Author’s response to reviews

Title: Gender-based Violence Screening Methods Preferred by Women Visiting a Public Hospital in Pune, India.

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Version: 1 Date: 03 Nov 2017

Author’s response to reviews:

Dated November 3rd, 2017

To,

The Editor,

Biomedical Central Women’s health.

Subject: Point-by-point response to the editors and reviewer’s comments on BMWH-D-17-00003
Gender-based Violence Screening Methods Preferred by Women Visiting a Public Hospital in Pune, India.

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Editor Comments:

Thank you for your submission to BMC Women's Health. In addition to addressing the reviewers' comments, please address the following editorial points:

- Please include a "List of abbreviations" after the conclusions.

Response: Thanks for this comment. We have now added the list of abbreviations after the conclusions.

- Please ensure that your manuscript adheres to STROBE guidelines for reporting observational studies (http://www.strobe-statement.org/index.php?id=strobe-home) and please include a completed STROBE checklist as an additional file.

Response: Thanks. We have now used STROBE checklist and included it as additional
- Please remove all color and shading from tables. Guidelines can be found here: https://bmcwomenshealth.biomedcentral.com/submission-guidelines/preparing-your-manuscript#preparing+tables

Response: Table has been revised as instructed.

- Please include the questionnaires used in your study, in the original language(s) and in English translation, as additional files. Guidelines are here: https://bmcwomenshealth.biomedcentral.com/submission-guidelines/preparing-your-manuscript#preparing+additional+files

Response: We have included questionnaire as additional file (Supplementary file 1).

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Reviewer reports:

Anuradha Paranjape (Reviewer 1):

1. My biggest concern with this paper is that the methods section is very brief and appears to omit details. It appears to be a convenience sample - how did the counselors decide which women to approach? It is certainly possible that there was selection bias. One example - if women were accompanied by a mother in law or other family members it is possible that such women were not interviewed.

Response: We thank the reviewer for this comment. We have provided more detail in the methods section that describes how this sample of women was identified. For this study, we did not use a convenience sample. However, we were not able to obtain a truly random sample of all women attending each of these departments. What we were able to do is systematically obtain a
representative sample of women in these wards. This was done as follows: we had two counselors who had daily duties to provide counseling and care to patients in each of these wards. We pre-assigned days during the week in which each counselor was to complete 3-4 interviews in the clinic that they were serving. Once assigned, and after their daily commitments were completed, the counselors identified one prospective woman who was waiting and requested her to participate in the interview. If she agreed, informed consent was obtained and the interview was completed. After this point, an additional 2-3 interviews were conducted consecutively in that same ward. All women with or without an accompanied person accessing care in the institution were approached by the study counselor and were consented. We only had two women refusing to be part of the study. Whether their refusal was influenced by who was accompanying such as mother-in-law, was not documented. However, we believe that this is such a small number that selection bias although possible will play a very inconsequential part.

2. Second, the definition of GBV is open to bias-since it is self-reported and some women may not consider themselves to be abused, which is why the prevalence is lower (or incidence).

Response: In our study, we used previously used definition by Sharma et.al (2010) and adapted questions from National Family Health Survey (NFHS -3) and other studies to assess gender based violence. The prevalence of GBV in our study falls within the reported prevalence (10-60%) for our region. It is possible that women may underreport self-reported GBV but generally GBV prevalence is assessed using standardized questionnaire and are subject to perception bias. We have added this as a limitation of the study (Page 8, paragraph 1).

3. It is not clear if the study measures lifetime abuse, incident abuse or prevalence over a certain time frame.

Response: Thank you for this comment. We measured partner based GBV, therefore the time frame for GBV is since marriage. We were interested in intimate partner violence. We understand that this is a very sensitive topic and therefore is subject to under-reporting. We have now clarified that in the methods section (Page 5, paragraph 2).

4. Third- were any safety measures in place if ongoing abuse or escalating abuse was disclosed?

Response: Thank you for this comment. Our study was conducted in a large public health care hospital and those reporting GBV were referred to appropriate counselling and clinical services. In the hospital, there is a specific protocol for addressing GBV if it is reported in alignment with standard hospital procedures.
5. Since there are significant issues with the methods, I cannot really comment on the findings

Response: We have revised the methods section for clarity. We believe that our study methodology is robust. The goal of the study was to assess the best screening strategy for GBV among women accessing care at a large public health care facility. We found that in person assessment by a trained counsellor is a preferred method of GBV screening.

6. The study was conducted before a paper that describes how well does the WHO definition of GBV work in an Indian context [5. Kalokhe, AS, Potdar RR, Stephenson, R, Dunkle, KL, Paranjape, A, del Rio C, Sahay, S, How well does the World Health Organization Definition of Domestic Violence Work for India? PLoS ONE, 2015; 10(3): e0120909. PMID [25811374]. Dr. Kalokhe has also developed a scale to measure Family violence in an Indian context - and that definition is inclusive of acts of abuse where the perpetrator is an in-law. This study was conducted in Pune, India, which is where BJMC is located (full disclosure, I am co-I and I am a BJMC/Sassoon alumna).

Response: Thank for this additional information. We reviewed this article and believe that this paper is not relevant to our study goal.

Khurshed Alam (Reviewer 2): Gender-based violence (GBV) is a major global public health issue which is a risk factor for adverse health outcomes. Early identification of GBV is crucial for improved health outcomes among the victims. Interactions with health care providers may give a unique opportunity for routine GBV screening, if a safe, confidential environment can be established.

The authors followed a face to face interview method in between November 2014 and February 2015. It was done with a cross-section where women were interviewed about their opinions concerning GBV screening in a tertiary health care setting. Trained counsellors interviewed 300 women at different out-patient and in-patient departments using a semi-structured questionnaire. Twenty-three percent of these women reported experiencing GBV in their life since marriage. More than half (53%) women reported face-to-face interview as the most preferred method for screening. There were no major differences in these preferences by GBV history status.
The study has serious methodological limitations which are as follows:

1. Only women willing to report were interviewed, so a sample bias is very clear.

Response: Only women who consented to be interviewed were interviewed as part of the standard protocol for ethical engagement of research participants. All women who consented were interviewed. It is not correct that women who were willing to report GBV were interviewed. As mentioned above, we approached consecutive women accessing care in our institution and only 2 women refused to participate in the study. The focus of this study was to find the optimal GBV screening strategy in this hospital clinic setting.

2. As knowledge goes the hospital is mainly used by low income group, among whom GBV is usually high, for which finding is not matching with national or regional average.

Response: Again, GBV in our population reported is lower than the national average but higher then regional average (As per National Family health survey BBV reported in Maharashtra is 21.4%) and reasons are very well described in discussion section.

3. Many husbands in Pune used to take alcohol, who also commonly go for GBV but that is not reflected in the findings. That could be another method of detecting the GBV.

Response: We did not collect data on husband’s alcohol abuse as this study’s aim is different.

4. All the patients are not from the city, some may be from the rural areas as well. So, they may have some kind of reservation in disclosing GBV.

Response: Yes agreed. Currently, GBV is not being screened for in clinic or hospital settings, which is a primary reason for conducting this study.

5. The detection method, therefore, not a rigorous one and therefore, methodologically not sound. No new or innovative approach could be developed by the authors. In that sense the paper does not add any value to our knowledge.

Response: The goal of the study is to find if GBV screening is acceptable and what could be the preferred method of reporting GBV in a hospital setting. To our knowledge there is no study done in India that would inform the preferred method of GBV screening that need to be adopted in public health care settings as acceptable method by women presenting to hospital.