

EFFECTS OF VAW ON PREGNANCY AND NEWBORN

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**For DHEERA,
An initiative by Dr. Shantha Kumari,
President of The Federation of Obstetric and
Gynaecological Societies of India**

Have you ever seen patients in your OPD who have been victims of violence or abuse ?

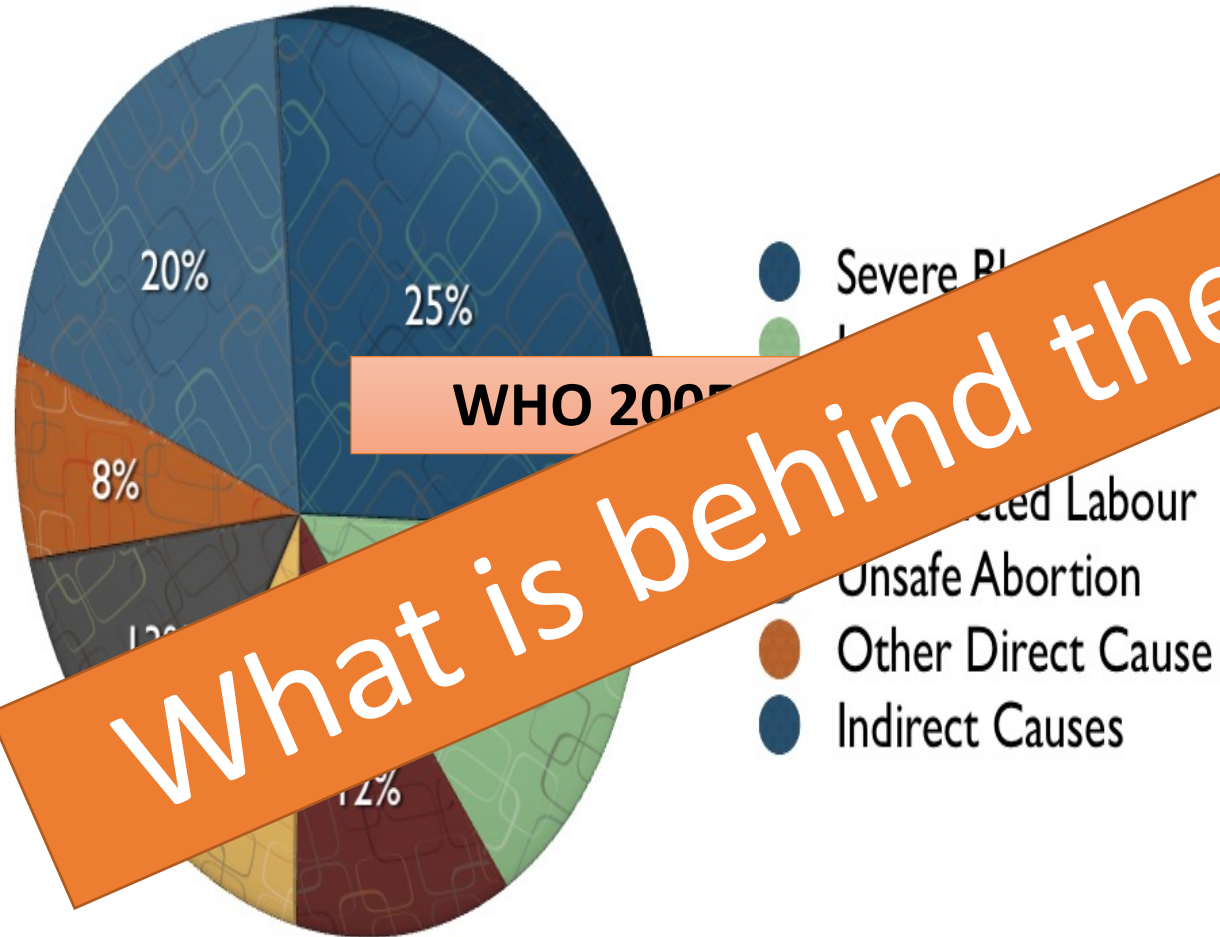
How do they present?

How have you diagnosed?

What are the common clinical presentations ?

CAN YOU RECOLLECT A CASE SCENE?

Causes of Maternal Death



The World Health Report 2005. Make every mother and child count.
Geneva, World Health Organization, 2005

90 per cent of maternal deaths are avoidable.

POSTPARTUM PERIOD 60%

50% in 24 HOURS-

6 CAUSES

3 DELAYS

HIGH levels of VIOLENCE during pregnancy

“

He hit me in the belly and made me miscarry two babies....
I went to the hospital with heavy bleeding and they cleaned me up.

– Woman interviewed in Peru

CASE STUDY - 1

PRIMI-PROM

Prolonged, obstructed labor

Presented with

Rupture uterus-shock

MATERNAL MORTALITY

History revealed later

- H/o brutal kicking on the abdomen by husband and pushed violently falling on a sharp edge

DEATH DUE TO
VIOLENCE

CASE STUDY - 2

G3P2L2 28 WKS -2 LSCS

APH-shock-placenta accreta

Hysterectomy-10-blood
transfusions-bladder involvement

What precipitated
bleeding?
Husband kicking on
abdomen!

CASE STUDY - 3

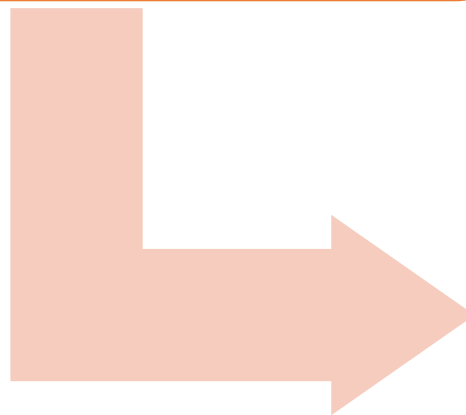
**A woman with severe
preeclampsia and
unconscious -**

**Eclampsia with CVA
leading to maternal
mortality.**

**Actually - Violence by Husband
Postmortem- Fracture skull and
cerebral hemorrhage.**

**DIRECT DEATH DUE TO
VIOLENCE**

**Hidden Violence
Masquerading as
Maternal disorder**



**DEATH DUE TO
ECLAMPSIA**

CASE STUDY - 4

- G3P2L2-2 Previous LSCS-Full Term
- Rod implanted-fracture femur/hip joint.
- Collapsed in front of a hotel
- Brought to Hospital in 108-
- in active labor with severe hypertension
- Emergency LSCS done-consent by RMO



**PUSHED FROM 2ND FLOOR- 3 YEARS BACK
NOW ABANDONED IN LABOUR**



CASE STUDY - 5

G3P2L0D2 with 2pr LSCS
- 36 weeks -severe
anemia

- Both times H/O Physical violence –
- kicking on the abdomen brutally by husband-followed by loss of fetal movements.
- 3rd pregnancy- parents brought her home-
- Transfused blood – LSCS-Live baby

CASE STUDY - 6

- G6P2L2A3
- 2 previous cesarean sections
- 3 induced- abortions
- Acute Hemorrhage, shock, sepsis, incomplete abortion

- Severe form of physical , emotional violence-forced abortions – abandonment
- DV history brought out only by screening
- Received 4 transfusions

STAB INJURY-HUSBAND-inebriated-lacerations on face Perforation-uterus-IUFD— LAPAROTOMY-RENT REPAIR



Obstetrician
and
Gynaecologist-
a Specialist
Stakeholder in
women's
Health-

A unique position

To assess and provide support for
women who experience Violence
because of the nature of the
patient–physician relationship

Many opportunities for intervention that occur during the course of

Adolescence

Pregnancy,

Family planning,

Annual examinations,

Other women's health visits.

HOW TO ELICIT HISTORY

INDIRECT QUESTIONS

The following may be helpful:

Is everything alright at home?"

Are you getting on with your partner?"

SCREENING TOOLS

- Abuse Assessment Screen
- Humiliation, Afraid, Rape, Kick (HARK) Screen
- Hurt, Insult, Threaten, Scream (HITS) Screen
- Ongoing Abuse Screen
- Ongoing Violence Assessment Tool
- Partner Violence Screen
- Slapped, Thrown and Threatened Screen
- Woman Abuse Screen Tool (WAST)
- Women's Experience with Battering Scale

WHO 2018

- The WHO recommends that all health professionals be trained in first-line response to family violence.
- The steps are to: listen, believe, inquire about needs, validate the person's experience, enhance safety and offer ongoing support.
- “Universal screening” or “routine enquiry” (i.e. asking all women at all health-care encounters) about IPV is not recommended. However, the WHO guidelines identify ANC as a setting where routine enquiry could be implemented if providers are well trained on a first-line response and minimum requirements are met

ENSURE SAFETY

- The evidence on benefits and potential harms of clinical enquiry and subsequent interventions is lacking or uncertain.
- A minimum condition for health-care providers to ask women about violence is that it must be safe to do so (i.e. the partner is not present) and that identification of IPV is followed by an appropriate response
- Detailed guidance on responding to IPV and sexual violence against women can be found in the 2013 WHO clinical and policy guidelines



REGISTRATION and PRE – TEST

POST-TEST and FEEDBACK



**Certificate will be awarded to participants on course attendance
and submission of Registration, Pre-Test, Post-Test, Feedback**

Many women in many parts of the world speak the same
language - the language of silence !

Anasuya Sengupta

*And its up to us -Obstetrician and
gynecologists - to be the voice of the silent
victim*