

Factor Influencing Gender Based Violence among Pregnant Women Attending Antenatal Clinic in PHC of Syangja District, Nepal

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Abstract

Pregnancy and childbirth were a time of unique vulnerability to violence victimization because of changes in women's physical, social, emotional, and economic needs during pregnancy. This study aims to determine the factors associated with gender-based violence among pregnant women attending antenatal care clinic (ANC). A cross-sectional study was conducted among 202 pregnant women attend antenatal ward of primary health care centre (PHC) of Syangja district during September 2014 to December 2014 by using semi-structure questionnaire with face to face interviews. SPSS software was used for analysis the data. The prevalence of gender based violence (GBV) among pregnant women was found to be 91.1%. The socio-demographic variables such as ethnicity, religious, the age of respondents, the age of marriage, occupation, and annual income had no association with the experience of different types of GBV ($p > 0.05$). However, there was a statistically association between husband education ($p=0.03$), the age of marriage ($p=0.039$) and type of marriage ($p=0.013$) in case of psychological and economic violence whereas there was no statistically association between with other types of violence. In conclusion, gender based violence during pregnancy was a major prevalent public health problem in Syangja district of Nepal. Focus on age of marriage, types of marriage and education of husband may reduce gender based violence among the pregnant women. Women's empowerment, economic autonomy, sensitization, awareness and needed of large-scale population-based surveys were the major recommendation of this study.

Abstrak

Faktor yang Memengaruhi Kekerasan berdasarkan Jenis Kelamin pada Wanita Hamil yang Mengunjungi Klinik Antenatal di Pusat Pelayanan Kesehatan Primer Daerah Syangja, Nepal. Kehamilan dan kelahiran anak merupakan waktu rawan yang khusus untuk penganiayaan kekerasan karena perubahan fisik, sosial, emosi, dan kebutuhan ekonomi wanita selama kehamilan. Penelitian ini bertujuan untuk menentukan faktor yang berkaitan dengan kekerasan berdasarkan jenis kelamin pada wanita hamil yang datang ke klinik ANC. Penelitian *cross sectional* dilakukan pada 202 wanita hamil yang mengunjungi bagian antenatal PHC di daerah Syangja selama September 2014 hingga Desember 2014 menggunakan kuesioner semi terstruktur dengan wawancara tatap muka. Perangkat lunak SPSS digunakan untuk menganalisis data. Prevalensi GBV di antara wanita hamil diperoleh sebesar 91,1%. Variabel sosio demografik seperti suku, agama, usia responden, usia pernikahan, pekerjaan, dan pendapatan per tahun tidak berkaitan dengan pengalaman berbagai jenis GBV ($p>0,05$). Walaupun demikian, ada hubungan secara statistik antara pendidikan suami ($p=0,03$), usia kehamilan ($p=0,039$), dan jenis pernikahan ($p=0,013$) pada kasus kekerasan psikologis dan ekonomi walaupun tidak ada hubungan secara statistik dengan jenis kekerasan yang lain. Kesimpulannya, kekerasan berdasarkan jenis kelamin selama kehamilan merupakan masalah kesehatan masyarakat yang paling utama di daerah Syangja, Nepal. Berdasarkan pada usia pernikahan, jenis pernikahan, dan pendidikan suami dapat mengurangi kekerasan berdasarkan jenis kelamin pada wanita hamil. Pemberdayaan wanita, kemandirian ekonomi, sensitisasi, kepedulian dan perlunya survei berdasarkan populasi skala besar merupakan rekomendasi utama penelitian ini.

Keywords: antenatal clinics, factor, GBV, Nepal, PHC, pregnant women

Introduction

Gender-based violence is a global pandemic which takes different forms like physical violence (i.e. pushing,

kicking, throwing objects, hitting with hands or objects, choking, attacking with a knife or blade, and shooting, sexual and emotional abuse), sexual violence (i.e., forced sexual relations, demanding sex or

psychological/emotional (i.e., insults, belittlement, threats to woman or someone she cares about or threat of abandonment). The causes of gender-based violence are multidimensional including social, economic, cultural, political and religious.^{1,2} Different forms of GBV cause physical and mental harm, limit access to education, incur medical and legal costs, reduce productivity, and lower income.

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Women and girls are the most at risk and most affected by gender-based violence because women who suffer abuse during childhood are at greater risk than other women of becoming victims of violence as adults.^{3,4} Women may believe that pregnancy is a protective factor against violence and that their partners will be more sympathetic towards them.⁵ But, pregnancy and childbirth were a time of unique vulnerability to violence victimization because of changes in women's physical, social, emotional, and economic needs during pregnancy.⁶ Violence during pregnancy poses a severe threat to women's health and in the extreme can even cause the mother and her unborn child's death. Similarly, violence during pregnancy is associated with adverse pregnancy outcomes such as low birth weight, spontaneous abortion, bleeding during pregnancy, preterm labor, preterm delivery and higher neonatal deaths.⁵ Extreme stress and anxiety provoked by violence during pregnancy may lead to preterm delivery or reduce women's ability to obtain nutrition, rest, exercise, and medical care.⁷

To improve the health of pregnant women and their infants, it is important that research investigates the risk factors for violence among the pregnant women.⁶ This study aims to determine the factors associated with gender-based violence among pregnant women attending antenatal care clinic (ANC).

Methods

Between September 2014 and December 2014, a cross-sectional study was conducted in the antenatal ward of primary health care centre (PHC) of Syangja district. The study populations were pregnant women attending the antenatal clinic in PHC of Syangja district of Nepal at the time of the study. The sample size was determined using the formula $n_0 = z^2pq/d^2$, where n_0 is calculated sample size, d is a degree of accuracy which is 0.07, z is the confidence interval (1.96), and p is the proportion which is 50%. The calculated sample size was 196. But when finite total expected pregnancy (N) at Syangja district was 7,802 then final population correction

$n = n_0 / (1 + n_0 / N)$ was applied. Now the required sample size for the study was 192, and it was increased to 202 to take care of nonresponse error (5%). Required pregnant women were selected by consecutive sampling method where simple random sampling method were used to selected three primary health centers from each three constituencies. All pregnant women who attended the antenatal clinic of PHC facility were eligible for the study. Pregnant women were excluded if they are admitted for delivery and did not attain ANC at PHC.

The data were collected using a semi-structure questionnaire with face to face interviews. The validity of the data collected was ensured by experts. A pilot study was conducted on 10% of sample size at the size in Sisuwa PHC, Kaski district. Local language (Nepali and Gurung) were used for the face-to-face interview. Data analysis software (Ms. Excel and SPSS version 20) were used for data processing and analysis. All statistical tests were carried out at 5% (0.05) level of significance. Descriptive and inferential statistics (mean, median, mode, standard deviation, Chi-square test) were preferred for data entry and analysis.

Results and Discussion

The mean age of pregnant women attends the ANC was 22.96 ± 3.723 years (15-37 years). The majority, 77.7% (157) were from rural areas, 99% (200) were married, and 49% (99) were of upper caste group as shown in Table 1. Similarly, the mean age of marriage was 19.35 ± 2.356 years (13-27 years) and have majority 70.3% (142) was done arrange marriage. More than half 54.5% (12) of respondent's had monthly income less than NRs. 10,000. Likewise, majority 30.9% (56) of respondent's husband income was between Rs 20,000-40,000. Majority 46.5% (94) of respondents were a housewife, and more than half 57.7% (116) of respondent's had secondary education level. Similarly, majority 59.8% (119) of respondent's husband were mostly involved in going abroad, and majority 54.3% (100) of respondent's husband education level had secondary education level. Majority 33.7% (68) of respondents was of 24-30 weeks. 98% (197) of respondents became pregnant on the desire of both husband and wife.

Table 2 explains that out of 202 respondents 91.1% (184) experience any kind of gender-based violence during pregnancy. Among them, majority 39.7% (73) of respondents experienced only one type of GBV. Out of 91.1%, majority 87% (160) of respondents experienced economic violence where about half 53.8% (99) psychological violence followed by 41.8% (77) sexual violence and 4.3% (8) physical violence.

Table 3 shows there was not statistically association between experience in types of violence (psychological, economic, physical and sexual violence) of residence,

Table 1. Socio-Demographic Characteristics

Demographic Characteristics	Frequency (n)	Percentage (%)
Residence (n=202)		
Rural	157	77.7
Urban	45	22.3
Ethnicity (n=202)		
Upper caste group	99	49
Disadvantage Janajatis	52	25.7
Dalit	26	12.9
Relatively advantaged janajatis	19	9.4
Disadvantage non-dalit terai caste group	3	1.5
Religious minorities	3	1.5
Religious (n=202)		
Hindu	193	95.5
Buddhist	6	3
Muslim	3	1.5
Age of the Respondents (n=202)		
15-20 years	33	16.3
20-25 years	104	51.5
25-30 years	53	26.2
30-35 years	10	5.0
>35 years	2	1.0
Age of Marriage (n=202)		
≤ 20 Years	121	59.9
> 20 Years	81	40.1
Type of marriage (n=202)		
Arrange marriage	142	70.3
Love marriage	60	29.7
Marital status (n=202)		
Married	200	99
Widowed	2	1
Occupation of pregnant women (n=202)		
Housewife	94	46.5
Unemployed	61	30.1
Services	15	7.4
Student	14	6.9
Agriculture	11	5.4
Business	7	3.5
Husband occupation (n=199)		
Abroad	119	59.8
Services	45	22.6
Business	12	6
Unemployed	10	5
Agriculture	9	4.5
Daily Wage Labour	3	1.5
Student	1	0.5
Monthly Income (NRs) of respondents		
Less than 10,000	12	54.5
10,000-20,000	9	40.9
Above 40,000	1	4.5
Husband monthly income (NRs)		
Less than 10,000	11	6.1
10,000-20,000	39	21.5
20,000-30,000	56	30.9
30,000-40,000	35	19.3
Above 40,000	33	18.2
Don't know	7	3.9
Education level of pregnant women		
Illiterate	1	0.5
Primary	19	9.5
Secondary	116	57.7

Higher secondary	48	23.9
Bachelors and above	17	8.5

Husband education level

Continue Table 1.

Demographic Characteristics	Frequency (n)	Percentage (%)
Illiterate		
Can read and write	1	0.5
Primary	15	8.2
Secondary	100	54.3
Higher secondary	40	21.7
Bachelor and above	17	9.2
Don't know	10	5.4
Pregnancy weeks		
12-18	25	12.4
18-24	19	9.4
24-30	68	33.7
30-36	58	28.7
>36	32	15.8
Pregnancy desire persons		
Only husband	1	0.5
Both of you	197	98
Family	4	2

Note:

Mean Age: 22.96±3.723; Max age 37 years; Min age 15 years

Mean Marriage Age: 19.35±2.356; Max age 27 years; Min age 13 years

Mean Pregnancy Week: 27.49±6.889; Max. 40 Weeks; Min. 12 Weeks

Table 2. Types of Gender Based Violence Experienced by Pregnant Women

GBV	Frequency (n)	Percentage (%)
Experience of GBV (n=202)		
Yes	184	91.1
No	18	8.9
Faced of GBV		
Only one	73	39.7
Two	68	37.0
Three	37	20.1
Four	6	3.3
Types of GBV (n=184)		
Control(Economic Violence)	160	87.0*
Psychological Violence	99	53.8*
Sexual Violence	77	41.8*
Physical Violence	8	4.3*

*Multiple Responses

ethnicity, age of respondents, religious, occupation, and respondents education ($p>0.05$). Arrange marriage had high prevalence than love marriage that was statistically significant with experience of psychological violence where $p=0.013$. The respondent husband who had a secondary level of education had a high prevalence of psychological violence in comparison with another level that was statistically significant which $p=0.030$. In the case of economic violence (control), the respondents who had married below 20 years had high prevalence of economic violence and statistically significant i.e. $p=0.039$. But there was no statistical association

between husband education, types of marriage and age of marriage with other types of violence (i.e. physical violence and sexual violence).

Table 3. Association of Experience of Different Types of Gender based Violence with Study Variables

Demographic Characteristics	P			
	Experience of Psychological violence	Experience of Economic violence	Experience of Physical violence	Experience of Sexual violence
Residence	0.805	0.789	0.498	0.768
Ethnicity/Caste	0.209	0.727	0.887	0.335
Age group	0.101	0.943	0.942	0.315
Religious	0.332	0.506	0.823	0.484
Age of marriage	0.311	0.039*	0.878	0.149
Type of marriage	0.013*	0.576	0.277	0.967
Respondent occupation	0.236	0.970	0.561	0.665
Husband occupation	0.594	0.365	0.307	0.254
Respondent education	0.180	0.366	0.956	0.665
Husband education	0.030*	0.971	0.495	0.798

*Significant by Chi-square

In this study, the prevalence of GBV among pregnant women was found to be 91.1%. It clearly reflects that gender-based violence among pregnant women attending antenatal clinic was a major public health problem. These findings suggest that gender-based violence during pregnancy demands special attention, because it affects women in a moment of great physical and emotional vulnerability.⁸ This was consistent with study conducted in Amhara regional state of Ethiopia which shows that the prevalence of domestic violence was 78.0%.⁹ Unlike in our study, gender-based violence was incomparable higher to the prevalence of GBV among pregnant women at Paropakar Maternity and Women Hospital, Kathmandu, study in Parsa District of Nepal and study in Nigeria.^{7,10,11} Probable reasons for the high prevalence recorded in this study are culturally embedded. In the part of the country where the study was conducted, there is an obvious power imbalance between men and women.⁷ Similarly, this might have been because rates of gender-based violence vary, depending on how gender-based violence is defined (e.g. physical, emotional or sexual abuse), the way the questions were posed (the number of and detail in the questions), and the way in which the questions were asked (for example, written survey or face-to-face interview). Other differences may be due to the characteristics of the women studied, the use of single versus multiple interviewers, and whether women are questioned about current or past abuse.¹²

There was not statistically association between experience in types of violence (psychological, economic, physical and sexual violence) of residence, ethnicity, age of respondents, religious, occupation, and respondent's education ($p > 0.05$). Similarly, concealment was a major finding in a study of north central Nigeria which shows that violence an with the age, educational level,

occupation and religion of the women.¹³ But it was inconsistent with the study was done in Parsa district of Nepal which shows that Muslim had a high prevalence of violence as compared to another caste which was statistically significant ($p=0.017$).¹¹ One reason for the difference was the number of Muslim religious respondents was 1.5% in this study. In this study, there was statistically association between husband education ($p=0.03$) and type of marriage ($p=0.013$) in the case of psychological violence and age of marriage ($p=0.039$) in economic violence whereas there was no statistical association between other types of violence. This was the consistent with the study conducted in a study of north central Nigeria which shows that husbands which had lower educational level were more frequently exposed to violence ($p=0.05$).¹³ Similarly, a study done in Parsa district of Nepal shows that types of marriage were significant association with the prevalence of GBV ($p=0.005$) which was consistent with this study.¹¹ These findings suggest that arrange marriage there was strongly associated with the experience of gender-based violence that take a long time to understand the nature of husband, a family where they couldn't explain any difficulties. Likewise, study conducted in Iran shows that age of marriage was significant association with the violence (crude odds ratio (COR)=2.40) which was similar to this study.¹⁴ Generalizations cannot be made by these results because this was a cross-sectional study and the focus was on a specific sample. This study was unable to identifying causal relationships, which was the limitation of the study.

Conclusions

In conclusion, gender-based violence during pregnancy was a major prevalent public health problem in Syangja district of Nepal. Focus on the age of marriage, types of

marriage and education of husband may reduce gender-based violence among the pregnant women. Health-care providers should increase their awareness to husband and family of the risk of gender-based violence and early marriage to protect women from GBV among pregnant women. Women's empowerment and economic autonomy, sensitization and needed of large-scale population-based surveys to better understand the best approach to screen for GBV during pregnancy were the major recommendation of this study.

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