale.	Doesn't capture sexual, financial and emotional violence, likert scale was not found to be suitable.
ABUSE ASSESSMENT SCREEN	5 item scale, captures physical, emotional, sexual violence, threats and violence from other family members as well.	Doesn't capture financial violence, starts with sensitive question on physical violence.

These tools capture intimate partner violence only where as in Indian context violence from husband and/or marital family members is more common. Further, in order to accommodate for the limited time that women have at their disposal, the tool was required to be short as well as being sensitive to identify women facing violence.

None of these tools were appropriate for the current study as women who were being approached while they were waiting for their turn at the clinic had very little time to spare. So the tool needed to be short, appropriate and sensitive. These tools screened for IPV, and in India women experience violence from their intimate partners as well as family members. WAST was too long for administration whereas HITS was found to capture only physical violence. AAS was initially found to be appropriate but when it was piloted, the team realised that there was a need to modify it. AAS begins with enquiry about physical violence first "Have you ever been emotionally or physically abused by your partner or someone important to you?" which was not found to be appropriate. The counsellors found that starting with less sensitive questions such as asking about fear from husband and/or family member was more appropriate. Asking about financial violence was also important

in the Indian context and so that was added. The screening form thus finalized covers different forms of violence including physical, emotional, sexual and financial. A woman was identified as facing domestic violence, if she answered 'yes' to any of the questions asked on the screening form.

The intake form of the crisis centre that is used for documenting all counselling sessions was used as the tool for collecting data (see ANNEXURE). The intake form contains information on the socioeconomic background of the woman, her experience of violence, present health complaints and her coping mechanisms. A few specific questions were added to the form for the purpose of this study. By doing so, the woman did not have to participate in another interview for the study. For each intervention, one member of the research team sat through the counselling so as to ensure comprehensive documentation and reduce the participant burden as well as to support the counsellors in their work.

Figure 2.3
Screening Tool

SCREENING FORM

Reg No: _____
Date: _____

Screening will be carried out by making the following statement and asking the questions below:
Many women experience violence with their husband or partner, or some other family member and are unware of the fact that this violence can lead to all kind of health problems. Because violence is so common in many women's lives, and because there is help available at X hospital for women being abused, we now ask every woman at the ANC about their experiences with violence. Please be assured that your answer to these questions will be kept strictly confidential.

1. Are you currently afraid of your husband (partner) or someone else in your family? Yes/No. If yes, from whom?
2. Does your husband give you money for household expenditure? Does your husband or someone else in your family demand money, vehicle, house or anything else from you?
3. Has your husband (partner) or someone else in your family threatened to hurt you or physically harm you in some way? Yes/No
4. Has your husband (or partner) forced you into sex or to have any sexual contact you did not want?
   Yes/No
5. Since you have been pregnant, are you facing any of the above mentioned problems? Yes/No. if yes, which one?

2.5 Training

i. Training of Healthcare Providers

Training of healthcare providers constituted an important component of intervention. These trainings were carried out in both the study hospitals with the aim to build awareness of healthcare providers about violence against women as a public health issue and their role in responding to it comprehensively. Specifically, this activity was carried out to build their understanding of violence during pregnancy, the need to screen women coming for their ANC visits, and referring them to available support services.

The providers belonging to different cadres of ANC, PNC and ICTC centre were trained in different groups in interactive and participatory training sessions. Also, the specific role that these healthcare providers can play was emphasized. For example, nurses who spend more time with patients at the bedside can be trained to provide psychological first aid to the women facing violence. Some of the providers who were trained in first training were selected as trainers for the subsequent training of new providers posted in the department.

Each training session was designed for two hours and the content of the training was based on the evidence from the literature on violence during pregnancy. The latest evidence on the prevalence and health consequences of violence during pregnancy, WHO guidelines on screening women in healthcare settings and critical role that healthcare providers can play in responding to these women was emphasized during these trainings. In addition to this, value clarification of healthcare providers about VAW was carried out to clarify their personal biases and the rationale & the objectives of the study were explained during training. Further, these trainings helped in identification of referral chains in hospitals by keeping in mind the privacy and confidentiality of women. This activity also helped in finding a suitable place for screening in hospital B where crisis centre was not established. In hospital B, it was decided that the screening will be carried out in rooms located adjacent to the room where weight and blood pressure of women is checked.

ii. Training of Counsellors

As the hospital B did not have a crisis centre, the counsellor of gynecological department of hospital B was deputed for a week to crisis centre of hospital A. The training process and content were planned with a view to perspective-building, as well as developing knowledge and skills for screening women experiencing domestic violence and for counselling. During this, the counsellor was exposed to counselling sessions, screening women for violence,

and documentation of cases. Counsellor also attended a five-day course on feminist counselling organised by CEHAT. This course aims to equip the counsellors to learn the principles and values of feminist counselling and how they can be applied particularly in relation to violence against women.

2.6 Ethical Issues

Research on domestic violence faced by women is associated with various ethical challenges. One of the core ethical concerns is with ensuring the safety and psychological well-being of both women and the research team. Considering this, various steps were taken to mitigate the associated risk.

Ensuring privacy and confidentiality of women: There were concerns that relatives of women accompanying her for ANC would come to know about woman's visit to a counsellor and women might face repercussions for same. During observations in both the hospitals we found that no family member was allowed to enter the out-patient department (OPD) during ANC. Also, at the end of the screening the woman was told that she could merely say that the counsellor was giving information about proper diet during pregnancy.

Ensuring emotional well-being of women while speaking about violence: There was apprehension that conversation on issues of violence during the screening and counselling session could trigger emotional responses among women. Also, we felt that this could affect the emotional health of counsellors due to the nature and intensity of incidents of domestic violence being narrated by the women. Women were given the option of refusing to answer questions that they found uncomfortable or to withdraw at any point of time. Further, counsellors have an open door policy in which women can return to them at a later point in time. The content of the training of counsellors dwelt on dealing with the emotional outbursts of clients. For the emotional health of counsellors, self-care was emphasized during their training. Also, case presentations and de-briefing sessions were conducted regularly to discuss challenges, difficult situations and provide active support.

2.7 Pilot Study

The team carried out a pilot study in one of the study hospitals. It extended over a week and pregnant women were screened for two days. It was considered adequate considering that 40 to 50 women come for ANC registration. Out of the 102 women screened for violence, 11 informed counsellor about facing violence while three said that they had faced violence in the past. Two women had normalized the violence that they were facing. So, the total

prevalence rate during pilot was found to be 15.7 per cent. The various objectives of the pilot study along with the changes that resulted in the final methodology are mentioned below:

- **To assess the proposed study methodology:** The rationale behind this objective was to determine feasibility of the procedures stated in the proposal. Some of these procedures included screening of all women on the same day of ANC registration without interfering with their ANC procedures and to give counselling session on subsequent visit. Another important aspect of this objective was to assess the mechanisms that were in place for ensuring privacy and confidentiality during the process. The team was able to screen all the women on the days of registration without any confusion and chaos among women. The hospital staff cooperated for referring the women to counsellor in the waiting time between the two procedures. Also, the doctor who was the last contact point for ANC procedures, reminded every woman about visiting the counsellor.

- **To test the appropriateness of screening instrument:** This was drawn from the fact that the long term expected outcome of this study is to create a model, which is replicable in all the healthcare settings with ANC services. Further, if healthcare professionals need to screen women for violence then the screening instrument should not only be sensitive and specific but also short and easy to administer. As mentioned earlier, considerable changes were made in the screening instrument after the pilot. These changes were in the form of changing the sequence of questions and addition of financial violence.

- It also helped in further refinement of the process of taking informed consent and asking screening questions. Both informed consent and the screening instrument were translated into Hindi and Marathi. The translated documents were discussed among counsellors and researchers for their appropriateness and suitable changes were made accordingly. Mock sessions for administering the instrument effectively were carried out.

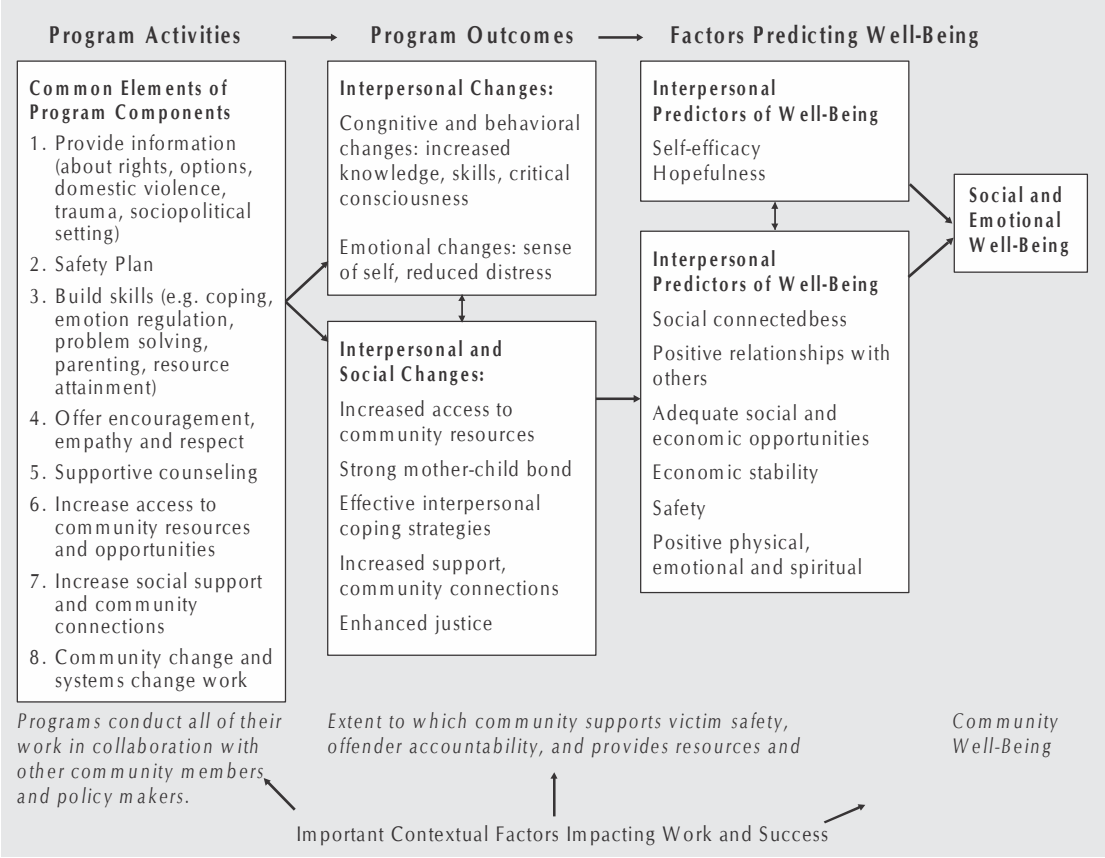
3. INTERVENTION

This chapter explains the intervention and the framework that was used to conceptualise the change expected because of intervention. We have attempted to explain the various components of this framework in the context of the intervention. The expected outcomes from the intervention in the form of improved coping strategies, safety behaviour, physical and mental health of women and decrease in violence are mapped with the outcomes and the predictors mentioned in the framework.

3.1 Framework

The conceptual framework for the study is based on Sullivan's social and emotional well-being framework (Figure 3.1).

Figure 3.1
Social and Emotional well- being framework



This framework was developed to evaluate domestic violence programmes aiming to restore well being of survivors. It describes the activities of the programmes which lead to changes at intrapersonal and interpersonal level. These changes manifest in the form of various predictors resulting in emotional and social well-being of survivors. The theory of change which includes how the intervention results in improvement in coping, safety and health seeking behaviour was developed according to this framework.

3.2 Intervention

Programme activities in the framework are related to components of the intervention. It was conceptualized that the various components of the intervention will bring changes for women at the intrapersonal and interpersonal level.

The intervention provided to women in this study was counselling based on the feminist perspective. One of the key messages given to women during this counselling intervention is that she is not at fault for the violence she is facing and then there is no justification for violence. Women are explained about the dynamics of violence, including the cycle of violence, power imbalance and patriarchy. One of the major components of this intervention is providing space to woman to share her feelings and providing emotional support. The intervention focuses on helping women recognise the strengths and resources available to them. All the strategies in the form of safety and coping behaviour planned during the counselling sessions are developed in a participatory manner with the counsellor working with women to explore various options.

Various components of intervention according to the framework are explained below:

1. Provide information: Counsellors encourage women to describe their experiences of violence, and through this they discuss with them that violence is not a result of they being at fault, rather it is an abuse of power. Through this exercise women feel validated, trusted and believed. Further, counsellors discuss with women that violence is non-negotiable. They work with women to develop ways in which they could resist violence. Such an environment is created by providing comprehensive information on laws that prevent violence and if women face violence what are the redressal mechanisms for them. Women also are explained about their rights when they approach the police to record a complaint. Often women are not aware of their rights and hence such information is a powerful tool for them.

2. Safety plan: An important component of counselling intervention is to assess the safety of women and engaging with them to devise a safety plan in order to reduce and mitigate the negative physical and psychological impact of violence. Counsellors discuss with women various strategies for increasing their safety like registering a police complaint, leaving the house when the violence escalates, taking the help of local community leaders with whom women have already established relationships, and calling upon neighbours for support. Counsellors also help women in finding an alternative shelter, whether it is contacting a formal shelter organization or helping women in identifying friends or family with whom they could stay. For women who have attempted suicide or are contemplating self-harm, attempts are made to help women realize the will to live. Counsellors enable women to recognise that the violence that she is facing has pushed her to attempt suicide.

3. Build skills: This component of the intervention is different from the Sullivan's framework. Counsellors help women to take steps to make police complaint, enhance their skills to negotiate for non-violence, garner parental and other support, present their case in the courts, police stations, and learn skills to stop violence. It is important to note that such attributes are expected to increase self-efficacy and worth amongst survivors of violence.

4. Offer encouragement and empathy: Counsellors have emphatic and non-judgmental approach towards survivors. The most important aspects of the emotional support is the way in which counsellors provide space for women to think and reflect upon their options (like MTP in case of unwanted pregnancy), to make informed decisions, to grieve, to gain emotional strength, and to heal from the trauma inflicted upon them.

5. Supportive counselling: As emotional health consequences are very common due to violence, it is important to provide emotional support to women. Counsellors help women in dealing with feelings of rejection by the partner, lack of support and suicidal ideation. Emotional support during counselling sessions focused on a number of different issues. Counselling focuses on the value of life and one's health, help in gaining perspective on the circumstances which led to the attempts, instilling hope, as well as emphasizing the importance of one's future and family.

6. Offer access to community resources and opportunities: Counsellors carry out a variety of interventions so as to ensure that women get access to resources. Women often do not have the means to start an independent life because they may not be employed, parental family may view them as a burden and hence may not offer her a place to

stay for more than a limited number of days. For women to believe that they can exist independently, several resources need to be mobilized. Shelter facilities, housing facilities, skill building and employment are some of the ways in which women's confidence can be built about their abilities to exist independently.

7. Increased social support and community connections: Intervention aims at providing comprehensive social support ot women through referral to various agencies like hospital for abortion or family planning services, police, shelter and legal services. Counsellors help women develop strategies for bringing in social support form natal family, relatives, friends, employers and neighbours.

8. Community engagement and social change work: The crisis intervention department in the hospital is engaged in influencing health sector's response to survivors of violence. The staff of centre is engaged on multiple levels of work such as advocacy efforts for hospitals to employ screening for women facing violence in antenatal departments, ensuring crisis counselling services for women at the level of hospitals, and engaging with communities and other stakeholders to improve quality of response to survivors of domestic violence. The centre also conducted workshops for developing deeper understanding of community volunteers about the issue of domestic violence. They were also trained in basic counselling skills.

3.3 Outcomes

Both intrapersonal and interpersonal changes are the expected outcomes due to intervention. Intrapersonal changes are those which result at the level of the individual, i.e. changes in thinking, perspective and understanding. On the other hand, interpersonal changes are those which are in connection with the woman's social environment like support from family. Factors at both interpersonal and intrapersonal level were addressed to ensure comprehensive social and emotional well-being of women,

a. Intrapersonal changes

1. Cognitive and behavioural changes: This entail changes among women about the understanding of phenomenon of violence. Some of these are: recognising that violence is not their fault; recognising threat to safety, and understanding the impact of violence on physical and mental health.

2. Increased knowledge, skills and critical consciousness: This includes recognition among women about violence as illegal, and information about their rights and various available support services. Survivors develop skills to take action against abuse like defending oneself during an episode of violence and registering a police complaint.

3. Emotional changes among women: This includes increased self-worth, mitigating the feelings of self-blame, reduced distress and better emotional health.

b. Interpersonal and Social Changes

1. Increased access to community resources: Increased access to safe spaces, negotiation with parental family, garnering support from them, formal shelter and employment.

2. A strong mother-child bond: The intervention helps in improving the bond between survivor and her children by enhancing her ability to take care of them. It also helps her in understading the impact of violence on her health during pregnancy and its likley impact on pregnancy outcome.

3. Effective interpersonal coping strategies: This includes stepping out of the house, taking up a job and using redressal mechanisms.

4. Increase support and community connections : Women will have increased support from the natal family, local community leaders and mahila mandals.

5. Enhanced justice: Intervention will have enhanced access to justice due to their ability to recognise violence as unacceptable and recording a police complaint.

3.4 Predictors

Further, the framework states various predictors at interpersonal and the intrapersonal level, which are targeted by the intervention to achieve social and emotional well being.

a. Intrapersonal predictors of well- being

1. **Self efficacy:** Belief and determination among women that they can change their situation and end abuse against them.

2. **Hope:** The situation will change and the willingness among women to take actions to address the violence.

b. Interpersonal and social predictors of well- being

1. Social connectedness and positive relationship with others: Strong support from various informal and formal systems. Informal support systems include family, relatives, friends while the formal system includes police, health system etc.

2. Safety: Increased physical, emotional and economic safety.

3. Health: improvement in physical and emotional health and health-seeking behaviour of women

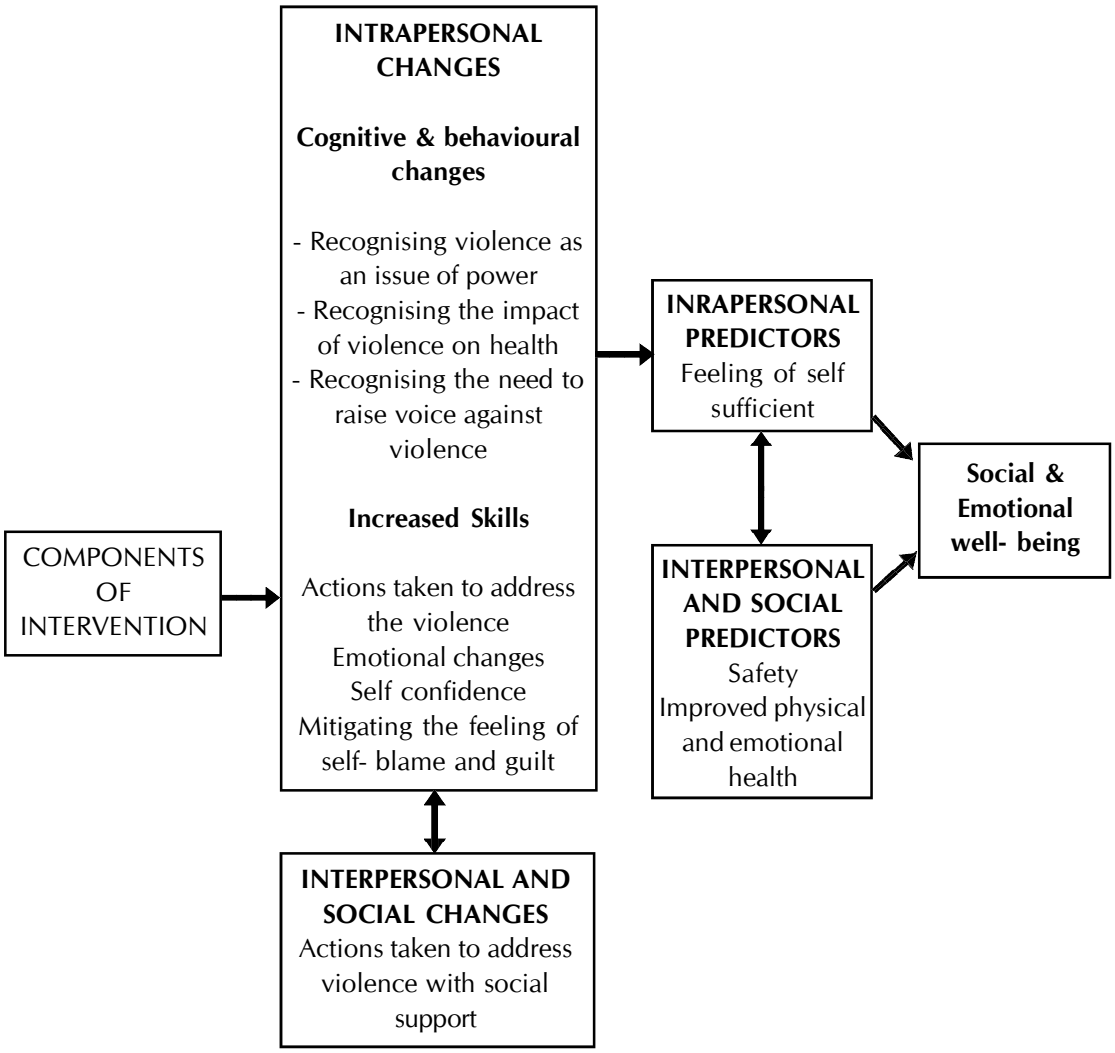
4. Possessing adequate resources: Having relevant resources for changing situations like court orders, employment, shelter services, etc.

5. Social, political and economic equity: No discrimination from systems like health and judicial in supporting women facing domestic violence like providing abortion services and appropriate treatment.

3.5 Outcomes and predictors analysed in the study

For the present study, some of the variables in the framework were combined together to frame and analyse the major outcome of cognitive and behavioural changes, coping, safety behaviour and health of women. Figure (3.2) shows a schematic presentation of the analysed themes as per Sullivan's framework.

Figure 3.2
Outcomes Analysed



3.6 Operational Definitions

The Table 3.1 below presents the operational definitions of various outcomes and predictors analysed in the study. The detailed information on these variables are provided in individual chapter.

Table 3.1
OPERATIONAL DEFINITIONS

1. **Recognising violence as an issue of power:** The understanding of woman that domestic violence is a purposeful behaviour done by the abuser for controlling her.
2. **Recognising the impact of violence on health:** The understanding of woman about the association of health problems she is facing and violence.
3. **Recognising the need to raise voice against violence:** The understanding of woman that violence is not acceptable and there is a need to raise voice against it.
4. **Actions taken to address the violence:** These are the actions taken by women at individual level like taking a job, undergoing abortion etc.
5. **Self confidence:** The belief of woman that whatever will be the situation in future, she will be able to face it.
6. **Mitigating the feelings of self blame and guilt:** The ability of women to realize that the violence they are facing is not their fault.
7. **Other emotional changes:** These are the changes executed by women to reduce the emotional consequences of violence like focusing on her health.
8. **Actions taken with the help of social support:** These are the efforts of woman with support of various informal and formal systems.
9. **Feeling of being self sufficient:** The belief of the woman that she can live independently and a violence free life.
10. **Safety:** The ability of women to use safety strategy during an episode of violence.
11. **Improved physical and emotional health:** This is defined as the better self reported health status of women, and reduced physical and emotional health consequences due to violence.

4. PREVALENCE OF VIOLENCE

This chapter gives an account of the number of women screened, who consented to participate and the women facing violence during pregnancy. It also explains the different categories of suspected and non-realization of violence and their contribution to total prevalence.

4.1 Women screened

Screening of pregnant women coming for ANC registration was carried out for 73 days in each hospital extending over 10 months. The process of screening ended when we had an adequate sample size. During the period of screening, about 2,778 women came in contact with the counsellors. Of these, 2,515 women consented to participate in study. Thus, the participation rate in this study is 90.5 per cent. The most common reason cited by women who refused to participate in the study was, "there is nothing like this in our household, and everything is fine".

Table 4.1
Summary of Screening Data

	Women came in contact[1]	Consented to participate[2]	Women reported violence[3]	Suspected[4]	Sought services[5]
Hospital A	1969	1771	288	71	101
Hospital B	809	744	120	42	54
Total	2778	2515	408	113	155

1. Women who came for their ANC registration and counsellor spoke to them about study
2. Women who gave written consent to counsellor for participating in the study
3. Women who reported violence when asked by counsellor during screening
4. Women who didn't reveal facing violence during pregnancy, but counsellor doubted it based on nonverbal communication
5. Women who were found to be facing violence during pregnancy and sought services from counsellor.

Of the 2,515 women who consented to participate in the study, 16.2 per cent reported violence. This prevalence of violence during pregnancy lies in the estimate range of 0.9 to 20.1 per cent documented in the literature (Gazmararian et.al., 1999).

Table 4.2
Total Prevalence of Violence during Pregnancy

Prevalence	Number	Per cent
Women facing violence during pregnancy	229	9.1
Non recognition of violence	96	3.8
Violence in past	83	3.3
Total	**408**	**16.2**

Of 408 women who were facing violence, 155 sought services from the counsellor. There were 3.3 per cent women who reported facing domestic violence in the past. These women informed the counsellor that there was no violence in the last 12 months and they do not require any help at present and would seek services in the future if required. Further, there were about 3.8 per cent of women who reported abuse during pregnancy, but they felt that it is part and parcel of life, and normalized the violence they were facing. Women gave various justifications for abusive behaviour of the husband such as stressful conditions at work place and considering the act of violence as a demonstration of care and concern.

Some of the narratives of women reflecting non recognition of Violence

"Husband drinks alcohol and beats me sometimes. He drinks and gets angry because he works in a factory where there is lots of tension." (24 years old woman, married for 3 years, completed primary education, never employed)

"Very often husband hits me, but it is ok as wife is meant to bear the pain." (18 years old woman, married for 1 year, completed primary education, currently unemployed).

A 24-year-old woman, married for 7 years, completed secondary education, currently employed said "*What is new about husband shouting and beating his wife as this is the story of every household"*.

There is adequate evidence about the acceptance of violence among women. A multi-country survey by UNICEF found that about 54 per cent women of reproductive age group in India feel abuse from husband is fine under certain circumstances (UNICEF, 2009). The recent NFHS (2015- 2016) survey found that there are various reasons given by women in justifying the violence from the husband. These include not respecting in-laws (41 per cent), not taking proper care of children (35 per cent) and not cooking food properly (30 per cent).

Significantly, 5 per cent of the women who were screened did not disclose violence but the counsellors suspected it. The assessment of counsellors indicated lack of eye contact, fear, and hesitation among these women. Some of the observations of the counsellors about these women documented in the screening form include:

"Survivor was keen to know about the support services but was hesitating to reveal anything about relationship with her husband" (A 23 years old woman)

"Survivor gave history of repeated STIs but refused to discuss it and was in a hurry. She got scared and kept quiet when asked about forced sex by husband" (30 years old woman, married for 8 years, illiterate, currently unemployed).

The hesitation on the part of the women to disclose violence and seek help due to stigmatization is well evidenced (Liang et.al., 2005; Hardesty et.al., 2011; Overstreet & Quinn, 2013). Overstreet and Quinn explained in their intimate partner stigmatization model how the help seeking behaviour is affected by stigma internalization, anticipated stigma, and cultural stigma. The internalization of stigma involves negative feelings of weakness and helplessness about the self. The anticipated stigma refers to the *"what others will think when they will come to know about the violence they are facing"*. The prevailing cultural beliefs in the society also discourage women from seeking help. Stigma is known to operate with other factors like lack of resources in keeping women silent about the abuse they are facing.

During the process of screening, counsellors made sure to offer positive messages to women, affirming the availability of support services at the level of hospital and the helpline number was shared. It is particularly important for women suspected of facing violence and for those who normalize it as they can change their mind to raise their voice against violence.

Out of 155 women who sought services from counsellors, post-intervention assessment was carried out with 142 women. As 13 women were not contactable at six weeks post-delivery, the total sample of the study was 142.

5. SOCIO-ECONOMIC CHARACTERISTICS

This chapter provides information on the socio-economic and demographic characteristics of women facing violence. The various characteristic mentioned include age, marital status, number of living children, education and employment.

5.1 Age of women

Table 5.1
Age of Women

Age Groups	Frequency	Per cent
18 to 24	58	40.8
25 to 31	73	51.4
32 to 38	10	7
Above 38	1	0.7
Total	**142**	**100**

The age of women varied from 19 to 40 years and the mean age was found to be 25.31 years (SD = 4.06 years). The mean age of the pregnant women facing violence in this study is consistent with the findings of the facility-based studies estimating the prevalence of violence during pregnancy (Dunn, 2002; Grove et al., 2016; Sigalla et.al., 2017). The age distribution of the majority of women was in the range of 18 to 24 and 25 to 31 years. More than half (51 per cent) of the women were in the age group of 25 to 31 years while another 41 per cent were 18 to 24 years old. Only 8 per cent of women were found to be 32 or above years of age.

5.2. Marital status

Most (97 per cent) of the women were married. Nine married women reported their present marriage as the second marriage. Seven of these nine women also reported violence from first husband while in two cases; women cited the death of first husband as the reason for the second marriage. One woman was separated and was not cohabiting with her husband for at least one year or more. There were four women who were in live-in relationships and had been abandoned by their partners after pregnancy.

Table 5.2
Marital Status of Women

Marital Status	Frequency	Per cent
Currently married	137	96.5
Separated	1	.7
Live- in relationship	4	2.8
Total	**142**	**100**

5.3 Age at Marriage

The women in the present study reported getting married at as young an age as 13 years, while the mean age of women at marriage was found to be 21.20 years (SD = 3.4 years). About 10 per cent of women got married before they were 18 years of age despite the fact that the permissible legal age of marriage in our country is 18 years for girls (Prohibition of Child Marriage Act, 2006). A larger proportion of women (53 per cent) reported getting married at the age of 21 and above. All four women who were in live-in relationships were more than 18 years of age when they started cohabiting with their partners.

Table 5.3
Age at the Time of Marriage

Age Groups	Frequency	Per cent
Below 18	14	9.9
18 to 20	49	34.5
21 and above	75	52.8
Not married	4	2.8
Total	**142**	**100**

5.4 Number of years of marriage

About three- fourth of women (74.7 per cent) were in the early years of marriage, i.e. up to five years while another 22.5 per cent of women were married for more than five years. The women who were in live-in relationships were staying with their partners for more than one year.

Table 5.4
Number of Years of Marriage

Number of years	Frequency	Per cent
Less than 1 year	16	11.3
1 to 5	90	63.4
6 to 10	20	14.1
11 to 15	10	7
16 to 20	2	1.4
Not married	4	2.8
Total	**142**	**100**

5.5 Type of marriage

66 per cent of the women reported that their marriage was arranged by their parents while 31 per cent women reported selecting their spouse on their own and getting married with or without the consent of parents. Of those who reported an arranged marriage, four women narrated being forced to marry by their parents when they did not want to.

A narrative of forced marriage from study:

I used to stay with my mother, three sisters and brother in Delhi. My father abandoned my mother and married another lady. My stepmother ill-treated me. When I was 14 years, my stepmother and father got me married to an old man. Everybody saw his photo, but nobody showed it to me. He was a drunkard. After marriage, he took me to Mumbai. After reaching here, I came to know that, he is married and he has a daughter about my age (20 year old woman).

Table 5.5
Type of Marriage

	Frequency	Per cent
Arranged marriage	94	66.2
Love marriage	44	31
Live in relationship	4	2.8
Total	**142**	**100**

5.6 Type of family

More than half (51.4 per cent) of the women reported staying in a joint family with in-laws while one- third of women were staying in a nuclear family. There were five women who were staying with their natal family along with husband for more than a year. The husbands in these cases were economically dependent on natal family.

Table 5.6
Type of Family

Type	Frequency	Per cent
Nuclear	48	33.8
Joint	72	50.7
Extended	17	12
Others	5	3.5
Total	**142**	**100**

5.7 Number of living children

Close to half of the women (45 per cent) in this study were primigravida considering that they were in the early years of marriage and 40 per cent had one child. Another 15 per cent of women reported having two or more living children.

Table 5.7
Number of Living Children

Number	Frequency	Per cent
0	64	45.1
1	57	40.1
2	17	12
3	4	2.8
Total	**142**	**100**

5.8 Education

Of the women, 68 per cent had completed secondary education, 11 per cent had completed graduation and two women were post graduates. Nearly 8 per cent of women in the study never attended school in their life.

Table 5.8
Education Level of Women

Education	Frequency	Per cent
Illiterate	11	7.7
Primary	17	12
Secondary	97	68.3
Graduation	15	10.6
Post- graduation	2	1.4
Total	**142**	**100**

5.9 Employment

About 29 per cent of women reported engaging in paid work. The majority of these women reported that they were working in the informal sector as domestic worker, housekeeper and factories. Some of them also reported working in the formal sector as nurse, teacher and a receptionist. 22 per cent of women who reported that they are not employed at present reported working before marriage. This is also evident in the history narrated by women where they report "not allowing seeking employment "as one of the forms of violence by husband.

Table 5.9
Occupation of Women

Occupation	Frequency	Per cent
Never employed	70	49.2
Currently unemployed	31	21.9
Currently employed	41	28.9
Total	**142**	**100**

6. HISTORY OF VIOLENCE

The following chapter describes the history of violence as reported by women at the time of intervention, which includes the number of years of abuse, relationship with the abuser and the experience of different forms of violence. This chapter also presents the bivariate analysis of the socio-economic characteristics and violence

6.1. Onset of Abuse

About three-fourth (74.6 per cent) of women reported facing violence soon after marriage. The forms of violence reported were dowry demands, taunts on the woman's skills at cooking and household work, overburdening of house work, etc. 25 per cent of the women reported the onset of violence as being later in their marriage, citing varied reasons for this such as husband's involvement in habits like alcoholism and gambling, husband suspecting the woman of infidelity, and discovery/confrontation of husband's extra- marital relationship by the woman.

Some narratives of women facing violence soon after marriage:

"After marriage, my husband started hitting me for small matters. He shouts at me and hits me in front of his family members. My MIL accuses me for not keeping him happy." (24 year old woman, married for 3 years, completed secondary education, currently unemployed)

"I got married at a very young age. Since the first day of marriage, my husband is not good with me. He always says "I don't like you; I don't want to see your face". He comes to me only when he needs sex." (27 year old, married for 9 years, completed primary education, never employed)

Excerpts from history of some women who faced violence later in marriage:

A 30-year-old woman married for 12 years reported facing violence from husband for last 10 years. She said *"My husband works as a driver at some business family's house & earns Rs 12,000 /month. After two years of marriage, he fell in to bad company and got in to a habit of alcohol consumption, followed by abusing me verbally & physically. He has stopped taking responsibility of our two children and giving money at home."* (30 years old, married for 12 years, completed secondary education, never employed)

A 25-year-old narrates experience of violence *"I got married 2.5 years ago and it was a love marriage. I converted my religion to Muslim from Hindu as my husband is Muslim. However, after one year into marriage, I realized that he is already married and has 2 kids from his first wife."* (21 years old, married for 2.5 years, completed secondary education, currently unemployed)

Table 6.1
Number of Years for which Women is Facing Violence

Number of years	Frequency	Per cent
Facing violence since marriage	106	74.6
Below 1 year	18	12.7
1 to 3 yrs	9	6.3
4 to 6 yrs	6	4.2
7 and more	3	2.1
Total	**142**	**100**

6.2 Relationship with abuser

In about 60 per cent of the cases the abusers were husband and marital family while in more than one-fourth (27.5 per cent) cases the abuser was the husband.

Table 6.2
Relationship with Abuser

Relationship	Frequency	Per cent
Husband	39	27.5
Boyfriend	3	2.1
Marital family	16	11.3
Husband and Marital Family	84	59.2
Total	**142**	**100**

The violence from marital family is peculiar to India and other South Asian countries as women experience violence not only from their intimate partner but also their marital family members. This needs to be factored into any research or intervention on domestic violence. Restricting the questions to IPV will under report the prevalence.

6.3 Different forms of violence in domestic relationship

Almost all women (98.6 per cent) reported facing emotional violence. The different forms of emotional abuse perpetuated by abusers include verbally abusing women and her natal family (93.7 per cent), persistent criticism (69.7 per cent), isolation (47.9 per cent) and restricting mobility of woman (40.8 per cent).

Table 6.3
Forms of Violence

Type of violence*	No.	Per cent
Physical Violence	106	74.6
Emotional violence	140	98.6
Sexual Violence	57	40.1
Financial Violence	103	72.5

* Multiple responses

The most common form of violence reported by women is emotional in nature. This is also reported in other research studies which state that emotional abuse is the most common form of abuse and it acts as a precursor to physical abuse (Schmacher & Leonard, 2005; Karakurt, 2013). The various tactics by which the abuser tries to control woman have also been conceptualized in the wheel of power and control explaining the dynamics of intimate partner relationship (Duluth model). This wheel indicates that the abuser uses a combination of different strategies to exert control over the woman and emotional forms of abuse are central to these strategies. This has also emerged in the narrative history given by the women where the husband and marital family has intentionally tried to isolate the women from natal family so that they feel helpless and don't try to raise their voice against the abuse.

…..my MIL doesn't allow me to keep in touch with my natal family members including brothers & sisters. My husband and MIL always criticize my brothers and sisters. Due to this I am unable to meet my sister for past one year who stays very close to my marital home". (25 year old woman, married for 3 years, completed primary education, never employed)

Physical violence was found to be the second most common (74.6 per cent) form of violence experienced by women followed by financial violence which was faced by 72 per cent of the women. The most common ways of perpetuating physical violence by

the abusers include slapping (71.8 per cent), pulling hair (34.5 per cent) and pushing (23.9 per cent). Denying access to the basic needs of woman such as food, shelter, etc. and not allowing her to seek employment were the forms of financial violence reported by women. It is interesting to note that some women were able to articulate that the husbands were careful to use forms of physical abuse that do not leave any marks of injury. A 29-year-old woman, married for four years, with a secondary education and never employed, said that *"He always hit me on the joints so that there are no marks on my body."*

40 per cent of women reported sexual violence within the marriage from the husband. The common forms of sexual violence faced by women include forced sex, denying use of contraceptives and forcing to have children. A woman facing sexual violence told the counsellor:

"…. My husband forces me to have anal and oral sex. If I refuse him, he hits me with a rod and threatens me that he will go to some other woman. I often get injuries in my genital area, but cannot seek treatment fearing that the doctor will come to know about abuse from husband." (25 year old married for 7 years, completed primary education, currently unemployed)

Women facing sexual violence from intimate partner face an added burden in meeting their sexual and reproductive health needs because of lack of autonomy. These women face difficulties in accessing abortion in case of unwanted pregnancy, using a family planning method and seeking treatment for their reproductive health problems. The recognition of these difficulties is important for the providers so that they can offer a comprehensive, safe and effective treatment to women (Gillies, 2015). The fact that a large number of women spoke about sexual violence is an important finding in the light of the ongoing debate about criminalizing sexual violence within the marital relationship in the Indian context.

7. HEALTH OF WOMEN

This chapter describes the various health consequences reported by women due to violence during pregnancy. It also presents information about the obstetric history of women, the ANC seeking behaviour and the characteristics of present pregnancy.

7.1 Health Consequences

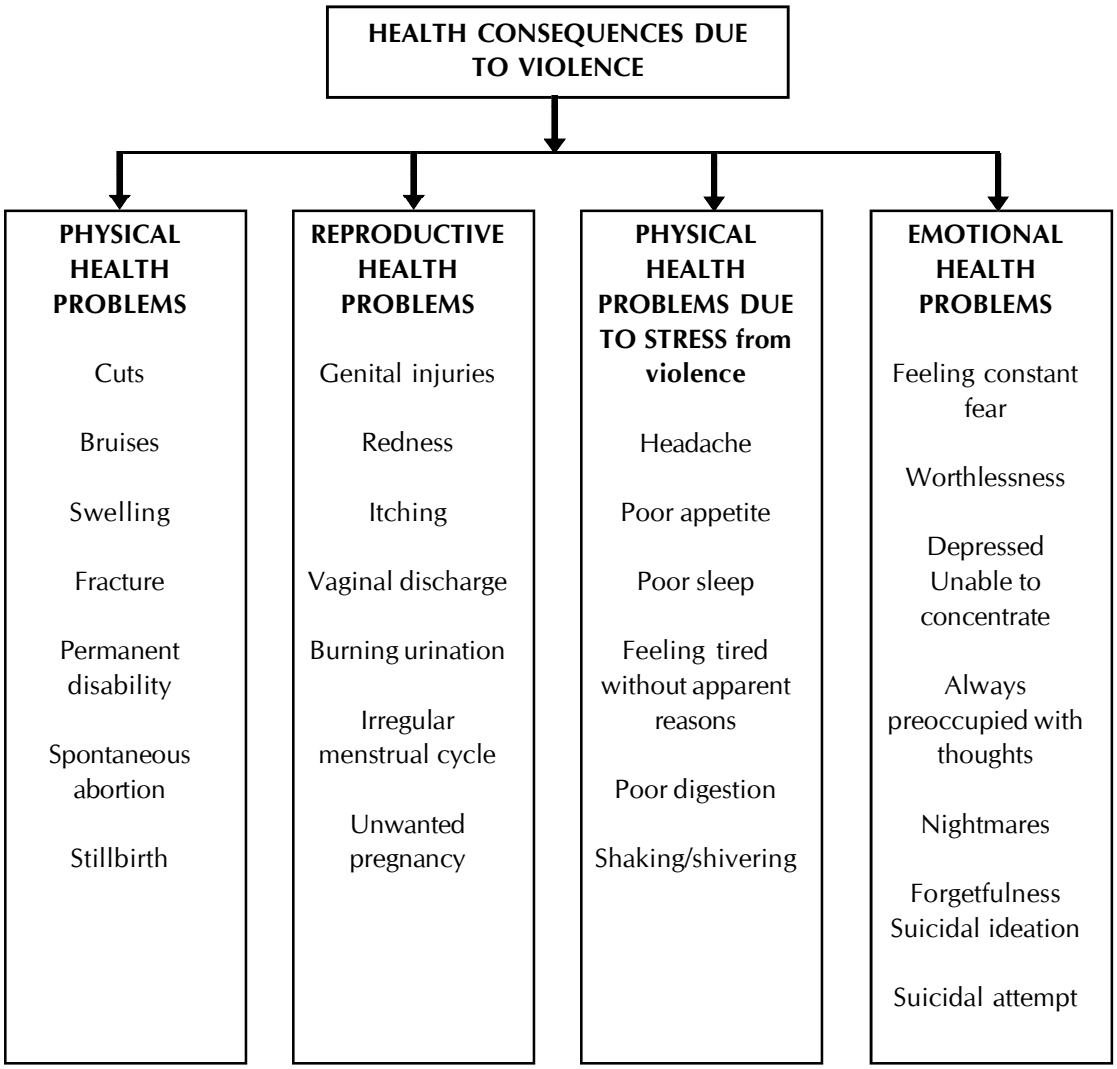
Violence significantly affects the physical and mental health of women. This association is well documented in literature (Ellsberg et.al., 2008; Maselko & Patel, 2008, Satyanarayana & Carey, 2009) based on research studies conducted in India as well as other countries. Pregnancy marks a stage which has increased vulnerability for women staying in an abusive relationship.

During pregnancy, violence affects not only the health of women, but also results in poor birth outcomes (Devries et.al., 2010). The establishment of this relationship has resulted in a greater focus on using a public health approach to address the issue of violence against women. This resulted in identifying the unique position of healthcare providers in the early identification of women facing violence and the opportunity to implement hospital-based interventions for women.

The self-reported health consequences of women in this study were categorized as physical health problems, reproductive health problems, and physical health problems due to stress from violence and emotional health consequences. The physical health problems include injuries resulting from physical violence like cuts, bruises, swellings, etc. The reproductive health problems comprise of genital injuries, discharge, itching etc. while physical health problems due to violence-related stress constitute headache, poor appetite, weakness, etc.

The emotional health consequences can vary from feeling fear, depression, worthlessness, suicidal ideation and many others that have debilitating effect on woman's health status. These health problems have been presented in the form of a framework in Figure 7.1.

Figure 7.1
Different Health Consequences Due To Violence during Pregnancy



The physical health consequences due to violence were reported by about 41 per cent of women. The most common of these were cuts, bruises and swellings due to physical violence. Some women who reported physical health consequences also reported on the treatment that they sought and their contact with healthcare providers.

"……my husband is very abusive. Once he banged my head and I got unconscious. My MIL took me to hospital where an emergency CT scan was done. When the doctor asked my MIL about the reason for the injury, she said something fell on my head from roof." (24 year old, married for 4 years, completed secondary education, never employed)

"……whenever he hits me, he takes me to a nearby clinic. Once when I got my eardrum ruptured because of abuse, the clinic doctor came to know that my injury has resulted from abuse and he told my husband not to hit me in future." (25 year old, married for 8 years, completed primary education, never employed)

The above excerpts show that women do seek treatment in the event of physical injuries as a result of violence. Also, doctors do get an idea about the nature and the cause of such injuries

Table 7.1
Health Consequences due to Violence

Health consequences*	Frequency	Per cent
Any physical health problem	58	40.8
Any emotional health problem	137	96.5
Any physical health problem because of stress	92	64.7
Any Reproductive health problem	30	21.1

* Multiple responses

Nearly 21 per cent of women attributed their reproductive health problems like genital injury, discharge and burning urination to sexual violence from husband. Women were less likely to seek treatment for their reproductive health problems because of the stigma associated with these problems. One woman explained the reason for not seeking treatment for vaginal discharge: *"I feel embarrassed to speak about it to my mother, then how will I tell this to doctor."* (23 year old, married for 3 years, completed graduation, currently unemployed).

Nearly 65 per cent of the women related their physical health problems like headache, loss of appetite and sleep to stress resulting from violence.

…… I don't feel like eating. They always criticize me for each and everything. How can one eat and sleep when there is so much tension at home." (26 year old, married for 2 years, completed secondary education, never employed)

The findings of the present study revealed a huge burden (96.5 per cent) of emotional health problems like, persistent feelings of fear, worthlessness and suicidal ideation due to violence among women.

Table 7.2
Common Health Consequences due to Violence

Common Health problems *	Frequency	Per cent
PHYSICAL HEALTH PROBLEMS		
Cut/bruise	37	26.1
Swelling on body	43	30.3
REPRODUCTIVE HEALTH PROBLEMS		
Genital injury	15	10.6
Vaginal discharge	22	15.5
Burning	11	7.7
PHYSICAL HEALTH PROBLEMS DUE TO STRESS		
Headache	78	54.9
Poor appetite	88	62
Can't sleep	84	59.2
EMOTIONAL HEALTH PROBLEMS		
Feeling fear	89	62.7
Nervousness/tension/worried	87	61.3
Restlessness	53	37.3
Feeling unhappy	104	73.2
Feeling worthless	45	31.7
Presence of suicidal thoughts	46	32.4
Ever attempted suicide	25	17.6
Nightmares	25	17.6
Forgetfulness	32	22.5
Inability to concentrate	52	36.6
Always preoccupied with thoughts	88	62

* Multiple responses

About 29 per cent of women were having suicidal thoughts at the time of screening while seven women had attempted suicide in present pregnancy.

A woman who attempted suicide during pregnancy said *"In front of my neighbours my husband said that this child doesn't belong to him and gave me talaq and asked me to leave. I couldn't bear this and slit my wrist by using knife."* (21 year old woman, married for 2 years, completed primary education, never employed)

7.2 Pregnancy Related Parameters

i. Present pregnancy-wanted/unwanted

About 22 per cent of women (31) reported that the present pregnancy is unwanted. The reasons for conception were forced sex, husband denying using any contraceptive, not allowing her to use any contraceptive and in cases of contraceptive failure husbands did not allow women to seek MTP. Of the 31 women, 10 came in the first trimester, 14 in the second trimester and 7 in the third trimester. As per the MTP law, nothing could be done for the seven women who came in third trimester. Five women who were in their first trimester were able to take the decision to undergo abortion.

"I was completely confused and worried what to do. But after talking to a counsellor, my anxiety was relieved. When I thought about abortion everybody started blaming me including my natal family and at some point I felt that I am making a mistake. But later, after talking to a counsellor I felt that if I am not prepared for the pregnancy, why to go ahead with it." (19 year old woman, married for 1 year, completed secondary education, currently employed)

Table 7.3
Gestational Age for Women with Unwanted Pregnancy

Trimester	Frequency	Per cent
First trimester	10	32.3
Second trimester	14	45.2
Third trimester	7	22.6
Total	**31**	**100.0**

ii. History of induced abortion and/or miscarriage

The history of past induced abortion and/or miscarriage was reported by about 16 per cent (23) of women. Nine (39%) out of these 23 women reported violence as the reason for inducing abortion and/or miscarriage. Women primarily attributed miscarriage to being overburdened with household chores and physical violence, whereas the induced abortion was due to son preference and financial violence from husband.

"…. During my earlier pregnancy, I stayed in marital house and had to do all household work. My mother in-law didn't allow me to register in hospital due to which I had a miscarriage later" (19 year old woman, married for 1 year, illiterate, never employed)

…"I delivered a girl after one year of my marriage. Soon after the birth of my daughter, they started pressurizing me for a son. When I conceived again, my husband took me to a hospital for sonography, which was different from where I delivered during my first pregnancy. After coming from the hospital, my husband gave me pills. I started bleeding within a few hours of taking the pills." (25 year old woman, married for 6 years, completed secondary education, never employed)

Table 7.4
Any History of Induced Abortion and/or Miscarriage

History	Frequency	Per cent
Yes	23	16.2
No	119	83.8
Total	**142**	**100**

iii. Delay in ANC due to Violence

The profile of women who got registered in the first trimester (26 per cent) in the study hospitals without any delay shows that they were young (18 to 24), primie, were at their natal homes and were educated up to secondary and/or graduation level. Half (50.7 per cent) of the women in the sample were in their second trimester when they got registered in study hospitals. For analyzing the delay in seeking antenatal care, delayed ANC registration for women has been considered as those who got their first ANC check- up done in the second or third trimester.

Table 7.5
Gestational Age in Trimesters

Gestational Age	Frequency	Per cent
First trimester	37	26.1
Second trimester	72	50.7
Third trimester	33	23.2
Total	**142**	**100.0**

It is common in the Indian scenario that women get their initial ANC from health settings, which are close to their marital home and in later months of pregnancy when they move to natal home they get registered in nearby hospitals. So, for examining the actual delay in ANC women were asked about any previous ANC check up at some other healthcare setting.. Of 105 women who got registered in study hospitals in the second and third trimester, 47 already registered at some other facility. So, the actual delay in registration was for 58 women, which accounts for about 41 per cent of the total sample (142).

Table 7.6
Time Lapse in seeking ANC

Time lapse	Frequency	Per cent
Yes	58	55.2
Already registered at some other facility	47	44.8
Total	**105**	**100.0**

41 out of 58 women (71 per cent of 58) reported violence as the reason for the delay in seeking ANC. There were various forms of violence cited by women in their history, which resulted in delay in maternal health-seeking. These include restricted mobility, lack of support (both physical and financial), overburdened with household chores and stressed out due to fights at home due to which ANC registration was not woman's priority.

"…. I conceived after six years, but still I couldn't come for my antenatal check up. Even my husband didn't bother to take me to the doctor when I was in so much pain. He is very short- tempered and needs everything on time. He gets furious and starts hitting me if he doesn't get what he wants. My whole day goes into taking care of his needs," (24 year old woman, married for 7 years, completed secondary education, never employed)

".....I was pregnant before marriage and was not able to go to hospital as husband was not committing for marriage because my in-laws were not accepting me." (21 years old woman, married for less than one year, completed primary education, currently unemployed)

There were 13 women who reported during history-taking that they felt that it is normal to register late.

"..... Even during my first pregnancy, I went to the hospital in my 8th month. Also, one should not tell about pregnancy to other people in the first three months" (30 year old, married for 8 years, completed primary education, currently unemployed)

Table 7.7
Reasons for Time Lapse in ANC Registration

Reasons	Frequency	Per cent
Due to violence	41	70.7
Not aware about pregnancy	4	6.9
Feels it is normal to register late	13	22.4
Total	**58**	**100.0**

A large body of literature has focused on studying the impact of violence during pregnancy on maternal health seeking behaviour (Taggart & Mattson, 1996; Dietz et.al, 1997; Islam et. al, 2017). A US-based study conducted among different ethnic groups found that the women facing physical violence, are especially more likely to delay prenatal care (Taggart & Mattson, 1996). Interestingly, women in this study reported that they delayed prenatal care out of fear that if they visited a hospital people would come to know about the physical abuse that they were facing. A study based on the data from NFHS- 3 has also found the constraining effect of physical violence during pregnancy on the uptake of antenatal care and has suggested that the maternal health services should recognize the needs of women facing violence during pregnancy (Koski, Stephenson & Koeing, 2011). This study also brought into the discussion the policy implication of the growing evidence on the relationship between violence during pregnancy and poor uptake of antenatal care. The authors of the study suggested that a substantial number of women facing violence are likely to miss or delay their prenatal care; it is more relevant to include the screening of women for violence in family planning programmes rather than in maternal health services.

IV. Anaemia and weight

Information about weight and haemoglobin was noted down from medical records of women who consented to participate in the study. The information about weight of women was available for 101 women and on haemoglobin levels, for 81 women.

Table 7.8
Weight of Women at Time of ANC Registration

Weight	Frequency	Per cent
38- 45 Kgs	18	17.8
46- 53 Kgs	35	34.7
54- 61 Kgs	23	22.8
62- 69 Kgs	15	14.9
70 & Above	10	9.9
Total	**101**	**100**

In our sample, about 18 per cent of women had weight in the range of 38 to 45 kg when they were registered at the study hospital. The women in the weight range of 46 to 53 kg were about 35 per cent. We compared the weight of the woman with the trimester of pregnancy. About 72 per cent of women weighing less than 46 kg were in their second and third trimester. Another 72 per cent of women weighing less than 54 kg and more that 45 kg were in their second and third trimester. This indicates that violence during pregnancy has a substantial impact on weight of women during pregnancy. This impact can be through lack of access to resources, healthcare services and inability to focus on health due to violence.

Table 7.9
Weight of Women and Trimester of Pregnancy

Age	1st trimester		2nd trimester		3rd trimester	
	Frequency	Per cent	Frequency	Per cent	Frequency	Per cent
38-45 Kgs	5	27.8	8	44.4	5	27.8
46-53 Kgs	10	28.6	16	45.8	9	25.6
54-61 Kgs	6	26.1	12	52.2	5	21.7
62-69 Kgs	2	13.3	10	66.7	3	20
70 Kgs & above	1	10	7	70	2	20

Table 7.10
Haemoglobin of Women at time of ANC Registration

Haemoglobin	Frequency	Per cent
Severe anemia (4-6.9)	4	4.9
Moderate (7-9.9)	33	40.7
Mild (10-10.9)	13	16
No anemia (>10.9)	31	38.3
Total	**81**	**100**

The hemoglobin level of women was classified according to the ICMR guidelines for anaemia in pregnant women (ICMR, 1998). About 5 per cent of women in our study were found to be severely anaemic while nearly 41 per cent and 16 per cent of women were found to have moderate and mild anaemia, respectively.

The total prevalence of anemia in our study, which includes severe, mild and moderate, was around 61 per cent. We compared this prevalence with other facility-based studies aiming to find out the prevalence of anaemia among pregnant women coming for their antenatal care. We found two studies carried out in government hospitals of South India located in urban settings. The study by Rajamouli and colleagues (2016) found that 58.36 per cent of women in their study were anaemic during pregnancy while the other study carried out in a Bangalore hospital found the prevalence to be 30.3 per cent (Samuel et.al., 2013).

In our study, the number of anaemic women was found to be higher than in these studies. The reason for this high prevalence could be due to the fact that women in this study were facing violence and are more prone to having poor health status. This increase in vulnerability in terms of low haemoglobin and less than adequate weight can be due to delayed antenatal care and treatment, lack of access to adequate diet and poor appetite due to violence related stress.

A number of narratives of women about their present health status reflect the symptoms due to clinical parameters of low haemoglobin and weight gain.

A woman with haemoglobin of 7.4g/dl said *"My mother-in-law and husband force me to do all the household work. Now I feel extreme giddiness. Even when I lie down I feel that my head is turning around"*. (30 year old, married for 8 years, completed primary education, never employed)

".....I don't know what is happening inside my head. At home, when I am stressed out, I cannot stand. Last week I fainted two times while working .I feel my throat is dry and empty." (27 year old having haemoglobin of 6.4, married for 3 years, completed graduation, currently employed)

8. FEASIBILITY OF INTERVENTION

The study aimed to assess the feasibility of counselling intervention in a hospital setting for pregnant women experiencing domestic violence. The feasibility of any intervention acts as a precursor to measure its impact. The public health approach is known for its evidence-based interventions, and in order to implement them, there is a need to evaluate these interventions (Bowen et al., 2009).

The implementation of the intervention, the dialogue with health providers and counsellors, and the responses of women who participated in the intervention provided critical insights into the feasibility of this intervention in a hospital setting.

8.1 Can Pregnant Women Be Screened in ANC Clinics Given the Overcrowding?

The intervention was able to screen 93 per cent of the women who came for their ANC registration in the two study sites. During the course of the study, counsellors were able to screen and provide intervention to women without any adverse event. Women accompanied by the abusers were handled carefully by the counsellors by devising strategies such as telling reli / husbands ? that the information being provided was on healthy diet during pregnancy, signs of complications during pregnancy and how to take care of the child. The time required for screening was 5 to 8 minutes for each woman.

Women also found the intervention and its setting to be a safe and accessible place to seek support in the future as well. There were a few women who decided to seek help after two to three months of the screening process. The positive messages that counsellor offered during the process of screening motivated them to take a decision to come back for services.

A 20-year-old woman, married for a year, completed secondary education, currently employed who came to the counsellor after three months of screening said *"....that day when you asked me about problems at home, I didn't get the courage to speak about it. I came for ANC twice after that, but was not sure to discuss about my personal issues."*

8.2 Will Women Be Willing To Receive Intervention?

The participation rate in this study was found out to be 90.5 per cent. The reason for refusal given by majority of women who refused was that there was no violence at home

so they did not want to participate in study. In the WHO multi-country study on women's health and domestic violence, the participation rate was about 85 per cent whereas it varied from 87 to 94 per cent in a study carried out by INCLEN International in five cities of India.

A 26-year-old woman, married for six years, who had completed secondary education, and was currently unemployed said, *"I delivered in this hospital during my last pregnancy as well, so I am aware of all the procedures. When the doctor told me to visit this room, I was surprised as I didn't come here last time. I thought something new must have started and after speaking to counsellor, I came to know about this work. You are doing a very good work as there are lots of women who need such kind of support services."*

Another 24-year-old woman, married for five years, who had completed primary education, and had never been employed discussed with the counsellor how her perspective changed after speaking with counsellor. She said, *"I see this happening in my neighbourhood every day. I never thought about it like this before. I used to think that these women have to face abuse from their family because it's in their fate"*.

In hospital A, all the follow-up sessions with counsellor coincided with their ANC visits thus indicating that the intervention is feasible. In hospital B, where the ANC date is given to women after three to four weeks about 37 per cent of women came to hospital to speak with the counsellor in particular after first counselling session. This indicates that women were able to appreciate the messages from counsellor to make an earlier visit for dealing with violence for their overall wellbeing. Also, the nature of information sought by women from counsellors indicated their trust and the comfort level with counsellors; women asked counsellors about safe sex during pregnancy, side effects of various family planning methods and about their health problems. Some women expressed their desire to meet the counsellor post-delivery, and many of them visited the counsellor at the time of discharge to express their gratitude for the services received.

A woman in PNC ward after meeting with counsellor said *"....my husband has not come to see me and my child after delivery. It's only my mother who has accompanied me to the hospital. I am extremely thankful to you for providing us emotional support during this period."* (23 year old woman, married for 2 years, completed graduation, currently unemployed)

8.3 Will The Health Department and Staff Recognize this as Part of Essential Clinical Care?

As per the intervention, though the screening was to be carried out by counsellors, it was found that the trained providers played an active role in referring women who were suspected to be facing violence by the providers. Of 142 women, 14 (9.8%) were identified and referred to the counsellors by providers before the screening process. These women were accompanied by the nurses, aayabais or doctors to the counsellors for screening.

A doctor escorted a nine-month pregnant woman to the counsellor and suggested that the woman needed intervention as she faced physical abuse from husband. When later the counsellor asked the woman about the interaction with the provider, the woman said *"doctor asked me about the reason for the delay in ANC registration. Initially, I didn't say anything but when doctor asked me that is there any problem at home, I revealed everything to the doctor"* (19 year old woman, married for 1 year, completed primary education, never employed)

In another case, an aayabai brought a woman and her mother sitting in the queue for ANC and informed counsellor that they were in distress and needed support. The woman later revealed that *"I was crying while speaking to my mother about my husband's behaviour. The aayabai saw this and asked us to come along with her."* (24 year old woman, married for 3 years, completed secondary education, currently employed)

There was another case where the technician of integrated counselling and testing centre (ICTC) referred a pregnant woman to a counsellor when the woman told the technician that her husband was not agreeing to come to hospital for HIV testing.

It was observed that in general the referrals from the departments where pregnant woman comes increased remarkably after the study started in hospitals. There were women who were referred to counsellor from ANC follow-ups, PNC wards and immunization department. Besides referring women to counsellors, the providers also played crucial role in intervening in some of the cases. They participated proactively in helping women to seek treatment and other services from hospital.

We observed that women were referred by departments of ANC, PNC, immunization and ICTC thus underscoring the need to conduct training of all cadres of the hospital in asking and identifying abuse in pregnant women and providing support. In addition to the above examples where staff identified and referred women, there were other instances where they played crucial roles of intervening in some of the cases.

In the case of a 28-year-old woman who was pregnant for the third time and who had previously undergone C Section deliveries, was being forced by her husband and mother-in-law to do laborious work. They had a misconception that a C-section is conducted when a woman does not engage in physical activities. The nurse handled the case very tactfully and spoke to husband in the woman's presence. She explained to her husband the reasons and complications that may necessitate a C-section delivery. She also explained why the woman had had to undergo C-section in the previous deliveries. Later, during follow up, the woman told the counsellor that the meeting with the counsellor really helped her and improved her situation at home.

The providers were also sensitized to the issues related to access to abortion and the need for early abortion services. The staff nurses ensured that the five women in the study who were facing violence and wanted to terminate the pregnancy were given early dates for the ultrasound. Routinely, women have to wait for two weeks to get a USG which may create problems as they may cross the legal gestational limit for a MTP.

Overall, the providers played an important role in telling every woman to visit the counsellor after completing the ANC procedures, accompanying women who were suspected or identified by providers to the counsellors, and in providing specific services to women. They played a crucial link that ensured high participation in the study.

8.4. Feasibility of Intervention in Hospital B

As the study was implemented in two different settings, one with a crisis centre and the other without it, it is important to report on the implementation of the intervention in hospital B.

The implementation of this intervention project in hospital B was a completely new project as the HCPs were not aware of the role of the health system in responding to VAW. The providers to be involved in training were mobilized by involving the senior administrator of the hospital. The Medical Superintendent (MS) of the hospital was met in person by the researchers to discuss with them the significance of having such an intervention in the hospital. One of the key strategies adopted was to convince the senior administrators to implementing the study intervention was to present them with the data indicating the burden of violence during pregnancy and its health consequences. The HCPs of different cadres were instructed to attend training from the MS of the study hospitals, which showed their commitment to implement such an initiative.

In hospital B, the screening process was also carried out in the waiting time between various ANC procedures. The process of screening was conducted in gynecological department where the family planning counsellor sits in a separate cabin. It was easy for researchers to establish rapport with the hospital staff as the family planning counsellor introduced the researchers to other staff members. There was immense support from hospital staff which was significant in facilitating the screening and counselling intervention.

There were some challenges initially in providing counselling sessions to women in hospital B. Unlike hospital A, women receive their blood report on the same day and are called for follow- up after a period of two to three weeks. So, to ensure the safety of the women, the counsellor convinced women to attend the counselling session on the same day. In cases where woman expressed time constraints for attending a counselling session on the same day, the counsellor made sure that the safety planning was done with the woman. There were no problems faced by women to follow-up as the counsellor used to sit inside the gynecological department.

In terms of outcomes due to intervention, there was no significant difference in proportion of the women who reported better outcomes in hospital B. In fact for some of the outcomes like coping strategies and health, a larger proportion of women in hospital B reported change due to intervention. This is a very significant finding which emphasizes that the healthcare providers can be trained to provide support services to women. The detailed table on the comparison of outcomes in two hospitals is in the Annexure (page-114).

8.5 How many counselling sessions are required at the minimum?

The follow- up of women for counselling coincided with a health visit, hence each session was planned in a manner that would assess the safety of women, provide her emotional support and encouraged her to take active steps to stop violence. The understanding of the present study suggests that there can be no fixed number of counselling sessions that can be ascertained to have an impact for women. For the present study, two intervention sessions were planned. All the women in both the hospitals received a minimum of two sessions of intervention while there were 68 (47.8 per cent) women who attended more than two sessions. So, the number of follow- ups both face-to-face and over telephone varied from 1 to 13 in hospital A while it was 1 to 9 for hospital B.

The number of counselling sessions required to have an impact can vary from woman to woman. Also from our experience of the crisis centre, we know that even a single counselling session that provides women space to share their feelings can be helpful to

them. Tiwari and colleagues (2005) in their paper also discussed how even a single 30 minute counselling session can have a "cathartic effect". It helped in releasing bottled up tension as the women had never had any opportunity in past to share anything about violence.

8.6 Challenges

It was observed that there were two issues faced by pregnant women while accessing healthcare services. One was related to access to abortion and the other is abusive and rude behaviour of providers.

i. Access to abortion

Women facing violence during pregnancy faced obstacles in accessing abortion services because of several unscientific and unlawful practices at the level of hospital such as conditional access to abortion, discouraging women if it is a first pregnancy, and insisting on the signature of husband despite a known person willing to sign the consent form.

In one of such case, a 38-year-old married woman pregnant for two months was denied abortion with the direction that the abortion would be provided only if she would agree to a CuT insertion. Further, a 23-year-old woman pregnant for first time was discouraged from having an abortion by informing her that abortion could cause secondary infertility.

The intervention in such cases was directed towards speaking to the doctors about the urgency of providing the abortion service to women and the irrelevance of these practices.

ii. Abusive and rude behaviour of providers

During intervention, some women shared the verbal abuse faced by them from the healthcare providers at the time of delivery. Women were found to be so scared of the doctors that they gave false obstetric history. This was evident when counsellors found the discrepancies in what doctor had written on medical papers and the information given by women to counsellor during screening. Also, women were found to be reluctant to ask doctors about the future scheduled appointments and timings of medicine administration written on their hospital papers. This was found as a contraindication as at one level providers were trained to be sensitive to women and recognize violence against them but at another level such practices continued when women entered the delivery room.

9. IMPACT OF INTERVENTION

This chapter summarizes outcomes and predictors of social and emotional well-being at the level of the individual as well as in the context of social environment. The outcomes are described as cognitive and behavioural changes, emotional changes the actions taken at individual level and with the social support.

9.1 Intrapersonal Changes

i. Cognitive and behavioural changes: increased knowledge, skills and critical consciousness

In order to empower women to raise their voice against violence, it is important to change their perceptions about the phenomenon of violence. Women often perceive that they are responsible for the violence they are facing and tend to normalize it because of gender role socialization. These perceptions and beliefs influence women's decision to disclose, seek help and take action against the abuse. So, to build the capacity of women facing violence, it is essential to change women's understanding and perceptions about violence.

Raising critical consciousness forms an essential element of empowerment counselling (Sara & Sullivan, 2016). It includes making woman aware of the dynamics of violence, cycle of violence and their ability to end the violence. This helps women to realize that the cause of violence lies external to them and encourages them to take action against oppression. In the present study, counselling addressed woman's response to violence such as normalizing violence, considering violence as her fault, not involving natal family due to perceptions of burdening them etc.

The data from counselling sessions with women was analysed to present cognitive and behavioural changes. This is based on what women reported, and not on a pre-determined checklist.

The percentages mentioned below under-represent the actual number of women whose perceptions changed as these are taken from the narratives and were not sought from women in the form of a checklist. There is a possibility that women reported only those changes that they felt were more significant for themselves. These changes have resulted in building their self-confidence and their capacity to take action and develop safety behaviour.

Table 9.1
Self-Reported Cognitive and Behavioural Changes

Self- reported changes	Frequency	Per cent
Recognising violence as an issue of power	86	60.6
Recognising the impact of violence on health	93	65.5
Recognising the need to raise voice against violence	85	59.9

* Multiple responses

a. Recognizing violence as an issue of power

According to the feminist counselling principles, violence is perpetrated by an abuser in order to stay in a powerful position which is ascribed by the rigid gender roles of our society (Guidelines for Counselling Women facing Violence, CEHAT, 2008). It is behaviour of the abuser mediated through violence in order to establish or maintain power and control over women. It is important that women recognize that the violence faced by them is an issue of power.

In this study, this theme has been defined as the understanding of woman that domestic violence is a purposeful behaviour by the abuser for controlling the woman. In other words, the abuser does not inflict violence because of illness, stress, addiction, or the other woman in case of extra- marital relationship, or because someone instigates him/ her (marital family). We found that about 61 per cent of women in our study explicitly stated in their narratives about their recognition of violence as an issue of power. A narrative of the woman in this context is:

"…I realized that my husband intentionally doesn't allow me to talk to my natal family members so that I cannot raise my voice against him." (21 year old woman, married for three years, completed secondary education, never employed)

b. Recognizing the impact of violence on health

One of the main emphases of the intervention was to draw an association between the health consequences of woman and the violence she is facing to mitigate the consequences. The basic premise to make this relationship was to enable her to take steps to improve her health. Many women at 6 weeks post- delivery reported that they were able to recognize how violence was impacting their health by describing it as - not eating properly, always thinking about abuse, not able to seek healthcare because of violence,

restricted mobility and lack of physical and financial support. About 65 per cent of women informed the counsellor that the most important change that they feel in themselves is their ability to associate their poor health with violence.

Post-counselling intervention 65 per cent women stated that they started recognizing the impact of violence on health. It has been defined as the understanding of women about the association between violence and poor health and the mechanisms by which violence impacts their health.

Some narratives of women recognizing the impact of violence on their health:

"I was not bothered about my health and was completely preoccupied with the thoughts about why this has happened to me. My health started deteriorating. My hemoglobin was very low. Had I not reached Dilaasa, my health would have deteriorated very badly. When I talked to counsellor I realized how violence from husband is making me sick. It (the counselling intervention) has actually positively affected my health as I started eating properly." (24 year old, married for 3 years, completed post- graduation, currently unemployed)

".....I realized that how the abuse from my husband is impacting me and my child." (23 year old, married for 5 years, illiterate, never employed)

c. Recognizing the need to confront voice against violence

A number of women said that the intervention helped them to understand that violence is not acceptable and there is a need to raise once's voice against it. The women were able articulate that they have to do something about the abuse to change their situation. Nearly 60 per cent of women reported that they now understood that they have to take steps to stop abuse.

Some excerpts

".....I used to think that as I got married by my choice, I have to bear it. After I spoke to counsellor, I understood that there is no point in living my entire life in fear of violence from my husband." (22 years old, married for 2 years, completed secondary education, currently employed)

"Earlier when there was any disagreement or fights between us, I used to cry but now I understand that there is no use of crying. I have to do something for myself and make my

husband realize that I can also fight against him." (26 year old woman, married for 8 years, completed primary education, never employed)

c. Actions taken at individual level

These are the steps taken by woman at her own level to address the violence. The various actions of women analysed under this include: took up a job, moved out of the house, raised voice against abuser, joined a livelihood programme, and underwent MTP, or gave the child up for adoption.

To assess the number of women who adopted a different action after the intervention which resulted in a change in their situation, a Chi- square test was conducted. The results of the Chi-square test shows that a significant percentage ($p < 0.05$) of women adopted an action at the individual level. About 51 per cent of women who had not taken any action to safegaurd their well-being, did so after the intervention.

Table 9.2
Number of Women who took Action at Individual Level due to Intervention

Actions at individual level- PRE	Actions at individual level POST			Chi-square value
	Yes	No	Total	(p)
Yes	49 (67.1%)	24 (32.9%)	73	3.948
No	35 (50.7%)	34 (49.3%)	69	(0.04)***

ii. EMOTIONAL CHANGES: SENSE OF SELF, REDUCED STRESS

a. Self-confidence

The confidence building of women is a component of emotional support provided to women by the counsellor through validating her feelings and stressing upon her strengths. About 24 per cent of women reported that they have gained confidence after speaking to counsellor. Self confidence in women has been defined as the feeling among women that whatever will be the situation in future, she will be able to face it.

Some narratives of women are:

She said that *"I gained confidence". I still remember the day when I visited counsellor for the first time and I was crying continuously. My whole attitude has changed. I realized*

that one should not bear the violence as it encourages the husband to inflict more violence and woman should fight for her rights." (27 year old woman, married for 9 years, completed primary education, currently unemployed)

"I got confidence to fight against my husband as I came to know about my strengths" (30 year old woman, married for 10 years, illiterate, currently unemployed).

b. Mitigating feeling of self-blame and guilt

Social conditioning of women results in acceptance of violence as a part of domestic lives. Women often try to locate the fault in themselves, such as not being able to cook, or take care of the household or husbands needs or marital family. These messages are also given by paternal families and the underlying aspect that marriage should not break at any cost. About 24 per cent women said that discussion with counsellor about how violence was not their fault stayed with them and helped them build a positive self-image. The counselling intervention is directed towards improving the psychological well-being of women. In the process of doing this, it is important to make women understand that they are not responsible for the violence they are facing. Mitigating feelings of self-blame and guilt has been defined as the ability of women to realize that the violence they are facing is not their fault.

A 29-year-old woman, married for four years, completed secondary education, never employed said *"I used to think that I put on weight after my first pregnancy and so I am not attractive to him anymore. And that is why my husband goes to other women, but after coming here I know that I should not blame myself for what he is doing. I should question it and tell him that it is not acceptable to me"*.

c. Other emotional changes

These are the changes that help in minimising the emotional consequences as a result of stressors. The various emotional changes considered in the study include got on with daily routine, focused on taking care of children and concentrated on her health. The emotional changes before and after intervention were cross tabulated to see the percentage of women who reported change after intervention. 67 per cent reported on their ability to comprehend that violence had an impact on their health. This is a significant post-intervention outcome.

Table 9.3
Number of Women with Emotional Changes due to Intervention

Emotional changes-PRE	Emotional changes-POST			Chi-square value
	Yes	No	Total	(p)
Yes	16 (80%)	4 (20%)	20	1.45
No	82 (67.2%)	40 (32.8%)	122	-0.24

9.2. Intrapersonal Predictors of Well- Being

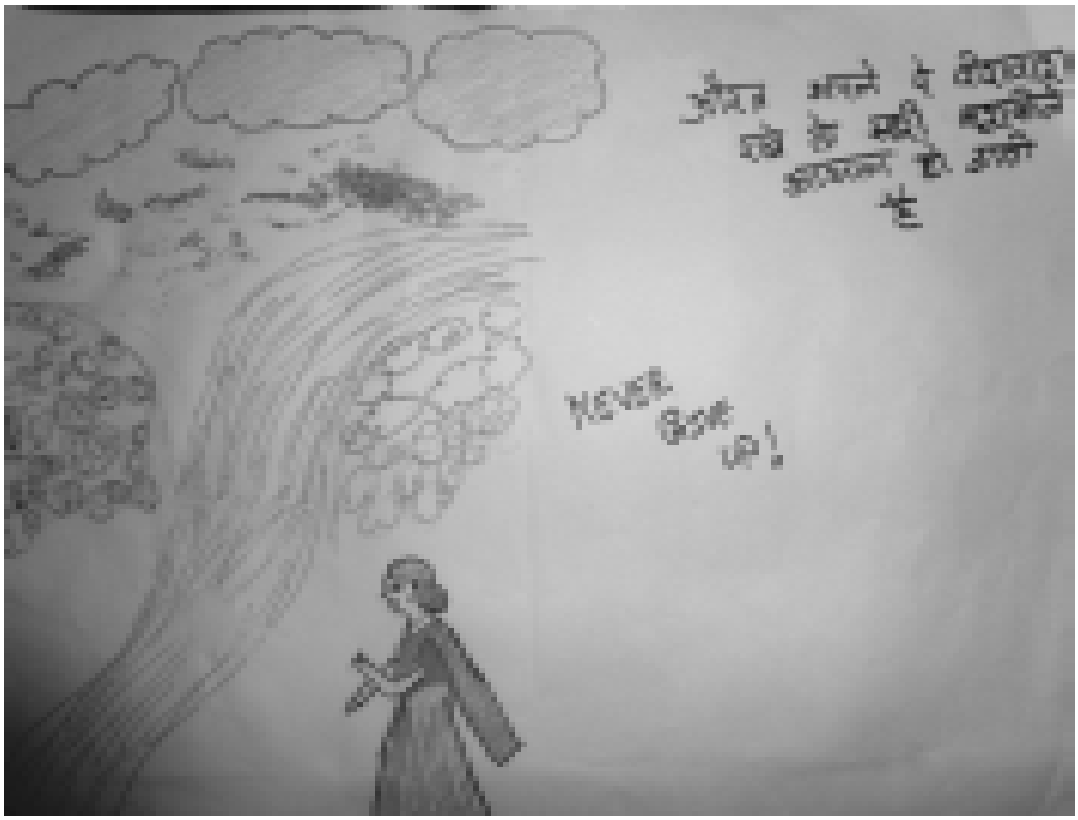
i. Feeling of self sufficient

Despite, being vulnerable owing to the physical aspects of child birth and the lack of support from their family, 23 per cent of the women reported being confident of living independently and asserted their right to live a violence-free life. Such feelings helped them overcome fears of being abandoned, deserted, etc.

"….Even if he leaves me, I am not scared now. Earlier I was scared that how I will survive along with my children if he will abandon us." (24 year old, married for 5 years, completed secondary education, never employed)

"….I realized that woman can take care of herself and her child. I don't need husband for this. Although, I have taken this decision very late but I am firm on it". (21 year old, married for 2 years, completed graduation, currently unemployed)

The drawing on next page is done by one of the woman who received counselling intervention during this study. The woman participated in a two-week campaign that was organized in the hospital to end VAW.



9.3 Interpersonal Changes

The changes at interpersonal level in the present study are presented by assessing the actions taken by women at informal and formal level. This outcome covers the various changes mentioned in the well-being framework.

i. Actions at informal and formal level

These are defined as the steps taken by women to address violence with the help of various informal and formal support systems. The informal support systems include family, friends, relatives, and neighbours while formal include organizations, community leaders, police and legal system.

Among these steps, the most important is telling about violence that woman is facing to other people as it helps her to ventilate her feelings. This holds a special significance in Indian context where domestic violence is essentially considered to be a personal family matter. There is shame and stigma associated with reporting domestic violence associated with the pressure on woman to maintain the sanctity of marriage (Kaur & Garg, 2008).

For about 16 per cent of women in this study, screening process carried out during the study was the first time that they had spoken to someone about the violence they were facing. This was also reflected in the narratives of women while speaking to the counsellor.

When the counsellor asked a woman that why she did not share the violence she was facing with anyone, she said *"I didn't want to give tension to anyone". I thought that whatever is happening, it is my fate and if I will share it with anyone it will bring shame to my family."* (25 year old woman, married for 3 years, completed primary education, never employed)

The intervention in such cases was focused towards making women realise that sharing would help her in establishing a supportive relationship with which would enable her to raise her voice against violence. There are studies that have provided the evidence that social connectedness is the most important strategy for women facing domestic violence (Davis, 2002; Lu & Chen, 1996).

Also, there is a predominant notion among women that sharing about violence would not change their situation as others would not be willing to intervene. Some naratives are as follows :-

"..... I don't want to tell this to my natal family as I had a love marriage and they were against it. I am also feeling guilty as my decision had gone wrong and why my family will help me now when they warned me before marriage that my husband is not good." (25 year old woman, 2 years of marriage, completed secondary education, currently employed)

Further, many women told the counsellor that in the past sharing their experience of violence with someone had not always helped them. Rather, it had resulted in a reinforcement of feelings of self-blame and guilt for women. This was specifically true for the cases where women shared their experience with their natal family but family refused to intervene out of the fear of breaking their daughter's marriage.

"....My MIL has been torturing me since the time of marriage. My husband never supported me. I told this to my parents but my father never speaks for me. In fact, he hits me and always tells me to adjust. My mother never speaks against my father and I am blamed by everyone." (29 year old woman, married for 6 years, completed secondary education, never employed).

Some verbatim accounts of women taking actions are mentioned below:

"My mother is my biggest support as now I can share anything with my mother. She supported me both emotionally and financially during my pregnancy." (21 years old, married for 3 years, completed secondary education, currently unemployed)

"… I realized that my husband does not care for me and the children. My family supported me in this period, which encouraged me to file complaint against my husband." (27 years old, married for 8 years, completed primary education, never employed)

It is noteworthy that none of the woman in our study reported disclosing violence with the healthcare providers in the past even when they went to the hospital to seek treatment for their injuries resulting from the episodes of physical violence. This implies that there is need to make healthcare providers sensitive and spread awareness among women about the kind of the help that HCPs can offer them.

Table 9.4
Number of Women who took Action at Informal and Formal level due to Intervention

Actions taken at informal and formal	Actions taken at informal and formal level- POST			Chi-square value
level- PRE	Yes	No	Total	(p)
Yes	111 (91.7%)	10 (8.3%)	121	18.746
No	12 (57.9%)	9 (42.1%)	21	(0.000)***

9.4 Interpersonal predictors of well being

Safety and physical and emotional health of women are the predictors considered at interpersonal level in the study. The change in violence faced by women has been presented as a component of enhanced safety.

i. Safety

Domestic violence affects not only the physical, but the emotional safety of women as well. There is evidence from the various intervention research studies carried out in western countries that a safety planning activity with women greatly improves their situation (Ramsay, 2009; Tirado-Munoz, 2014). These activities help women in building their capacity to engage in activities that can promote their safety and well-being (Gilboe-Ford, 2017).

The threat to the woman's safety exists even when she is separated from the abuser. This aspect is important while offering a safety intervention to women facing violence. Such intervention should not only address the immediate risks to women, but should also look at the safety of women as an ongoing issue even when she is not staying with the abuser (Gilboe- Ford, 2017). Another element to be emphasized during such intervention is the psychological safety of women. This is a key component of safety planning as women facing violence experience a lot of emotional health consequences, including suicidal ideation (Alhusen et al., 2015).

Drawing on these lines, the intervention in this study also helps a woman to devise a safety plan by understanding the potential risks and the resources available to her. Counsellor make an assessment of woman's safety by asking a series of questions which are related to severity and frequency of violence and threats from the abuser.

The various informal support systems available to women are explored during this assessment and information about the various formal support systems is given to women by the counsellor. In cases of suicidal ideation, the counsellor helps woman to mitigate the feelings of blame and hopelessness, validate her feelings and suggest coping mechanisms that will increase her confidence. The counsellor involves the woman in a participatory method to develop strategies in order to protect her from violence and its consequences.

At post- intervention assessment, women were asked about the safety measures adopted by them after the intervention. These strategies were documented both in response to an immediate episode of violence as well those that were implemented by women to ensure safety in future. For example, if a woman is planning to leave the matrimonial house, then keeping her valuables at safe place and saving money is suggested.

Table 9.5
Use of Safety Measures at Post-Intervention

Measures	Frequency	Per cent
Adopted a safety measure	51	35.9
Recalled a safety measure	88	62.0
Not able to adopt during episode of violence	3	2.1
Total	**142**	**100.0**

The results from this study show that about 36 per cent of women reported adopting safety measures in post intervention assessment. About 62 per cent of women recalled a safety measure at the time of the post-intervention assessment and asserted that they would adopt them in future. These women shared the preferred safety measure that they were planning to use. Only in three cases, was there an immediate episode of physical violence, when the women did not adopt any safety measures. The reason given by women was that they did not have access to the phone to call the police. The other two women said that they did not take any action hoping that the husband would change after the birth of the child.

About 37 per cent of the women filed a non-cognizable complaint against the abuser in which the police records the statement of women about violence but does not take any action against the abuser. This complaint plays a significant role as an evidence of documentation of violence faced by women in case she wants to take legal action against the abuser in future

The other most common (35 per cent) coping strategy adopted by women was keeping their valuables at safe place. Women narrated being more aware of keeping important documents, belongings in a safe space so that if the violence escalates and she has to leave her documents are not damaged / confiscated by the abuser. These include Aadhar card, marriage certificates, birth certificates of children, property papers, ATM card, jewellery and bank account details.

Table 9.6
Types of Safety Measures

Type of measure	Frequency	Per cent
Filed NC	19	37.3
Called 100/103	2	3.9
Stepped out of the house in the event of physical violence	3	5.9
Shouted for help from neighbours	3	5.9
Did MLC	1	2.0
Started saving money	2	3.9
Kept her valuables at safe place	18	35.3
Threatened the abuser will action	3	5.9
Total	**51**	**100.0**

Following are some narratives of the women who used safety measures:

"….He came to hit me. But like earlier, I didn't keep quiet. When he abused me, I also defended myself by stepping out of the house" (24 year old, married for 2 years, completed secondary education, never employed).

".….My husband once tried to abuse me physically. He was drunk and was angry at me for not giving him food. He got angry and started pushing me. I screamed to call the people on the street for help. Within a few minutes, people gathered and told my husband to leave the place as he was drunk" (22 year old, married for 3 years, completed primary education, currently unemployed)

The evidence of increase in safety behaviours of women facing violence is reported by a study conducted by McFarlane and colleagues (2004). This was a randomized control trial in which the safety intervention was given to women over the telephone and improvement in behaviour of women was assessed at 3, 6, 12 and 18 months after the initial recruitment. The study concluded that the intervention was very effective in improving the safety behaviour of women. The checklist adopted by this study in assessing the safety behaviour is comparable to the safety behaviours adopted by women in our study. Some items of the checklist include hiding money, keys, important documents and asking for assistance from neighbours.

Change in violence faced by women: After intervention, women were asked about violence at two points of time. One was before delivery and the other was at six weeks post-delivery. There was no sexual violence reported before the delivery and at six weeks after delivery by women. Emotional violence was the most common form of violence reported by women before delivery as well as six weeks after delivery. It got reduced to 2.5 times at six weeks post-delivery. Similarly, there were substantial decrease reported by women in emotional and financial violence.

Table 9.7
Change in Violence faced by Women after Intervention

	At intervention (per cent)	Before Delivery (per cent)	At 6 weeks post delivery (per cent)
Physical violence	74.6	12	3.5
Emotional violence	98.6	83.8	34.5
Financial violence	72.5	55.4	11.3

ii. Physical and emotional health

To measure the health status of women at six weeks post-delivery, women were asked about the change in their health status in the form of "better, worsen and remained same". The women who shared that their health improved were nearly 84 per cent, while for remaining the health status remained the same.

The women who reported no improvement in their health status were significantly less likely to act at the informal and formal level. These women were proportionately less likely to seek support from their informal support systems like natal family. This shows that the support from informal and formal systems helps women in alleviating the impact of violence. The role of social support to mitigate the consequences of violence during pregnancy has also been highlighted by a study carried out in antenatal care setting of Tanzania (Sigalla et.al., 2017).

Table 9.8
Health Status of Women at Post- Intervention Assessment

Present health status post intervention		
	Frequency	**Per cent**
Better	119	83.8
Remained the same	23	16.2
Total	**142**	**100**

At six weeks post-delivery, women did not report any physical health complaints due to violence. This is also evident from the fact that only five women reported experiencing physical violence at six weeks post- delivery which includes slapping and pushing. In four out of these five women, there was the birth of a girl child.

There were some women who reported delivery related health complaints like pain at the site of stitches, abdominal pain, back pain etc. Further, none of the women admitted to any reproductive health problem due to violence.

Emotional health problems due to violence were found in 33 per cent of women while the physical health problems due to stress associated with violence was reported by nearly 10 per cent of women. So, a considerable decrease was found in all types of health problems of women after intervention. These findings were found to be in agreement with the studies, which have tested similar interventions.

Table 9.9
Health Consequences due to Violence at Post- Intervention Assessment

Health consequences due to violence at 6 weeks post- delivery*		
	At intervention (per cent)	**At 6 weeks post delivery (per cent)**
Any emotional health problem	96.5	33.1
Any physical health problem because of stress	54.7	10.5

* Multiple responses

Table 9.10
Emotional Health Consequences due to Violence at Post-Intervention Assessment

Consequences	**Frequency**	**Per cent**
PHYSICAL HEALTH PROBLEMS DUE TO STRESS		
Headache	11	7.7
Poor appetite	5	3.5
Can't sleep	12	8.5
EMOTIONAL HEALTH PROBLEMS		
Feeling constant fear	16	11.3
Hands, legs, body shake/shiver	2	1.4
Nervousness/tension/worried	22	15.5
Restlessness	6	4.2
Feeling unhappy	21	14.8
Feel worthless	3	2.1
Always feel tired without any apparent reason	5	3.5
Nightmares	2	1.4
Forgetfulness	5	3.5
Inability to concentrate	7	4.9
Always preoccupied with thoughts	15	10.6

* Multiple responses

A Few studies that have assessed the impact of similar interventions have used standardized scales to measure the health status of women. A randomized controlled trial done by Tiwari et.al. (2005) among pregnant women facing violence in ANC setting found that the empowerment counselling intervention results in improvement of health status of women. The authors used the Short Form Health Survey (SF-36) to measure the health related quality of life. The women in study reported higher physical functioning and lesser role limitations due to emotional problems. Another study carried out on similar lines in Peru found that there was no statistically significant difference in health-related quality of life following the interaction ? (Cripe et.al., 2010).

Another common measuring tool used for measuring the psychological distress due to violence by research studies is General health questionnaire (GHQ-12) (Crempien et.al., 2011; Amoran et. al., 2017). As all women in our study reported having emotional health consequences due to violence during pregnancy, we compared these emotional consequences with items of GHQ-12. We found that all the 12 items of this standardised scale were covered in the intake form under different sections.

In this study an important component of counselling intervention was to inform women about the various family planning methods and strategize with her so that she could use a choice-based method after delivery. At six weeks after delivery, about 25 per cent of the women reported adopting some family planning method while another 20 per cent said that they had decided to adopt family planning method later. The women who said that they would adopt a method after sometime were mainly told by the doctor to wait due to medical reasons like low haemoglobin. About 50 per cent of women told the counsellor that they would speak to their husbands about adopting a family planning method.

Outcome of pregnancy

As violence during pregnancy impacts not only the health of the woman, but also that of the unborn child as well, the present study has also looked at the outcomes of pregnancy in the context of violence.

About 89 per cent of women reported having live births during post-intervention assessment. One of these women who reported having a live birth at six weeks, later, at a follow up, admitted to the death of the child due do an unknown cause.

Table 9.11
Outcome of Pregnancy

Outcome	Frequency	Per cent
Live Birth	127	89.
Preterm Birth	3	2.1
Still Birth	3	2.1
Spontaneous Abortion	4	2.8
Induced abortion	5	3.5
Total	**142**	**100.0**

Three women reported preterm birth and the same number of women had still births. All the women ascribed the stillbirths to immediate episodes of physical violence.

None of the four women who had spontaneous abortion reported any episode of physical violence, although they did report emotional violence in form of verbal abuse, and threats. The role that emotional violence can play during pregnancy in leading to miscarriage cannot be ignored. A large scale study carried out in African setting found that the emotional violence during pregnancy is the most common predictor of fetal loss (Alio et.al., 2009).

Five women decided to undergo induced abortion because of violence from the husband. The narrative of a woman who underwent abortion is mentioned below:

"...my husband is very abusive since marriage. After my first delivery, I told him to adopt a family planning method, but he refused. I have conceived again within 1 year of birth of my child. I don't want to continue with the present pregnancy as there is nobody to support me." (23 year old woman, married for 5 years, completed secondary education, never employed)

About 58 per cent of live births were of males while 34 per cent were females. Around 28 per cent of the women in the present study had delivered through C-section which is low as compared to national average (NFHS-3). The proportion of babies with low birth weight, i.e. less than 2500 grames was about 15 per cent.

NFHS 3, which is a household survey covering both rural and urban areas, found the prevalence of low birth weight to be 21.5 per cent. A facility-based study investigating the risk factors of low birth weight in district hospital of Tamil Nadu found the prevalence to be 11.6 per cent of a sample of 300 (Dandekar et.al., 2014). Another recent study carried out in Osmanabad district of Maharashtra found the prevalence of LBW to be 13.8

per cent in a sample of 655 (Ahankari et. al., 2017). There is no Indian study looking at the prevalence of low birth weight among women facing violence during pregnancy. However, in our study the prevalence rate was found to be slightly on the higher side (15 per cent) as compared to the similar hospital-based studies among women in general. This reflects the increased predisposition of having low birth weight babies among women facing violence during pregnancy. As all women reported facing the emotional violence during pregnancy, the relationship of birth outcomes was compared with other forms of violence by looking at their care history. It was found that women who were experiencing physical and sexual violence in addition to emotional violence reported stillbirths and low birth weight. Women with suicidal thoughts were found to be more likely to have low birth weight babies.

Table 9.12
Sex of Baby

Sex	Frequency	Per cent
Male	82	57.7
Female	48	33.8
NA	12	8.5
Total	**142**	**100.0**

NA- cases of abortion, miscarriage, and still birth

Table 9.13
Weight of Baby

Weight	Frequency	Per cent
Less than 2500 gms	19	14.6
More than 2500 gms	111	85.4
Total	**130**	**100**

Table 9.14
Type of Delivery

Type	Frequency	Per cent
Normal	93	71.5
Caesarean	37	28.5
Total	**130**	**100**

10. DISCUSSION, IMPLICATION AND CONCLUSION

10.1 Summary of Findings

The present study yields valuable information on the feasibility and efficacy of a counselling intervention in antenatal care setting for pregnant women facing domestic violence. The participation rate in the study was about 91 per cent, which is an indicator of the acceptability of the intervention among women. It also signifies the safety and confidentiality that the health system offers for the implementation of such interventions.

The prevalence of violence during pregnancy in this study (16.2 per cent) was found to be similar to the range cited in most of the studies. The screening process also captured a considerable number of women who were hesitant to disclose and admit the violence they were facing. The study emphasized an important screening strategy that all the women should be made aware about the avenues of support that are available, in case they decided to seek help in the future.

The findings from the study contribute to filling a gap in the literature by providing detailed information about the phenomenon of violence during pregnancy in the Indian context, and the impact of a screening and counselling intervention to address the same. As intervention was conceptualised in the antenatal care for early identification of women facing violence, the majority of women in our study were young, in the early years of marriage, and pregnant for the first time. Emotional violence was found to be the predominant form of abuse faced by women followed by financial and physical violence.

The study made a unique attempt to provide a comprehensive picture of the different forms of health consequences due to violence. The physical and reproductive health problems due to violence in lifetime were reported by 41 per cent and 21 per cent of women respectively. As it is widely evident, the study also found a profound impact of violence on emotional well-being as almost all the women reported emotional health problems. Suicidal ideation during pregnancy was reported by about 29 per cent of the women. This is an extremely important finding considering that globally, studies have found homicide and suicide to be the wast significant contributors to maternal deaths (Palladino et al., 2012; Gentile, 2011). This has implications for maternal health reporting in India, which does not include deaths of pregnant women due to suicide and homicide. A critical finding is the

high prevalence of anaemia among women in the present study as compared to other facility-based studies among pregnant women attending antenatal care Implication ?.

Another important aspect that was explored in this multi-component study was the impeding effect of violence during pregnancy on antenatal care seeking. A large proportion (29 per cent) of women were unable to register for ANC in the first trimester because of violence. This signifies the importance of routine enquiry during ANC as these women are likely to miss their scheduled visits.

The feasibility of an intervention in the healthcare setting was reflected in the ease of the implementation of study processes and the experiences of various stakeholders such as. A high participation rate (91 per cent) of women in the study indicated their willingness comfort to speak about sensitive issues like violence in healthcare setting. The follow-up of women was also found to be possible during subsequent ANC visits and even for seeking support services specifically. Most importantly, women were found to be satisfied with the support services provided by counsellors. The providers played a crucial role in facilitating the process of screening and providing health services to women like family planning and abortion. The positive experiences of counsellors during screening and interaction with health system also shows the practicality of the intervention.

One of the distinctive characteristics of the study is the reporting of the changes in understanding of the phenomenon of violence among women. These changes are important as they act as the precursors to the concrete actions taken by women against violence. This has not been considered as an outcome by any other study assessing the impact of counselling intervention. We found that the most common change among women as a result of the intervention was an understanding of the intrinsic relationship between violence and their health. The other important changes were recognising violence as an issue of power and the need to raise their voice against violence. The empathetic listening of women's problems and emotional support provided during counselling are the two most important approaches which resulted in increased self-confidence and helped women to raise their voice against violence. The results of the study indicate positive impacts of intervention on coping and safety behaviour of women.

There was a significant number of women who acted against violence with the support of informal and formal systems a result of the counselling intervention. All women employed a safety strategy in the event of an episode of violence, while some women also did it for ensuring future safety. The effects of the intervention were also reflected in the health outcomes of the women at six weeks after delivery, where 84 per cent of women reported

better health status. One of the prominent findings of the study is that there was no difference in the impact of the intervention in two hospitals, as in one setting the counselling was provided by a trained counsellor, whereas and in the other by hospital staff trained to provide counselling.

To conclude, an intervention in antenatal care setting in response to pregnant women facing violence is feasible, and has the potential to positively impact the health, safety and coping behaviour of women.

10.2 Implications

i. Violence during pregnancy- routine enquiry during antenatal care

a. The need to enquiry for violence during pregnancy: The findings of the present study on the prevalence of violence during pregnancy and its health consequences warrant a routine enquiry of domestic violence by healthcare providers during pregnancy. As it is evident from the present study, violence during pregnancy has a profound effect on maternal health; it is have essential for healthcare providers to treat morbidities during the pregnancy keeping in mind considering violence as a social determinant of women's health. This will help healthcare providers to comprehensively address the needs of pregnant women.

Therefore, the screening of pregnant women for violence should be considered an essential component of antenatal care. The new guidelines from WHO on antenatal care for positive pregnancy experience have also strongly recommended the routine enquiry of violence during antenatal care and its inclusion as one of the parameters in maternal assessment (WHO, 2016).

The case for the inclusion of screening of pregnant women during antenatal care is further strongly supported by the fact that the prevalence of violence during pregnancy found in this study is comparable to the occurrence of the common obstetric conditions for which the pregnant women are repeatedly screened throughout the antenatal care provided in Indian healthcare settings. These conditions include hepatitis B, HIV, preeclampsia, thyroid disorders and gestational diabetes. The table mentioned below shows that the occurrence of these conditions during pregnancy varies in the same range as the prevalence of violence among pregnant women in India. Also, the identification of women facing violence during pregnancy by healthcare providers is critical as health consequences resulting from violence during pregnancy cause co-morbidity with these obstetric complications.

Table 10.1
Prevalence of common obstetric complications in India

Obstetric Complications	Prevalence (Per cent)
Pre- eclampsia	8-10 (national health portal)
Gestational Diabetes	9.9 (rural) to 17.8 in urban (NFHS-3)
Hypothyroidism	4.8 to 11 (Dhanwal, 2016)
Hepatitis B	1 to 9 (Narayanswamy, 2011)
HIV	0.88 (Gupta et. al., 2007)

b. Antenatal care-a window of opportunity: Although there is evidence that violence during pregnancy delays the antenatal care seeking by women, it is worth mentioning that often, antenatal care is the entry point, and the only institutional contact for these women. Also, the women coming for antenatal care are of reproductive age groups where screening can help in early identification of women facing violence. In addition to this, the frequent visits of women to the hospital during antenatal care also provide an opportunity for an empowerment counselling interventions in which multiple sessions are provided and women can easily follow- up during their antenatal visits (WHO, 2013)

c. Routine screening: It is well established that women hesitate to share the violence they are facing because of stigma, economic dependence on abuser, and perception that the others will not be able to help them (Shrivastava & Shrivastava, 2013; Katiti et. al., 2016; McCleary- Sills, 2015; Tonsing & Barn, 2016). Considering this, antenatal care offers an unparalleled opportunity for identifying women facing violence because there is repeated contact of women with healthcare providers at multiple levels throughout the pregnancy during antenatal care. The routine screening at these frequent contact points with healthcare providers increases the chances of disclosure of violence by women (Foy et.al, 2009). Routine enquiry about abuse also helps in provoking thoughts of seeking help among women even they do not make up their mind to seek help immediately (Laing, 2005). Our study also recorded nine women who did not disclose abuse during screening, but later sought help. This implies that the routine screening itself operates as an intervention which reinforces the message that violence is not acceptable and provides information about various available support services. There is evidence that routine screening by healthcare professionals increases the identification rates of women facing violence (McFarlane et.al., 1992; Saltzman et.al., 1995). To sum up, routine screening of violence during pregnancy in antenatal setting is recommended considering the dual vulnerability, and the opportunity to intervene offered by repeated contacts with the health system.

ii. Health Systems Response: Healthcare providers catering to the women during antenatal care are in a unique position to build rapport with women facing violence during obstetric appointments, to identify and to refer them to support services. The sympathetic attitude, validation of feelings, and referral to support services by healthcare providers play a crucial role in empowering women (Gerbert et.al., 1999).

Being in the healthcare setting, they can easily start the conversation with women about the violence at home by linking it with the various pregnancy complications (Clinical practice guideline, 2012). This was also found to work in the present study where counsellors explained to women the various health consequences of violence before asking about violence.

There are various opportunities during the process of antenatal care seeking into which the screening of pregnant women can be integrated. Doctors, nurses and paramedical staff providing various ANC services can ask structured screening questions about violence to pregnant women. Nurses taking anthropometric measures are in a key position to speak to pregnant women about violence. The potential of integrated counselling testing centre for HIV associated with all the health facilities can also be tapped for responding to pregnant women facing violence. The counsellors at the HIV and family planning centre can screen women during antenatal visits.

Despite this established role that healthcare providers can play, their potential to respond to women facing violence during pregnancy has been untapped so far. To enable the healthcare providers to respond, several factors at the level of health policy, healthcare delivery system and at the level of providers play an important role (Colombini et.al., 2012).

Such integrated intervention models can be scaled up only if there is commitment through the health policy. There is a lack of policy directive from the Indian government due to which healthcare delivery system does not recognise domestic violence as a priority. The recent national health policy ref. mentions the potential role of health systems in responding to gender based violence, but there are no details on implementation and allocation of funds.

Evidence-based policy is a fundamental concept of the public health (Brownson et.al., 2009). The evidence of domestic violence in India can be traced to the last two rounds of the national family health survey, which were conducted in 2005- 06 and 2015-16. Although, the data from these two rounds depict the huge magnitude of domestic violence, it has not

been utilised by policy makers to conceptualise interventions for domestic violence. Also, very often the other key health issue are given priority in terms of specific programmes and resources due to their more visible effects (Colombini et.al., 2012).

Further, the public health field is increasingly witnessing the growing importance of economic evaluation of public health policies and interventions. This includes the assessment of the cost of not intervening in the situation versus that of implementing an intervention to modify the situation. So, in this situation the risks will be substantial physical and mental health consequences for women facing violence, and an introduction of an intervention will result in better health outcomes for women, increased awareness about their rights, and improved safety behaviours. The fund allocation in interventions addressing violence against women should consider the healthcare costs resulting from violence.

There has been no data on medical cost of health consequences due to domestic violence in our country. A study carried out on evaluating the cost of domestic violence found that about Rs. 2,331 are spent by the family every year in the treatment of a woman for health consequences resulting from violence (CARE, 2011). If this is extrapolated to total Indian population using the prevalence of injuries due to violence in last 12 months from NFHS, the total health expenditure due to violence is Rupees 67.5 billion rupees annually. This amount accounts to around 14 per cent of the total allocation by government to health in the year 2017. This high monetary amount indicates the need to prioritise the issue of domestic violence in the perspective of the health by policy makers.

The training of healthcare providers on the issue of violence constitutes an essential element of integrating a screening policy in the clinical practice of healthcare providers. The study shows that involvement of healthcare workers of different cadres is important to bring the notion that a comprehensive response to violence requires the support from the whole system.

The identification of women facing violence should be followed up by a comprehensive on-site response, which includes medical care, counselling, shelter, legal aid and other support services. The disclosure should be responded to adequately, otherwise it can lead to re-victimisation, which can further endanger the woman's safety and can underscore her feelings of hopelessness and stigmatisation (Taft, 2002). It is important to note that the provision of these services in healthcare settings require the health system to collaborate with various agencies providing support services.

c. Future research: The present study has shown the effectiveness of a counselling intervention for pregnant women facing violence. The process of screening was carried out by counsellors of crisis centre for the purpose of study. Future research studies should involve healthcare providers in the screening process to establish the sustainability of such interventions in hospital settings. Further, the screening tool developed during this study should be validated in other hospital settings of India.

Conclusion

Violence during pregnancy is a grave public health problem that has a significant impact on the health of women. Antenatal care offers a potentially important time and space where a comprehensive response can be integrated with the healthcare delivery system. There is empirical evidence about the acceptability and impact of such interventions among women as well as providers. However, this health sector response to domestic violence during pregnancy is plagued with a plethora of challenges at different levels. It is clear that embedding this health sector response to women family violence requires commitment from the government in the form of polices based on available evidence, support from the institutions, and training of healthcare providers.

REFERENCES

Ahankari, A., Bapat, S., Myles, P., Fogarty, A., & Tata, L. (2017). *Factors associated with preterm delivery and low birth weight: a study from rural Maharashtra, India*. F1000Research, 6, 72. https://doi.org/10.12688/f1000research.10659.1

Ahmed, S., Koenig, M. A., & Stephenson, R. (2006). Effects of domestic violence on perinatal and early-childhood mortality: evidence from north India. *American Journal of Public Health*, 96(8), 1423-1428.

Ahuja RC, Bangdiwala S, Bhambal SS, Jain D, Jeyaseelan L, Kumar S, et al. *Domestic violence in India: A summary report of a multi-site household survey*. Washington DC: International Clinical Epidemiology Network and International Centre for Research on Women; 2000. pp. 9-21

Alhusen, J. L., Ray, E., Sharps, P., & Bullock, L. (2015). Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes. *Journal of Women's Health,* 24(1), 100-106. https://doi.org/10.1089/jwh.2014.4872

Alio, A. P., Daley, E. M., Nana, P. N., Duan, J., & Salihu, H. M. (2009). Intimate partner violence and contraception use among women in Sub-Saharan Africa. *International Journal of Gynaecology and Obstetrics: The Official Organ of the International Federation of Gynaecology and Obstetrics,* 107(1), 35-38. https://doi.org/10.1016/j.ijgo.2009.05.002

Almutairi, G. D., Alrashidi, M. R., Almerri, A. T., Kamel, M. I., & El-Shazly, M. (2013). How to screen for domestic violence against women in primary health care centers. *Alexandria Journal of Medicine,* 49(1), 89-94. https://doi.org/10.1016/j.ajme.2012.07.004

Alves, M. M. R., Alves, S. V., Antunes, M. B. de C., Santos, D. L. P. dos, Alves, M. M. R., Alves, S. V., ... Santos, D. L. P. dos. (2013). External causes and maternal mortality: proposal for classification. *Revista de Saúde Pública,* 47(2), 283-291. https://doi.org/10.1590/S0034-8910.2013047003642

Amoran, O. E., Oni, O. O., & Salako, A. A. (2017). Predictors of intimate partner violence among women of reproductive age group in Sagamu local government area in Ogun State, Western Nigeria: A community-based study. *Journal of Clinical Sciences,* 14(1), 36.

Antoniou, E., Vivilaki, V., & Daglas, M. (2008). CORRELATION OF DOMESTIC VIOLENCE DURING PREGNANCY WITH POSTNATAL DEPRESSION: SYSTEMATIC REVIEW OF BIBLIOGRAPHY. *Health Science Journal,* 2(1).

Babu, B. V., & Kar, S. K. (2012). Abuse against women in pregnancy: a population-based study from Eastern India. *WHO South-East Asia Journal of Public Health, 1*(2), 133–143. https://doi.org/10.4103/2224-3151.206926

Banerjee, G., Nandi, D. N., Nandi, S., Sarkar, S., Boral, G. C., & Ghosh, A. (1990). THE VULNERABILITY OF INDIAN WOMEN TO SUICIDE A FIELD-STUDY. *Indian Journal of Psychiatry,* 32(4), 305-308.

Blanc, A. K. (2001). The effect of power in sexual relationships on sexual and reproductive health: an examination of the evidence. *Studies in Family Planning,* 32(3), 189-213.

Boyle, A., & Jones, P. B. (2006). The acceptability of routine inquiry about domestic violence towards women: a survey in three healthcare settings. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners,* 56(525), 258–261.

Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., … Fernandez, M. (2009). How We Design Feasibility Studies. *American Journal of Preventive Medicine,* 36(5), 452-457. https://doi.org/10.1016/j.amepre.2009.02.002

Brownson, R. C., Chriqui, J. F., & Stamatakis, K. A. (2009). Policy, Politics, and Collective Action. *Am J Public Health,* 99, 1576-83.

CAMPBELL, J. C., & SOEKEN, K. L. (1999). Forced Sex and Intimate Partner Violence: Effects on Women's Risk and Women's Health. *Violence Against Women,* 5(9), 1017-1035. https://doi.org/10.1177/1077801299005009003

CARE. (2011) Domestic Violence Against Women-Cost to The Nation.

Chandran, M., Tharyan, P., MULIYIL, J., & ABRAHAM, S. (2002). Post-partum depression in a cohort of women from a rural area of Tamil Nadu, India. *The British Journal of Psychiatry,* 181(6), 499-504.

Chhabra, S. (2007). Physical violence during pregnancy. J*ournal of Obstetrics and Gynaecology: The Journal of the Institute of Obstetrics and Gynaecology,* 27(5), 460-463. https://doi.org/10.1080/01443610701406075

Chi-Chi Undie, M. Catherine Maternowska, Margaret Mak'anyengo, Harriet Birungi, Jill Keesbury, Ian Askew. (2012). *Routine screening for intimate partner violence in public health care settings in Kenya: An assessment of acceptability*. APHIA II OR Project in Kenya/ Population Council: Nairobi, Kenya

Clements, C. M., & Sawhney, D. K. (2000). Coping with Domestic Violence: Control Attributions, Dysphoria, and Hopelessness. *Journal of Traumatic Stress,* 13(2), 219-240. https://doi.org/10.1023/A:1007702626960

Colombini, M., Mayhew, S. H., Ali, S. H., Shuib, R., & Watts, C. (2012a). An integrated health sector response to violence against women in Malaysia: lessons for supporting scale up. *BMC Public Health,* 12(1), 548.

Colombini, M., Mayhew, S. H., Ali, S. H., Shuib, R., & Watts, C. (2012b). An integrated health sector response to violence against women in Malaysia: lessons for supporting scale up. *BMC Public Health,* 12(1), 548.

Copersino, M. L., Jones, H., Tuten, M., & Svikis, D. (2008). Suicidal Ideation Among Drug-Dependent Treatment-Seeking Inner-City Pregnant Women. *Journal of Maintenance in the Addictions,* 3(2-4), 53-64. https://doi.org/10.1300/J126v03n02_07

Crempien, R. C., Rojas, G., Cumsille, P., & Oda, M. C. (2011). *Domestic Violence during Pregnancy and Mental Health: Exploratory Study in Primary Health Centers in Peñalolén*. ISRN Obstetrics and Gynecology, 2011, 1-5. https://doi.org/10.5402/2011/265817

Cripe, S. M., Sanchez, S. E., Sanchez, E., Ayala Quintanilla, B., Hernández Alarcon, C., Gelaye, B., & Williams, M. A. (2010). Intimate Partner Violence During Pregnancy: A Pilot Intervention Programme in Lima, Peru. *Journal of Interpersonal Violence,* 25(11), 2054-2076. https://doi.org/10.1177/0886260509354517

Dandekar, R., Shafee, M., & Prasad Sinha, S. (2014). Prevalence and risk factors affecting low birth weight in a district hospital at Perambalur, Tamilnadu. *Global Journal of Medicine and Public Health,* 3, 2014-2277.

Davis, R. E. (2002). "The strongest women": exploration of the inner resources of abused women. *Qualitative Health Research,* 12(9).

De Castro, F., Place, J. M., Billings, D., Rivera, L., & A Frongillo, E. (2014). *Risk profiles associated with postnatal depressive symptoms among women in a public sector hospital in Mexico: the role of sociodemographic and psychosocial factors (Vol. 18)*.

Decker, M. R., Nair, S., Saggurti, N., Sabri, B., Jethva, M., Raj, A., ... Silverman, J. G. (2013). Violence-Related Coping, Help-Seeking and Health Care-Based Intervention Preferences Among Perinatal Women in Mumbai, India. *Journal of Interpersonal Violence*, *28*(9), 1924–1947. https://doi.org/10.1177/0886260512469105

Devries, K. M., Kishor, S., Johnson, H., Stöckl, H., Bacchus, L. J., Garcia-Moreno, C., & Watts, C. (2010). Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries. *Reproductive Health Matters,* 18(36), 158-170. https://doi.org/10.1016/S0968-8080(10)36533-5

Dhanwal, D. K., Bajaj, S., Rajput, R., Subramaniam, K. a. V., Chowdhury, S., Bhandari, R., ... Shriram, U. (2016). Prevalence of hypothyroidism in pregnancy: An epidemiological study from 11 cities in 9 states of India. *Indian Journal of Endocrinology and Metabolism,* 20(3), 387. https://doi.org/10.4103/2230-8210.179992

Dietz, P. M., Gazmararian, J. A., Goodwin, M. M., Carol Bruce, F., Johnson, C. H., & Rochat, R. W. (1997). Delayed entry into prenatal care: Effect of physical violence. *Obstetrics & Gynecology,* 90(2), 221-224. https://doi.org/10.1016/S0029-7844(97)00252-4

Dunn, L. L., & Oths, K. S. (2004). Prenatal predictors of intimate partner abuse. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN,* 33(1), 54-63.

Ellsberg, M., Jansen, H. A. F. M., Heise, L., Watts, C. H., Garcia-Moreno, C., & WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *The Lancet (London, England),* 371(9619), 1165-1172. https://doi.org/10.1016/S0140-6736(08)60522-X

Espinoza, H., & Camacho, A. V. (2005a). Maternal death due to domestic violence: an unrecognized critical component of maternal mortality. R*evista Panamericana de Salud Pública,* 17(2), 123-129.

Espinoza, H., & Camacho, A. V. (2005b). Maternal death due to domestic violence: an unrecognized critical component of maternal mortality. *Revista Panamericana de Salud Pública,* 17(2), 123-129.

Folkman, S., & Lazarus, R. S. (1980). An Analysis of Coping in a Middle-Aged Community Sample on JSTOR. *Journal of Health and Social Behaviour,* 21(3), 219-239.

Foy, R., Nelson, F., Penney, G., & Mcllwaine, G. (2000). Antenatal detection of domestic violence. *The Lancet,* 355(9218), 1915. https://doi.org/10.1016/S0140-6736(05)73366-3

Ganatra, B. R., Coyaji, K. J., & Rao, V. N. (1998). Too far, too little, too late: a community-based case-control study of maternal mortality in rural west Maharashtra, India. *Bulletin of the World Health Organization,* 76(6), 591.

Gazmararian, J. A., Petersen, R., Spitz, A. M., Goodwin, M. M., Saltzman, L. E., & Marks, J. S. (2000). Violence and reproductive health: current knowledge and future research directions. *Maternal and Child Health Journal,* 4(2), 79-84.

Gerbert, B., Abercrombie, P., Caspers, N., Love, C., & Bronstone, A. (1999). How health care providers help battered women: the survivor's perspective. *Women & Health,* 29(3), 115-135. https://doi.org/10.1300/J013v29n03_08

Goodwin, M. M., Gazmararian, J. A., Johnson, C. H., Gilbert, B. C., & Saltzman, L. E. (2000). Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996-1997. PRAMS Working Group. Pregnancy Risk Assessment Monitoring System. *Maternal and Child Health Journal,* 4(2), 85-92.

Gupta, S., Gupta, R., & Singh, S. (2007). Seroprevalence of HIV in pregnant women in North India: a tertiary care hospital based study. *BMC Infectious Diseases*, *7*, 133. https://doi.org/10.1186/1471-2334-7-133

Haeseler, L. A. (2013). Women's coping experiences in the spectrum of domestic violence abuse. *Journal of Evidence-Based Social Work,* 10(1), 33-43. https://doi.org/10.1080/15433714.2013.750551

Hamberger, L. K., Rhodes, K., & Brown, J. (2015). Screening and intervention for intimate partner violence in healthcare settings: creating sustainable system-level programs. *Journal of Women's Health (2002)*, *24*(1), 86–91. https://doi.org/10.1089/jwh.2014.4861

Hardesty, J. L., Raffaelli, M., Khaw, L., Thomann Mitchell, E., Haselschwerdt, M. L., & Crossman, K. A. (2012). An Integrative Theoretical Model of Intimate Partner Violence, Coparenting After Separation, and Maternal and Child Well-Being. *Journal of Family Theory & Review,* 4(4), 318-331. https://doi.org/10.1111/j.1756-2589.2012.00139.x

Hodgkinson, S. C., Colantuoni, E., Roberts, D., Berg-Cross, L., & Belcher, H. M. E. (2010). Depressive Symptoms and Birth Outcomes among Pregnant Teenagers. *Journal of Pediatric and Adolescent Gynecology,* 23(1), 16-22. https://doi.org/10.1016/j.jpag.2009.04.006

Islam, M. J., Broidy, L., Baird, K., & Mazerolle, P. (2017). Intimate partner violence around the time of pregnancy and postpartum depression: The experience of women of Bangladesh. *PLOS ONE*, *12*(5), e0176211. https://doi.org/10.1371/journal.pone.0176211

International Institute for Population Sciences (IIPS) and ICF. (2017). *National Family Health Survey (NFHS-4), 2015-16: India.* Mumbai: IIPS

James, L., Brody, D., & Hamilton, Z. (2013). Risk factors for domestic violence during pregnancy: a meta-analytic review. *Violence and Victims,* 28(3), 359-380.

Jasinski, J. L. (2004). Pregnancy and Domestic Violence: A Review of the Literature. *Trauma, Violence, & Abuse,* 5(1), 47-64. https://doi.org/10.1177/1524838003259322

Jejeebhoy, S. J. (1998). Associations between wife-beating and fetal and infant death: impressions from a survey in rural India. *Studies in Family Planning,* 29(3), 300-308.

Johnson, M. P., & Ferraro, K. J. (2000). Research on Domestic Violence in the 1990s: Making Distinctions. *Journal of Marriage and Family,* 62(4), 948-963. https://doi.org/10.1111/j.1741-3737.2000.00948.x

Karakurt, G., & Silver, K. E. (2013). Emotional abuse in intimate relationships: The role of gender and age. *Violence and Victims*, *28*(5), 804–821.

Kaur, R., & Garg, S. (2008). Addressing Domestic Violence Against Women: An Unfinished Agenda. *Indian Journal of Community Medicine?: Official Publication of Indian Association of Preventive & Social Medicine,* 33(2), 73-76. https://doi.org/10.4103/0970-0218.40871

Kendall-Tackett, K. A. (2007). Violence Against Women and the Perinatal Period: The Impact of Lifetime Violence and Abuse on Pregnancy, Postpartum, and Breastfeeding. *Trauma, Violence, & Abuse,* 8(3), 344-353. https://doi.org/10.1177/1524838007304406

Khaironisak, H., Zaridah, S., Hasanain, F. G., & Zaleha, M. I. (2017). Prevalence, risk factors, and complications of violence against pregnant women in a hospital in Peninsular Malaysia. *Women & Health,* 57(8), 919-941. https://doi.org/10.1080/03630242.2016.1222329

Khosla, A. H., Dua, D., Devi, L., & Sud, S. S. (2005). Domestic violence in pregnancy in North Indian women. *Indian Journal of Medical Sciences,* 59(5), 195-199.

Kiely, M., El-Mohandes, A. A. E., El-Khorazaty, M. N., & Gantz, M. G. (2010). An Integrated Intervention to Reduce Intimate Partner Violence in Pregnancy: A Randomized Controlled Trial. *Obstetrics & Gynecology*, *115*(2, Part 1), 273–283. https://doi.org/10.1097/AOG.0b013e3181cbd482

Lazarus, R. S. (1993). Coping theory and research: past, present, and future. *Psychosomatic Medicine,* 55(3), 234-247.

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A Theoretical Framework for Understanding Help-Seeking Processes Among Survivors of Intimate Partner Violence. *American Journal of Community Psychology,* 36(1-2), 71-84. https://doi.org/10.1007/s10464-005-6233-6

Lori Taggart MSN, A., & Susan Mattson RNC, P. (1996). Delay in prenatal care as a result of battering in pregnancy: Cross?cultural implications. *Health Care for Women International,* 17(1), 25-34. https://doi.org/10.1080/07399339609516217

Lu, L., & Chen, C. S. (1996). Correlates of coping behaviours: Internal and external resources. *Counselling Psychology Quarterly,* 9(3), 297-307. https://doi.org/10.1080/09515079608258709

Maselko, J., & Patel, V. (2008). Why women attempt suicide: the role of mental illness and social disadvantage in a community cohort study in India. *Journal of Epidemiology & Community Health,* 62(9), 817-822. https://doi.org/10.1136/jech.2007.069351

McCleary-Sills, J., Namy, S., Nyoni, J., Rweyemamu, D., Salvatory, A., & Steven, E. (2016). Stigma, shame and women's limited agency in help-seeking for intimate partner violence. *Global Public Health,* 11(1-2), 224-235. https://doi.org/10.1080/17441692.2015.1047391

McFarlane, J., Malecha, A., Gist, J., Watson, K., Batten, E., Hall, I., & Smith, S. (2004). Increasing the safety-promoting behaviours of abused women. *The American Journal of Nursing,* 104(3), 40-50; quiz 50-51.

McFarlane, J., Parker, B., Soeken, K., & Bullock, L. (1992). Assessing for Abuse During Pregnancy: Severity and Frequency of Injuries and Associated Entry Into Prenatal Care. *JAMA,* 267(23), 3176-3178. https://doi.org/10.1001/jama.1992.03480230068030

McFarlane, J., Soeken, K., & Wiist, W. (2000). An evaluation of interventions to decrease intimate partner violence to pregnant women. *Public Health Nursing (Boston, Mass.),* 17(6), 443-451.

McGirr, S. A., & Sullivan, C. M. (2017). Critical Consciousness Raising as an Element of Empowering Practice with Survivors of Domestic Violence. *Journal of Social Service Research,* 43(2), 156-168. https://doi.org/10.1080/01488376.2016.1212777

Mertin, P., & Mohr, P. B. (2000). Incidence and Correlates of Posttraumatic Stress Disorder in Australian Victims of Domestic Violence. *Journal of Family Violence,* 15(4), 411-422. https://doi.org/10.1023/A:1007510414571

Mitchell, R. E., & Hodson, C. A. (1983). Coping with domestic violence: Social support and psychological health among battered women. *American Journal of Community Psychology,* 11(6), 629-654. https://doi.org/10.1007/BF00896600

Mithal, A., Bansal, B., & Kalra, S. (2015). Gestational diabetes in India: Science and society. *Indian Journal of Endocrinology and Metabolism*, *19*(6), 701–704. https://doi.org/10.4103/2230-8210.164031

Narayanswamy, K. (2011). Hepatitis B and pregnancy: challenges in India. *Journal of the Indian Medical Association,* 109(10), 766-767.

Newport, D. J., Levey, L. C., Pennell, P. B., Ragan, K., & Stowe, Z. N. (2007). Suicidal ideation in pregnancy: assessment and clinical implications. *Archives of Women's Mental Health,* 10(5), 181-187. https://doi.org/10.1007/s00737-007-0192-x

Palladino, C. L., Singh, V., Campbell, J., Flynn, H., & Gold, K. J. (2011). Homicide and Suicide During the Perinatal Period: Findings From the National Violent Death Reporting System. *Obstetrics & Gynecology,* 118(5), 1056-1063. https://doi.org/10.1097/AOG.0b013e31823294da

Parker, B., McFarlane, J., Soeken, K., Silva, C., & Reel, S. (1999). Testing an intervention to prevent further abuse to pregnant women. *Research in Nursing & Health,* 22(1), 59-66.

Patel, V., Rodrigues, M., & DeSouza, N. (2002). Gender, poverty, and postnatal depression: a study of mothers in Goa, India. *The American Journal of Psychiatry,* 159(1), 43-47. https://doi.org/10.1176/appi.ajp.159.1.43

Pearlin, L. I., & Schooler, C. (1978). The Structure of Coping. *Journal of Health and Social Behaviour,* 19(1), 2-21. https://doi.org/10.2307/2136319

Peedicayil, A., Sadowski, L. S., Jeyaseelan, L., Shankar, V., Jain, D., Suresh, S., & Bangdiwala, S. I. (2004). Spousal physical violence against women during pregnancy. *BJOG: An International Journal of Obstetrics & Gynaecology,* 111(7), 682-687.

Pence, ellen. (1980). Duluth Model. Domestic abuse intervention programmes.

Perales, M. T., Cripe, S. M., Lam, N., Sanchez, S. E., Sanchez, E., & Williams, M. A. (2009). Prevalence, types, and pattern of intimate partner violence among pregnant women in Lima, Peru. *Violence Against Women,* 15(2), 224-250. https://doi.org/10.1177/1077801208329387

Purwar, M. B., Jeyaseelan, L., Varhadpande, U., Motghare, V., & Pimplakute, S. (1999). Survey of physical abuse during pregnancy GMCH, Nagpur, India. *The Journal of Obstetrics and Gynaecology Research,* 25(3), 165-171.

Rajamouli, J., Ravinder, A., Reddy, S., & Pambi, S. (2016). Study on Prevalence of Anemia among Pregnant Women attending Antenatal Clinic at Rural Health Training Centre (RHTC) and Chalmeda Anand Rao Institute of Medical Sciences Teaching Hospital, Karimnagar, Telangana, India. *International Journal of Contemporary Medical Research,* 3(8).

Ramsay, J., Carter, Y., Davidson, L., Dunne, D., Eldridge, S., Feder, G., ... Warburton, A. (2009). Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *The Cochrane Database of Systematic Reviews,* (3), CD005043. https://doi.org/10.1002/14651858.CD005043.pub2

Rodriguez, T. J. (2011). Psychological well-being and coping mechanisms of battered women. *Asian Journal of Health,* 1(1), 111-127.

Sajith, M., Nimbargi, V., Modi, A., Sumariya, R., & Pawar, A. (2014). Incidence of pregnancy induced hypertension and prescription pattern of antihypertensive drugs in pregnancy. *Int J Pharma Sci Res*, *23*, 4.

Samuel, T. M., Thomas, T., Finkelstein, J., Bosch, R., Rajendran, R., Virtanen, S. M., ... Duggan, C. (2013). Correlates of anaemia in pregnant urban South Indian women: a possible role of dietary intake of nutrients that inhibit iron absorption. *Public Health Nutrition,* 16(02), 316-324. https://doi.org/10.1017/S136898001200119X

Schumacher, J. A., & Leonard, K. E. (2005). Husbands' and wives' marital adjustment, verbal aggression, and physical aggression as longitudinal predictors of physical aggression in early marriage. *Journal of Consulting and Clinical Psychology*, *73*(1), 28–37. https://doi.org/10.1037/0022-006X.73.1.28

Seyle, H. (1978). *The Stress of Life*. McGraw-Hill Education.

Shamu, S., Abrahams, N., Temmerman, M., Musekiwa, A., & Zarowsky, C. (2011). A Systematic Review of African Studies on Intimate Partner Violence against Pregnant Women: Prevalence and Risk Factors. *PLoS ONE,* 6(3), e17591. https://doi.org/10.1371/journal.pone.0017591

Shrivastava, P. S., & Shrivastava, S. R. (2013). A Study of Spousal Domestic Violence in an Urban Slum of Mumbai. *International Journal of Preventive Medicine,* 4(1), 27-32.

Sigalla, G. N., Mushi, D., Meyrowitsch, D. W., Manongi, R., Rogathi, J. J., Gammeltoft, T., & Rasch, V. (2017). Intimate partner violence during pregnancy and its association with preterm birth and low birth weight in Tanzania: A prospective cohort study. *PloS One,* 12(2), e0172540.

Sullivan, C. M. (2012). Examining the work of domestic violence programs within a "social and emotional well-being promotion" conceptual framework. *Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved February*, *23*, 2014.

Supraja, T. A., Thennarasu, K., Satyanarayana, V. A., Seena, T. K., Desai, G., Jangam, K. V., & Chandra, P. S. (2016). Suicidality in early pregnancy among antepartum mothers in urban India. *Archives of Women's Mental Health,* 19(6), 1101-1108. https://doi.org/10.1007/s00737-016-0660-2

Suryavanshi, N., Naik, S., Waghmare, S., Gupte, N., Khan, S., Mave, V., ... Shankar, A. (2018). Gender-based violence screening methods preferred by women visiting a public hospital in Pune, India. *BMC Women's Health*, *18*. https://doi.org/10.1186/s12905-018-0515-2

Swailes, A. L., Lehman, E. B., & McCall-Hosenfeld, J. S. (2017). Intimate partner violence discussions in the healthcare setting: A cross-sectional study. *Preventive Medicine Reports*, *8*, 215–220. https://doi.org/10.1016/j.pmedr.2017.10.017

Taft, A. J., Small, R., Hegarty, K. L., Watson, L. F., Gold, L., & Lumley, J. A. (2011). Mothers' AdvocateS In the Community (MOSAIC)-non-professional mentor support to reduce intimate partner violence and depression in mothers: a cluster randomised trial in primary care. *BMC Public Health,* 11(1), 178.

Taylor, R., & Nabors, E. L. (2009). Pink or Blue ... Black and Blue? Examining Pregnancy as a Predictor of Intimate Partner Violence and Femicide. *Violence Against Women,* 15(11), 1273-1293. https://doi.org/10.1177/1077801209346714

Teixeira, C., Figueiredo, B., Conde, A., Pacheco, A., & Costa, R. (2009). Anxiety and depression during pregnancy in women and men. *Journal of Affective Disorders*, 119(1), 142-148. https://doi.org/10.1016/j.jad.2009.03.005

Tirado-Muñoz, J., Gilchrist, G., Farré, M., Hegarty, K., & Torrens, M. (2014). The efficacy of cognitive behavioural therapy and advocacy interventions for women who have experienced intimate partner violence: a systematic review and meta-analysis. *Annals of Medicine,* 46(8), 567-586. https://doi.org/10.3109/07853890.2014.941918

Tiwari, A., Leung, W.-C., Leung, T. W., Humphreys, J., Parker, B., & Ho, P. C. (2005). A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG: An International Journal of Obstetrics & Gynaecology,* 112(9), 1249-1256.

Tonsing, J., & Barn, R. (2017). Intimate partner violence in South Asian communities: Exploring the notion of "shame" to promote understandings of migrant women's experiences. *International Social Work,* 60(3), 628-639. https://doi.org/10.1177/0020872816655868

UNICEF. (2009). *Progress for Children* (No. 8) (p. 52).

Van Parys, A.-S., Verhamme, A., Temmerman, M., & Verstraelen, H. (2014). Intimate Partner Violence and Pregnancy: A Systematic Review of Interventions. *PLoS ONE,* 9(1), e85084. https://doi.org/10.1371/journal.pone.0085084

Vogel, J. (2013). Effective gender-based violence screening tools for use in primary health care settings in Afghanistan and Pakistan: a systematic review. *Eastern Mediterranean Health Journal ,* 19(3), 219-226.

Vu, A., Wirtz, A. L., Bundgaard, S., Nair, A., Luttah, G., Ngugi, S., & Glass, N. (2017). Feasibility and acceptability of a universal screening and referral protocol for gender-based violence with women seeking care in health clinics in Dadaab refugee camps in Kenya. *Global Mental Health,* 4. https://doi.org/10.1017/gmh.2017.18

Waalen, J., Goodwin, M. M., Spitz, A. M., Petersen, R., & Saltzman, L. E. (2000). Screening for intimate partner violence by health care providers. Barriers and interventions. *American Journal of Preventive Medicine,* 19(4), 230-237.

Wang, T., Liu, Y., Li, Z., Liu, K., Xu, Y., Shi, W., & Chen, L. (2017). Prevalence of intimate partner violence (IPV) during pregnancy in China: A systematic review and meta-analysis. *PloS One,* 12(10), e0175108.

World Health Organization (Ed.). (2016). *WHO recommendations on antenatal care for a positive pregnancy experience*. Geneva: World Health Organization.

World Health Organisation. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*.

ANNEXURES

1. INFORMED CONSENT

Namaste,

Thank you so much for coming to Dilaasa. I am working with CEHAT organisation which is the research centre of Anusandhan Trust. This centre is involved in research, training, service and advocacy on health and allied themes. CEHAT was also a partner in starting Dilaasa department of this hospital. Dilaasa means reassurance and thishospital based center seeks to provide psychosocial support to women survivors of domestic violence. Currently, we are working on a project that is trying to assess the effectiveness of counselling intervention in ANC setting for pregnant women facing domestic violence

As a part of this study, pregnant women will be screened for domestic violence during their first ANC visit. During this screening process, some questions will be asked from you. A counselling session will be given to those women who will be identified as experiencing violence and continuous individual support will be provided till 6 weeks post delivery. During this, some information from your ANC papers will also be recorded which will be kept confidential. Some of the questions during screening might be difficult to answer, but many women have found screening and counselling session useful.

If you agree to participate, session will take about 30-40 minutes of your time. Your participation will be very valuable in completing this study. I would like to assure you that information shared by you will be kept confidential and will be available to only those people who are conducting this study. During session, you can refuse to answer any question or to withdraw at any point of time.

Your decision to participate or not to participate is entirely voluntary and it will not affect your access to any of the health services. Is there anything you'd like to ask me at this point?

If you have any doubts, questions or clarifications you are free to contact the following address:

Sanjida Arora

Survey No. 2804 & 2805, Aaram Society Road, Santa Cruz (East), Mumbai- 400 055
Phone Number: 8976552582

If you have any concern about this research, you can contact Dr. Anant Bhan at 7747012060 and 9420160170

If you have agreed to participate, kindly sign the form or indicate so by putting your thumb impression.

Signature of respondent _____

Signature of interviewer _____ Date:

2. PRE- INTERVENTION FORM

DILAASA: CRISES CENTRE FOR WOMEN INTAKE FORM

A. Demographic and Socio-economic characteristics

Reg No :							Date:			
Age (in completed years):										
Religion	Hindu		Muslim		Christian		Buddhist		Others	

Marital Status	Single		Currently Married		Separated		Widowed	
	Deserted		Divorced		Live in relationship		Others	

Number of years of marriage			
Age at the time of marriage (in completed years)			
Number of living children (Write number against male and female)	MALE		FEMALE
Family type	Nuclear	Joint	Extended

Education							
Illiterate		Primary		Secondary			
Post Graduate		Vocation Course		Others			
Occupation							
Not Employed		Domestic worker		Informal sector		Others	
				(specify)			
Formal sector		Self-employed					
Woman's income (Monthly)							

Safe Address:				
Safe Phone Number to get in touch:				
Relationship with safe phone number:				
Self	Natal Family	Marital Family	Neighbours/Friends	Others

Do you have any important documents with you? (for intervention purpose)

Marriage certificate		Marriage photo		Birth certificate of children	
Ration card		List of streedhan		Receipts of Jewelry	
Investments in your name		Voter card		Health reports	
Academic certificates		Property papers		Bank account	
Any other		Passport			

Police Station nearest to residence?
Police Station nearest to incidence?

Date :	NC/FIR No.

B. Obstetric history

Current gestational age		
Time lapse between pregnancy suspected by woman and registration for ANC		
What was the reason for delayed registration (if there is a delay)		
(Probing: was busy, Not aware, Children at home, violence, any other (specify))		
Number of pregnancies		
Number of deliveries		
History of induced abortion (Write number against Yes)	Yes	No
History of miscarriage (Write number against Yes)	Yes	No

C. History of Violence

Number of years you have experienced violence:

What is your life story? (In terms of marriage or otherwise, type of marriage, how was your relationship with the abuser, severity of violence etc.) [Write in first person, in her own words]

Details of recent incident of violence:

Type of Violence faced

(Please tick from each type of violence) (A body map can be used to help the woman talk about where she was assaulted)

Physical	**Emotional**	**Sexual**	**Financial**
Beating, slapping by hand	Verbal abuse	Forced sex	Not allowing her to seek employment
Pinching	Persistent Criticism	Painful sex	
Pulling hair	Isolation	Forced oral sex	Denying access to money.
Pushing, shoving		Forced anal sex	
Twisting the arm	Threats to throw acid on her face	Withholding sexual pleasure	Denying right to her own income
Banging the head on the wall & floor	Threats to remarry		
Punching the face/chest/ abdomen			
Kicking face/chest/abdomen	Husband not communicating with her	Sexual advances from other family members	Asking her for an explanations for every expenditure
Belting the woman			
Human bites on different body parts	Threats against her family	Denying her the use of contraceptives	Denying her food and shelter
Use of blunt instruments			

Physical	Emotional	Sexual	Financial
Use of sharp instruments	Suspicion	Forcing her to have children	Demanding money, home, vehicle from her marital family
Strangulation			Any others (Specify)
Forcing her to consume poison	Restricting Mobility	Forcing her to have male children	
Any other (Specify)	Humiliating her in public	Any other (Specify)	
	Extra marital affair		
	Any other (Specify)		

Relationship with individuals who are abusive:

☐	Relationship
	Husband/Partner/boyfriend
	Marital family (specify)
	Natal family (specify)
	Children (specify)
	Others (specify)

D. Coping & help seeking behaviour after episodes of violence

At an individual level	Informal	Formal
Defended self during episode	Natal family	Caste/community panchayat
Got on with daily routine	Marital family	NGO
Took up a job	Friends	Political party
Focused on taking care of children	Neighbours	Area social workers
Stepped out of the house	Colleagues/ employer	Community leaders
Concentrated on her health	Any other (Specify)	Police station
Any other (Specify)		Shelter homes
		Lawyer and courts
		Joined a livelihood programme to enhance her skills
		Any other (Specify)

E. Impact on physical and psychological health

A. How would you describe your present health? (Any illness, injury, recent hospitalization, currently on medication, weakness, cannot do usual activities, anxiety, stress, etc.)

Brought her attention to the relationship between the violence she is experiencing and her physical and mental health status.

B. What are the health consequences of violence that you are facing?

Cuts, bruises, wounds	Headache	Inability to take care of one's own self (personal hygiene etc.)
Bone fractures	Poor appetite	Any other (Specify)
Burns	Can't sleep	
Permanent disabilities like loss of sight, hearing etc.	Feeling constant fear	
Swelling of any body part due to physical violence	Hands, legs, body shake/ shiver	
Genital injuries/sores due to forceful sex	Get nervous, tense or worried	
Redness in genital area	Poor digestion	
Itching in genital area	Restlessness	
Bleeding/spotting from vagina after being hit	Feel unhappy/ depressed	
Vaginal discharge	Weakness	
Any other (Specify)	Feel worthless	
	Thought of ending your life (suicide ideation)	
	Attempted to end your life	
	Always feel tired without any apparent reason	
	Nightmares	
	Forgetfulness	
	Inability to concentrate	
	Always preoccupied with thoughts	
	Any other (Specify)	

F. Safety assessment

The following questions to be asked to assess her safety. The more the number of yeses, the unsafe her going back would be. Here, it is important to draw up a safety plan with the woman so that she can protect herself. **A safety plan would have to be draw up even if the woman answers "No" to the above questions.**

1. Has the violence increased in frequency over the past year?
2. Has the severity of violence increased over the past year (From kicks & blows or there is use of instruments)
3. Do he and/or his family threaten to kill you? If yes, then do you believe that they can kill you?
4. Do he and/or his family threaten you with second marriage? If yes how serious do you think the threat is?
5. Have you thought of committing suicide? If yes, then have you attempted it, do you have any plan of committing suicide?
6. Is he violent towards your children and/or other family members? If yes, then has this increased in the past year?

Intervention

(Discussion with woman)

Reg of complaints (MLC, Police complaint)

Medical (Refer her to an OPD/IPD, Explain the health complaints that the woman is suffering)

Emotional Support (Reassure her that violence is not her fault, help her to understand the pattern of abuse, share with her that she is not alone, coping mechanism make specific suggestion like attend women's meeting, engage in paid work, skill building etc, stress on her strengths,. helping her to link it to a larger oppressive structure in which we live and how violence against woman happens most of the time.)

Social Support (Income generation, Skill building, Educational Support for children such as Balwadi, boarding schools)

Shelter:

Police (Information and explanation on the importance of filing an NC and other complaints)

Legal Counselling (her rights, procedure for injunction, PWDVA, stay order, maintenance, divorce)

SAFETY PLAN

Safety plan discussed with woman (physical and Psychological):

Expectations from the counselling services (In the woman's words)

Additional Questions for post- intervention assessment

A. Experience with pregnancy

What was the outcome of your recent pregnancy?

1. Live birth
2. Preterm birth
3. Still birth
4. Spontaneous abortion
5. Induced abortion

What is/was the sex of baby?

1. Male
2. Female

What was the weight of baby?

What was the type of delivery?

1. Normal
2. Caesarean

B. Violence

Since the last time we talked, has the violence increased or decreased? (Probe: Severity and frequency of violence)

C. Coping & help seeking behaviour during episode of violence

Since the last time we talked, were you able to cope with violence better than earlier? What were the coping mechanisms adopted by you? (Probe: shared the episode of violence with someone, contacted someone to intervene, contacted some formal agency etc.)

Reason (s) for not adopting any coping mechanism:

Have you decided to adopt any of these coping measures in future?

D. Health

a. How would you describe your present health? (Probe: appetite, sleep, anxiety, stress, suicidal ideation, concentration)

b. Do you think there has been any change in status of health after started visiting counsellor? If yes, in what way? (Probe: by using the health complaints reported by women during pre-intervention

c. Did you seek any treatment from healthcare provider for your health problems after discussing them with counsellor? Have you followed the treatment prescribed by healthcare provider?

E. Safety Measures

a. During this, did you use any of the safety measures discussed by counsellors with you? If yes, then what are the measures taken by you?

b. Reason (s) for not using any safety measures:

c. Have you decided to use any of these safety measures in future?

F. How has counselling sessions met your expectations?

4. TABLE

Changes	Hospital A	Hospital B	Total
Cognitive Changes			
Recognising violence as an issue of power	40 (53.3%)	46 (68.6%)	86
Recognising the impact of violence on health	50 (66.6%)	43 (64.1%)	93
Recognising the need to raise voice against violence	44 (58.6%)	41 (61.1%)	85
Actions at Individual Level due to Intervention	39 (52%)	45 (67.1%)	84
Emotional Changes	46 (61.3%)	52 (77.6%)	98
Feeling Of Self Sufficient	19 (25.3%)	14 (20.9%)	33
Actions At Informal And Formal Level	62 (82.6%)	61 (91%)	123
Safety			
Adopted a safety measure	28 (37.3%)	23 (34.3%)	51
Recalled a safety measure	44 (58.6%)	45 (65.7%)	88
Not able to adopt during episode of violence	3 (4.1%)	0	3
Health			
Better	57 (76%)	62 (92.5%)	119
Remained the same	18 (24%)	5 (7.5%)	23

Table 1 Comparison of Number of Women with Improved Outcomes Due To Intervention in Hospital A and B

Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Violence and Health

ISBN : 978-81-89042-82-0