

Prevalence of Intimate Partner Violence (IPV) in Pregnancy and its Determinants among Women Attending Antenatal Clinic in Honiara, Solomon Islands

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Abstract

Introduction: Intimate partner violence (IPV) during pregnancy is a common experience. Knowing the prevalence of intimate partner violence during pregnancy is the first step in helping to inform the development and implementation of interventions to prevent and treat sequelae. As there is no any previous study, this study aimed to assess the prevalence of IPV in pregnancy and its determinants among women attending antenatal clinic in Honiara, Solomon Islands.

Methodology: This was a cross-sectional study which was conducted at the National Referral Hospital (NRH) in Solomon Islands from 2nd May to 31st of May 2016. The data was collected using the World health Organisation (WHO) multi-country study questionnaire. Participants were given an open invitation and those who volunteered to take part in the study were provided with a participant information sheet. Written informed consent was obtained before administration of the questionnaire. Data were analysed using SPSS and a p-value less than 0.05 was consider statistically significant.

Results: Overall, 242 participants participated in the study. The pattern of emotional violence during pregnancy revealed that 'being insulted or made to feel bad about oneself' was the most common (48%) form of emotional violence. In terms of sexual violence, the most common form of abuse that women reported was being forced to have sex when they did not want to. A high proportion (39%) also reported having sex because they were afraid of what their partner might do if they refused. In terms of physical violence, the most common form of abuse appears to be being threatened with or had a weapon used against (34%). The woman's characteristic significantly associated with IPV was being currently/ever married. Women reporting IPV were found to be almost two times more likely to be smokers compared to non-smokers; however this finding was not statistically significant.

Conclusion: The results of the study showed different ranges of IPV among pregnant women in Solomon Islands. Considering the determinants of IPV which are highlighted in this study provides valuable information for future healthy interventions.

Keywords: Intimate Partner Violence; Pregnant Women; Antenatal Clinic; Solomon Islands

Introduction

Intimate partner violence (IPV) during pregnancy is a common experience [1]. Intimate partner violence is the currently accepted term used to describe what has been referred to as “woman abuse”, “woman battering,” or “domestic violence” [2]. IPV can happen within marriage, long-term partnerships or short-term intimate relationships, and can be perpetrated by ex-partners when these relationships have ended [3]. It has been documented as largely perpetrated by men against women, although such violence also occurs in same-sex couples and can be perpetrated by women against men [4].

The occurrence of IPV during pregnancy is of particular concern because of its potential harmful effects on the mother as well as the developing fetus [5]. IPV during pregnancy has been found to be associated with fatal and non – fatal adverse health outcomes for the pregnant woman and her baby due to the direct trauma of abuse to a pregnant woman’s body, as well as the physiological effects of stress from current or past abuse on fetal growth and development [6,7].

Studies have indicated certain women may be at increased risk of IPV during pregnancy due to socioeconomic status (SES), age, marital status, or minority status [8,9]. While IPV can be found at all SES levels, many studies identify increased risk of IPV among both pregnant and non-pregnant lower SES women [10,11]. It was further revealed from a study done in the United States that income and education levels were the most significant predictors of pregnancy violence [12].

The high prevalence of IPV during pregnancy has made it more common than some maternal health conditions routinely screened for in antenatal care [13]. Knowing the prevalence of intimate partner violence during pregnancy is the first step in helping to inform the development and implementation of interventions to prevent and treat sequelae [1].

As there is no any previous study, this study is conducted to determine the prevalence of Intimate Partner Violence in pregnancy and its determinants among women attending antenatal clinic in Honiara, Solomon Islands in 2016.

Methodology

This was a cross-sectional study conducted at the National Referral Hospital (NRH) in Solomon Islands. The NRH currently has an annual total of 5,800 deliveries and this captures women from Honiara’s antenatal population as well as referrals from other provinces. Data was collected from 2nd May to 31st of May 2016. All pregnant women irrespective of their gestational age and the number of visits to each clinic were eligible for the study. Those who were not willing to participate in the study were excluded.

The data was collected using WHO multi-country study questionnaire [14]. A small sample of participants was asked to read the questionnaire and face validity was assessed after translating of the questionnaire by two bilingual translators. The face validity was found to be satisfactory. The questionnaire consisted of 3 sections including variables related to social and demographic characteristics of the pregnant women (11 questions), maternal reproductive history (6 questions) and the women’s history of their experience of IPV in the last month (8 questions).

In this study the total violence refers to any types of IPV including emotional, sexual and physical violence. Emotional violence was defined as being insulted, scared or intimidated, belittled or humiliated, threatened with harm. Physical violence refers to threatened with or used a weapon, slapped or threw something, pushed or shoved, kicked or dragged, hit with fist or something else, choked or burned. Sexual violence was defined to forced sexual intercourse, had sexual intercourse because afraid, and forced to do something sexually degrading.

Before collecting the data, women who met the study inclusion and exclusion criteria were asked to read the information sheet to become aware of the aim of the study. Written consent was obtained before administration of the questionnaire.

Data were transferred to excel software for managing and cleaning then the analysis of the data was applied using SPSS (version 22) and descriptive analysis of variables was done to describe the socio-demographic characteristics of the women. Prevalence of various types of IPV (emotional, sexual and physical) reported by respondents was calculated. Chi squared test was used to determine the association between IPV status and various independent variables. Simple logistic regression was used to calculate unadjusted association between IPV status and various independent variables. Odds ratios and 95% confidence intervals were calculated. P-value less than 0.05 was considered statistically significant.

Approval to do the study was sought from the College of Medicine, Nursing and Health Sciences' (CMNHS) Health Research in Fiji and Ethics committee as well as the Solomon Islands National Health Research Ethics committee.

Results

Overall, 242 participants participated in the study and the response rate was 80%. Table 1 shows demographic characteristics of the participants. A total of 242 women participated in the study. Mean age of the participants was 27.82±6.04 years and ranged from 16 to 44 years. The majority of the women (55.4%) had secondary level of education, were married (52.5%), unemployed (59.9%)

Characteristic	Frequency	Percentage
Participant's age (years)		
less than 20	15	6.2
20 and above	227	93.8
Participant's education level		
No education	10	4.1
Primary	61	25.2
Secondary	134	55.4
Tertiary	37	15.3
Participant's Marital status	94	38.8
Defacto	127	52.5
Married	21	8.7
single		
Participant's Employment status		
Employed	69	28.5
Self-employed	17	7.0
Student	11	4.5
unemployed	145	59.9

Table 1: Demographic characteristics of participants.

The overall prevalence of IPV was 56%. Moreover, the prevalence of physical, emotional and sexual violence was 44%, 93.8% and 42.5%, respectively. Table 2 shows a detailed breakdown of the types of emotional, sexual and physical violence reported by respondents.

Type of violence	Frequency	Percentage
Emotional violence (n = 227)		
Insulted	109	48
Scared or intimidated	49	22
Belittled or humiliated	41	18
Threatened with harm	28	12
Sexual violence (n = 130)		
Forced sexual intercourse	64	49
Had sexual intercourse because afraid	50	39
Forced to do something sexually degrading	16	12
Physical violence (n = 107)		
Threatened with or used a weapon	36	34
Slapped or threw something	25	23
Pushed or shoved	16	15
Kicked or dragged	14	13
Hit with fist or something else	12	11
Choked or burned	4	4

Table 2: Frequency of different forms of emotional, sexual and physical violence reported by respondents (N = 242).

The pattern of emotional violence during pregnancy revealed that ‘Insulted’ was the most common (48%) form of emotional violence. In terms of sexual violence, the most common form of abuse that women reported was being ‘forced to have sex’. In terms of physical violence, the most common form of abuse appear to be being threatened with or had a weapon used against (34%), while only 4% of the women reported being choked or burnt on purpose.

Associations between IPV against women during pregnancy and selected vulnerability factors are presented in table 3.

Variable	IPV n (%)	No IPV n (%)	OR (95% CI)	p value
Age (years)				
Less than 20	8 (53)	7 (47)	0.88 (0.31 - 2.52)	0.82
20 or more	128 (56)	99 (44)	Ref	Ref
Marital status				
Currently/ever married	130 (59)	91 (41)	3.57 (1.34 - 9.55)	0.01
Single	6 (29)	15 (71)	Ref	Ref
Education level				
Secondary and lower	115 (56)	90 (44)	0.97 (0.48 - 1.97)	0.94
Higher education	21 (57)	16 (43)	Ref	Ref
Occupation				
Unemployed	86 (55)	70 (45)	0.88 (0.52 - 1.51)	0.65
Employed	50 (58)	36 (42)	Ref	Ref
Smoking				
Yes	27 (69)	12 (31)	1.94 (0.93 - 4.04)	0.08
No	109 (54)	94 (46)	Ref	Ref
Parity				
Multipara	74 (55)	60 (45)	1.09 (0.66 - 1.82)	0.73
Primi/nullipara	62 (57)	46 (43)	Ref	Ref

Table 3: Cross-tabulation of maternal characteristics and their experience of violence in pregnancy.

The woman’s characteristic significantly associated with IPV was being currently/ever married. Women reporting IPV were found to be almost two times more likely to be smokers compared to non-smokers; however this finding was not statistically significant.

Discussion

The results of the study showed that the most common form of abuse that women reported was being forced to have sex when they did not want to. A high proportion (39%) also reported having sex because they were afraid of what their partner might do if they refused.

In terms of physical violence, the most common form of abuse appears to be being threatened with or had a weapon used against (34%). The woman's characteristic significantly associated with IPV was being currently/ever married. Women reporting IPV were found to be almost two times more likely to be smokers compared to non-smokers, however this finding was not statistically significant.

It was also found that since certain characteristics are associated with an increased likelihood of IPV, disproportionate inclusion of high risk women in studies will also increase reported prevalence rates [15]. The Solomon Islands Family Health and Safety Study (SIF-HSS) revealed that the rate of IPV is higher in urban compared to rural women in the general population, suggesting that the higher rate in our study may also be influenced by the fact that it was done on a high risk population who experienced IPV which affect both mother and her unborn child [16,17].

The antenatal clinic setting and involvement of female nurses in our study may also have allowed greater disclosure of violence compared to the home where the perpetrator may hinder disclosure [18]. Being predominantly a patriarchal society and the associated gender inequality could also influence the high IPV rate [16]. Ranges of IPV prevalence have been reported by different studies around the world. The overall prevalence rate of IPV in developed countries ranged between 10 to 20% [19, 20] and higher rate was reported in African countries such as Ethiopia, Zimbabwe and the Gambia (25, 34 and 61%, respectively) [21-24]. A study conducted in Rwandan the life time violence prevalence was reported 35.3% among women attended antenatal care [25]. Studies conducted in different Pacific countries among women by an intimate partner the violence ranged between 9% to 68% [26-29] with a total rate of 27.9% [30] while the physical and/or sexual violence ranged 13% to 68% [14,31-34].

Younger women, those who are not married, and women from minority groups are also at increased risk for pregnancy IPV [35]. Many reports have identified an association between younger age and pregnancy IPV, with those abused up to four years younger on average [35]. Some national survey reports suggest a nearly double risk of pregnancy IPV for women under 20 [36,37]. Similarly, single women are at increased IPV risk during pregnancy compared with married women, with one study noting a fourfold increase in pregnancy IPV risk among single versus married women [38,39]. In the United States in particular, Native American and African American women have an especially increased incidence of pregnancy IPV [15,40].

Studies have demonstrated younger age among pregnant women to be associated with increased IPV [15]. However, we found in our study that women less than 20 years were less likely to experience violence compared to those 20 years and above (OR 0.88, 95% CI = 0.31 - 2.52), and this difference was not significant. Shamu., *et al.* (2013) have reported that an explanation of why women under 20 years of age were less likely to be abused may be that it is: 'further evidence of the role of gender inequality as these women may have learned to be submissive to their partners and may therefore avoid abuse by their compliance' [18].

Contrary to the literature that pregnancy IPV is higher among single women, we found that the only demographic factor significantly associated with violence during pregnancy was being currently/ever married; women who experience violence were 3.5 times more likely to be currently/ever married compared to single women (OR 3.57, 95% CI = 1.34 - 9.55). This confirms the fact that married/partnered women were living with their partners and therefore vulnerable to being abused.

Our study was conducted in a low-income earning populace where most of the participants were unemployed (64%), which could have increased their likelihood of experiencing violence. But none of the poverty indicators such as low education and unemployment were significantly associated with experiencing IPV in pregnancy.

In fact women with secondary or less education were less likely to experience violence compared to those with higher education, and this finding was not significant (OR 0.97, 95% CI = 0.48 - 1.97). This is consistent with women in the general population according to the SIFHSS, and it is an indication that while education of women is an important intervention many other factors contribute to women's risk of violence [16]. Similarly unemployed women were found to be less likely to experience violence compared to those employed (OR 0.88, 95% CI = 0.52 - 1.51). However this finding was not significant.

Many studies also describe an association between IPV and pregnancy smoking [15]. Even though from our study the majority of women reporting violence were non-smokers (80%), those who experience violence were almost 2 times more likely to be smokers compared to non-smokers (OR 1.94, 95% CI = 0.93 - 4.04). However this was not statistically significant. Contrary to the literature indicating that the risk of experiencing violence is positively associated with the number of children women have, our study did not find any association between parity and violence in pregnancy.

However this study is the first study which is conducted in Salomon Islands there were some limitations such as collecting the data using a self-reported questionnaire which usually increases the possibility of inadvertent or deliberate misreporting. It is notable that due to the use of a non-probability sampling method, the results of this study cannot be generalized to the total antenatal population in Salomon Islands.

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