Journal of
Social & Health Sciences

LOGIXS JOURNALS

Original Article

Exploring patterns of intimate partner violence during pregnancy through a descriptive lens

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Citation: Saifuddin S, Mahmood H, Amjad K, Murad S, Mumtaz H. Exploring patterns of intimate partner violence during pregnancy through a descriptive lens. J Soc Health Sci. 2023;2:25-33.

Received: 27 June 2023
Revised: 09 November 2023
Accepted: 07 December 2023
Published: 31 December 2023

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Abstract

Globally, intimate partner violence (IPV) against women is a serious concern, with significant underreporting in Pakistan. This study aimed to explore the patterns of IPV among pregnant women in a Pakistani setting. An exploratory study using nonprobability purposive sampling recruited 363 pregnant women visiting for check-ups at Akbar Niazi Teaching Hospital, Islamabad. Participants were interviewed using a structured questionnaire developed from an extensive literature review and prior research. Data analysis was performed using SPSS, descriptive statistics, bar charts, and chi-square tests, with the significance threshold set at $p < 0.05$. The demographic analysis revealed that a majority of women (56.75%) were aged 20–29, whereas most husbands fell within the 30–39 age group (68.60%). Educational disparities were significant ($p < 0.001$), with 48.76% of women lacking formal education versus 34.16% of their husbands having higher secondary education or above. The working status highlighted economic dependency, with 91.74% of women not working. Over 61% of pregnancies were unplanned, with 32.28% of participants reporting contraceptive nonuse due to partner opposition. The most reported controlling behavior was the restriction of medical care access (63.36%). Psychological violence was prevalent (25.07% reported humiliation or intimidation), while physical violence was less common (4.96% experienced object throwing). Sexual violence instances were comparatively rare, with 2.75% reporting nonconsensual sexual relations. This study underscores significant sociodemographic and economic disparities affecting pregnant women's exposure to IPV, with psychological violence emerging as the leading form of IPV experienced during pregnancy. These findings underscore the necessity for targeted interventions to improve healthcare access and support pregnant women's autonomy and well-being amidst IPV challenges.

Keywords

Intimate partner violence; Pregnant women; Domestic violence; Psychological violence; Maternal health

1. Introduction

Violence against female partners is widely recognized as a critical concern, affecting nations worldwide and significantly undermining the health and well-being of women and their families [1,2,3]. In 2018, the World Health Organization (WHO) report revealed that nearly one in every three women is at risk of experiencing some form of violence by an intimate partner, thereby highlighting the profound effects on their mental, sexual, and reproductive health [4,5]. The global prevalence of intimate partner violence (IPV) shows significant regional disparities, with reported rates of 33% in Africa, 33% in Southeast Asia, 31% in the Eastern Mediterranean, 25% in the Americas, 22% in Europe, and

20% in the Western Pacific [4,6,7]. Moreover, intimate partners are responsible for up to 38% of all homicides of women worldwide [8].

The development of IPV, originating from multifaceted interactions of factors at the individual, familial, community, and societal levels, underscores the complexity of effectively addressing this issue due to its wide-ranging personal to societal origins [9]. The risk factors for IPV include lower educational levels, exposure to child maltreatment, observing domestic violence, antisocial personality traits, substance misuse, and detrimental masculine norms [4,9,10]. Societal norms that prioritize men over women and restrict economic opportunities for women further increase this risk [11,12]. Furthermore, contributing elements for IPV include a history of violence, marital discord, ineffective communication between partners, and male controlling behaviors within relationships. Unfortunately, gender inequality and the societal normalization of violence against women continue to perpetuate these acts of violence as routine events [4,13].

IPV leads to wide-ranging impacts on women's health, including physical injuries, reproductive problems like unintended pregnancies and gynecological issues, and increased risks of sexually transmitted diseases, miscarriage, stillbirth, premature delivery, and low birth weight [14,15,16]. Psychologically, it causes depression, posttraumatic stress, and anxiety, with behavioral issues like substance abuse and risky sexual behaviors, particularly following childhood violence [4,17]. The significant health implications of IPV emphasize the critical need for examining this issue within vulnerable populations, such as pregnant women. Data indicates that 42% of IPV victims report injuries, face higher rates of sexually transmitted infections, and are twice as likely to undergo an abortion, along with increased risks of miscarriage, preterm births, and depression [4].

Transitioning from a global to a local perspective, in Pakistan, IPV is a significant concern, affecting a large proportion of women, with studies showing that 32% of women encounter physical violence and that up to 40% of ever-married women face spousal abuse [18,19,20]. The Human Rights Watch reports that 70–90% of Pakistani women experience some form of domestic violence, with serious outcomes such as approximately 5,000 annual deaths [21,22]. The prevalence of IPV is alarming during pregnancy, a period requiring increased safety. However, the healthcare system's failure to recognize IPV signs in pregnant women and inadequate law enforcement response exacerbates this issue [23].

The pressing issues identified in the Pakistani context emphasize the critical need for focused research on IPV during pregnancy. The Pakistan Demographic and Health Survey (2020–2020) has also indicated that IPV in Pakistan is prevalent but underreported, with almost half of the surveyed women subjected to physical violence from their partners [24]. Given these circumstances and the urgent need highlighted by national surveys, this study was conducted to explore the patterns of IPV during pregnancy, aiming to improve awareness, intervention programs, and healthcare responses for affected women.

2. Methodology

2.1. Study design and setting

This exploratory study was conducted at Akbar Niazi Teaching Hospital, situated in Islamabad's capital territory, near Bharakahu, which serves patients of various socioeconomic backgrounds. The study was conducted for six months, from March to August 2022. The Ethical Review Committee of the Armed Forces Post Graduate Medical Institute (AFPGMI), Rawalpindi, approved the study (No. 248-AAA-ERC-AFPGMI).

2.2. Sample size and study participants

Using the Raosoft calculator with a 5% margin of error, 95% confidence level, and a 50% response rate for an estimated population of 20,000, we determined a sample size of 377. After excluding 14 cases with missing data, we analyzed data from 363 pregnant women. Participants were recruited through nonprobability purposive sampling, targeting pregnant females in any trimester visiting the hospital for check-ups, fluent in Urdu, English, Punjabi, or Pushto, and who provided written informed consent. Women who were separated, divorced, or widowed were excluded from the study.

2.3. Data collection instrument

A structured questionnaire, developed through an extensive literature review and prior research, was used for data collection [25,26,27]. The survey included four distinct sections—sociodemographic characteristics, pregnancy characteristics, husbands' controlling behaviors, and IPV experiences—all of which were reviewed by field experts. The questionnaire was pretested with ten pregnant women to assess the instrument's clarity, participant comfort, and overall acceptability, whose responses were not incorporated into the main study data. After the pilot test, necessary modifications were made to the questionnaire, and the questionnaire was prepared for final use.

2.4. Intimate partner violence

The IPV experienced during pregnancy was categorized into three main types: psychological, physical, and sexual. Psychological violence encompassed acts aimed at demeaning or instilling fear, including insults, public humiliation, intimidation through yelling or menacing looks, and threats of harm to the victim or their loved ones. Physical violence was identified through actions that cause bodily harm, such as throwing objects with intent to hurt, pushing, shoving, kicking, dragging, hitting the abdomen, strangulation, choking, burning, and threats with a weapon. Sexual violence was defined by instances of nonconsensual sexual relations, coercion into sexual acts due to fear, and forcing victims into degrading sexual activities.

2.5. Data collection procedure

Face-to-face interviews were conducted in a private setting without attendants to ensure confidentiality and comfort, each lasting 10 to 15 minutes.

2.6. Data analysis

The data were entered into SPSS software (version 26.00) for analysis. Descriptive statistics (frequencies and percentages) were calculated to summarize the data. A bar chart was created to illustrate partners' controlling behaviors, and chi-square tests were conducted to analyze sociodemographic differences between pregnant women and their husbands, focusing on age, education, and working status. The results were considered significant at a p value < 0.05.

3. Results

Table 1 shows the sociodemographic characteristics of the pregnant women and their husbands. The majority of the women were in the 20–29 years age range (56.75%), whereas their husbands were often older, with most in the 30–39 years age category (68.60%). Significant differences were observed in educational levels between the partners (p < 0.001). Nearly half of the pregnant women had no formal education (48.76%),

compared to their husbands, where a substantial proportion (34.16%) had attained higher secondary education or above. Moreover, the table further shows gender-based economic disparities in working status, with a high percentage of women (91.74%) not working, indicating dependence on their husbands for financial support.

Table 1. Sociodemographic characteristics of pregnant women and their husbands (n = 363).

Sociodemographics		Wives' Information	Husbands' Information	Family Characteristics	*p* Value **
		Frequency (%)	Frequency (%)	Frequency (%)	
Age group (years)	< 20	38 (10.47)	1 (0.28)	-	< 0.001 ***
	20 – 29	206 (56.75)	97 (26.72)	-	
	30 – 39	115 (31.68)	249 (68.60)	-	
	40 and above	4 (1.10)	16 (4.41)	-	
Religion	Islam	-	-	342 (94.21)	-
	Others	-	-	21 (5.79)	
Residential area	Urban	-	-	144 (39.67)	-
	Rural	-	-	219 (60.33)	
Level of education	No education	177 (48.76)	115 (31.68)	-	< 0.001 ***
	Primary	51 (14.05)	42 (11.57)	-	
	Secondary	73 (20.11)	82 (22.59)	-	
	Higher secondary/above	62 (17.08)	124 (34.16)	-	
Working status	Not working	333 (91.74)	7 (1.93)	-	< 0.001 ***
	Working	30 (8.26)	356 (98.07)	-	
Monthly household income (in PKR)	Below 50,000	-	-	1 (0.28)	-
	50,000-100,000	-	-	346 (95.32)	
	Above 100,000	-	-	16 (4.41)	
Socioeconomic status (SES) *	Upper class (score range: 26 – 29)	-	-	24 (6.61)	-
	Middle class (score range: 5 – 25)	-	-	325 (89.53)	
	Lower class (score range: < 5)	-	-	14 (3.86)	
Family structure	Joint	-	-	255 (70.25)	-
	Nuclear	-	-	108 (29.75)	
Substance addiction of husband	No	-	-	297 (81.82)	-
	Yes	-	-	66 (18.18)	
Marriage type	Love	-	-	35 (9.64)	-
	Arranged	-	-	328 (90.36)	

* Classified the SES of the head of the family through the modified Kuppuswamy scale. ** Data were analyzed by using the chi-square test. *** Significant value ($p < 0.05$).

Nearly one-third of the cohort were first-time mothers (primipara), and a significant portion did not plan their current pregnancies, with 61.71% reporting no intention to conceive (Table 2). The significant reluctance to use contraceptives, as reported by 32.28% of participants, was primarily attributed to partner opposition, highlighting the influence of partner dynamics on reproductive choices and autonomy.

Figure 1 shows the percentages of pregnant women reporting controlling behaviors from their intimate partners. The most commonly reported behavior was medical care access restrictions, with 63.36% of women reporting this issue, highlighting a critical barrier to healthcare access for expectant mothers. Jealousy over-talking to other men was reported by 38.02% of respondents, indicating significant possessiveness. Restrictions on family meetings were reported by 12.40% of women, and indifference and rejection were reported by 9.64%, both of which point to concerning levels of social control and emotional manipulation during pregnancy.

Table 2. Pregnancy characteristics of the study respondents (n = 363).

Characteristics		Frequency (%)
Parity	Primipara	97 (26.72)
	Multipara	153 (42.15)
	Grand Multipara	31 (8.54)
Maternal pregnancy history	Primigravida	82 (22.59)
Number of living children	No Children	88 (24.24)
	1 – 3	207 (57.02)
	4 – 5	50 (13.77)
	More than 5	18 (4.96)
Pregnancy intention	No	224 (61.71)
	Yes	139 (38.29)
Duration of gestation of current pregnancy	First trimester	66 (18.18)
	Second trimester	107 (29.48)
	Third trimester	190 (52.34)
Contraceptive practiced before the current pregnancy	No	285 (78.51)
	Yes	78 (21.49)
Reasons for not using contraceptives (N = 285)	Partner opposition	92 (32.28)
	Unavailability	20 (7.02)
	Unawareness of contraceptive options	36 (12.63)
	Others	137 (48.07)

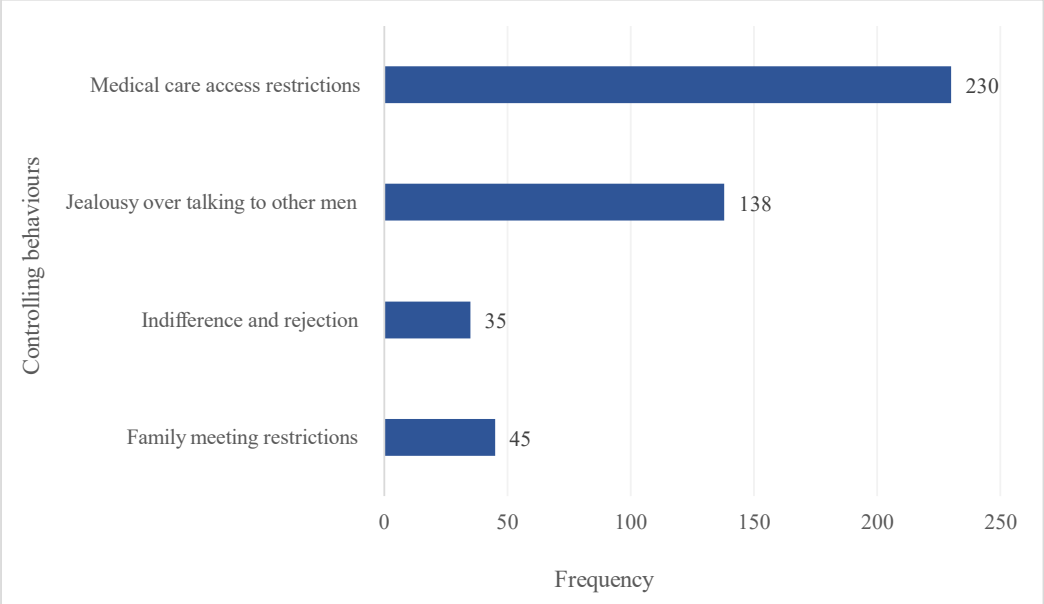

Figure 1. Intimate partners' controlling behaviors toward pregnant women (n = 363).

Table 3 shows the types of IPV reported by pregnant women. Psychological violence was highly reported, with 25.07% of women reporting being belittled or humiliated in public and the same percentage experiencing intimidation through yelling or menacing looks. The frequency of physical violence was lower, with the most common acts being objects thrown to hurt them (4.96%) and pushing or shoving (3.31%). Less frequent were incidents of being kicked, dragged, or hit in the abdomen, each reported by approximately 0.55% of respondents. Instances of sexual violence included nonconsensual sexual relations (2.75%), being coerced into sex due to fear (0.28%) and being forced into degrading sexual acts (1.93%).

Table 3. Intimate partner's violence during pregnancy (n = 363).

Type of Violence	Frequency (%)
Psychological violence	
Insulted or made to feel bad	74 (20.39)
Belittled or humiliated publicly	91 (25.07)
Intimidated by yelling or menacing looks	91 (25.07)
Threatened harm to them or loved ones	24 (6.61)
Physical violence	
Had objects thrown to hurt them	18 (4.96)
Pushed or shoved	12 (3.31)
Kicked or dragged	2 (0.55)
Abdomen hit	2 (0.55)
Strangled, choked, or burnt	1 (0.28)
Threatened with a weapon	1 (0.28)
Sexual violence	
Nonconsensual sexual relations	10 (2.75)
Coerced into sex due to fear	1 (0.28)
Forced into degrading sexual acts	7 (1.93)

4. Discussion

Our findings show significant sociodemographic differences between pregnant women and their husbands, with a notable disparity in educational levels and a commonness of financial dependency among women. A substantial number of pregnancies were unplanned, with reluctance to use contraceptives often linked to partner opposition, highlighting the need for enhanced dialog on reproductive autonomy. Moreover, controlling behaviors by intimate partners were predominantly related to healthcare access, suggesting potential adverse effects on maternal health outcomes. Psychological violence emerged as the primary form of IPV, with physical and sexual violence reported to a lesser degree. These patterns highlight critical areas for intervention to support the health and autonomy of pregnant women and address the multifaceted nature of IPV.

Our study supports findings from Pakistan, indicating that girls and boys face different educational opportunities, primarily owing to how household resources are allocated and other broader socioeconomic disparities [28,29]. These disparities start from primary school and continue to increase education levels, with boys often being more likely to receive higher education, reflecting the country's male-dominated culture. Additionally, we found that husbands usually manage household finances, which matches other local studies showing that this control over money leads to women having less say in household decisions [30,31,32]. This situation is connected to women having less power and independence, making it harder for them to stand up for themselves or make their voices heard because of fears such as the risk of divorce, losing their children, or not having enough support from their own families [31,33,34].

Our findings revealed that between 0.28% and 25.07% of pregnant women in our sample experienced various types of violence. The overall proportion of IPV among these women is nearly one-fifth, which is slightly below the global prevalence of 30% [4]. These findings are in line with those from a study conducted in Delhi, India, which reported a 21% prevalence of IPV among pregnant women [35]. The lower rates of reported IPV in Pakistan and its neighboring country, India, can be attributed to the cultural norms prevalent in these regions, which share similar attitudes that prevent women from reporting IPV [36,37,38]. This cultural influence could lead to data underreporting due to social stigma, fear of retribution, and a lack of support systems. In the meantime, the legal and

judicial frameworks in these countries are evolving; there is still potential for enhancing confidence and effectiveness in the reporting of IPV cases [39,40]. Low levels of education and awareness about IPV also contribute to the underreporting of violence [41]. Additionally, the absence of IPV screening initiatives in healthcare settings where women are likely to seek services during pregnancy could further contribute to the underreporting of such cases in these regions.

Despite the valuable insights reported by our study on IPV during pregnancy, it is essential to recognize its limitations. Specifically, being a hospital-based study limits the generalizability of our findings to the broader population of women of reproductive age facing IPV, as the limited sample size may not fully capture the diverse experiences within this group. Our sampling method did not include specific groups, such as women who were separated or divorced or who might have reported different IPV experiences. Additionally, reliance on self-reported data during interviews could introduce response biases, mainly if participants were reluctant to disclose their experiences. A significant limitation is our study's categorization of spouses' ages and working statuses separately, without examining intra-couple disparities, may limit insights into their direct impact on pregnancy outcomes and IPV, warranting further dyadic exploration. We recommend future research to adopt dyadic analyses to examine the effects of disparities within couples on IPV more closely. Nonetheless, the study's strengths are noteworthy, particularly its thorough review of national health standards and the application of rigorous data collection and methodology.

5. Conclusions

Our study revealed that sociodemographic disparities, particularly in education and financial dependency, along with controlling behaviors from partners, limit healthcare accessibility for pregnant women, potentially adversely affecting maternal health. The data indicate that psychological violence is the leading form of IPV experienced during pregnancy. Consequently, there is a critical need for the development and implementation of targeted interventions to enhance the well-being and independence of pregnant women, addressing the complex issues associated with IPV. Furthermore, establishing robust support systems within healthcare settings to identify and assist IPV victims proactively can significantly improve maternal and infant health outcomes.

Author contributions: Conceptualization, SS, HM, KA, and SM; methodology, SS, HM, KA, SM and HM; software, HM; validation, KA; formal analysis, HM; investigation, KA; resources, SS, HM, and SM; data curation, HM; writing—original draft preparation, KA, SM, and HM; writing—review and editing, SS, and HM; visualization, HM; supervision, SS, and HM; project administration, SM. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no specific grant from the public, commercial, or not-for-profit funding agencies.

Ethics statement: The Ethical Review Committee of the Armed Forces Post Graduate Medical Institute (AFPGMI), Rawalpindi, approved the study (No. 248-AAA-ERC-AFPGMI).

Consent to participate: We confirm that the data used in this study were obtained after obtaining written informed consent from the patients.

Data availability: The data supporting this study's findings are available from the corresponding author, Hassan, upon reasonable request.

Acknowledgments: None.

Conflicts of interest: The authors declare no conflicts of interest.

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