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SOCIO-DEMOGRAPHIC FACTORS ASSOCIATED WITH INTIMATE PARTNER VIOLENCE (IPV) DURING PREGNANCY AMONG WOMEN IN PAKISTAN

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Abstract

Background: The objective of the current study was to determine the specific socio-demographic factors of Intimate Partner Violence (IPV) during pregnancy in Pakistan.

Methods: The data used was limited to the Pakistan Demographic and Health Survey 2012-2013, to ever married women aged 15-49 years (n=3449) to analyze the differences in their socio-demographic characteristics and experiences of IPV during pregnancy. The relation between IPV during pregnancy and socio-demographic determinants was measured by calculating adjusted odds ratios (OR)with the use of multiple logistic regression modelsafter adjusting for women's age, education, wealth quintile, residence, and employment status.

Results: Comprehensively, the study estimates that around 10% of all ever-married females aged between 15-49 years in Pakistan had experienced IPV during pregnancy in a life time. The women who were in poverty, uneducated and unemployed experienced higher IPV.IPV during pregnancy was significantly associated with residence in rural areas (AOR 3.065; 95% CI 2.064-8.006), provincial belonging to KPK (AOR 2.458; 95% CI 1.780-3.39)) and Baluchistan (AOR 2.234; 95% CI 1.554-3.212) and having husbands who were unemployed (AOR 2.324; 95% CI 1.212 -4.456) and consumed alcohol (AOR 4.311; 95% CI 3.102-5.991).

Conclusion: The study concludes that more investment is imperative at a policy level to avert growing incidence of gender-based violence in Pakistan. The policy should focus on job opportunities, education, rural development and access to better public health care.

Introduction

Intimate partner violence is a deliberate violation of human rights that affects a vast number of women worldwide, including those who are pregnant (1). Intimate partner violence (IPV) is defined as "physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner" (2). IPV is pervasive globally and WHO reports that 15% to 71% of women experience IPV at some stage in their lifetime (3). While violence in IPV may be practiced by both genders (4), it is observed that women experience more physical trauma and require medical treatment as compared to male victims (5).

Furthermore, research indicates that for many women pregnancy does not provide protection from IPV and abuse can either begin or escalate during this time (6). IPV and pregnancy however are implicated in complex ways. Pregnancy can lead to occurrences of IPV or IPV can result in unintended pregnancies. Both scenarios put the women in an unfavorable and unsafe situation (3).

Recent population-based studies show regional variance in estimates of IPV during pregnancy. Surveys from developing countries report that prevalence of IPV during pregnancy ranges from 4% to 29%. On the other hand, research on developed countries report that IPV can occur during pregnancy for 1% to 20% of women (7).Studies on IPV experienced by women in Pakistan are limited but indicate an alarming escalation in its incidence during the last decade (8).Notably, 44% of women in Pakistan have reported consistent physical aggression during marriage, 23% of whom reported experiencing it during pregnancy as well (3). Moreover, research reveals that prevalence for physical violence and sexual violence in women is between 16%–76% and 12%–16% respectively. Psychological violence on the other hand, varies between 23% and 60% for women in intimate relationships (9). According to an interview based study, 34% of women in Karachi reported physical abuse by husbands, half of whom continued facing IPV during pregnancy as well. (2).

Risk factors for IPV during pregnancy: IPV for women has been associated with a number of factors. Factors correlated with IPV including alcohol, tobacco and drug use, depression and unintended pregnancy are established risk factors for IPV during pregnancy as well (10,11,12). For women in developing countries, the risk for physical abuse has been found to increase with age, marital status and duration of marriage, income, education of partners, parity, alcohol or

drugs intake, status of HIV infection, history of abuse in the family, and unintended pregnancy (13). IPV often peaks in late adolescence and young adulthood (14). Importantly, where IPV is present in married couples, women are more likely to report partner relationship problems (15) and sexual discord (16). Unemployment, low income and being a minority are predicators of male to female IPV (17).

Unemployed females and manual non-skilled workers are more than likely to have experienced IPV (18). An association between alcohol and illicit drug abuse with incidences of IPV is documented (19). For instance, men experiencing unemployment have been found to become are more prone to violence with an increase in alcohol consumption (20). There has been a higher incidence where both partners consumed alcohol and drugs which included cannabis (21).

(IPV) during pregnancy has not been studied with a nationally representative data in Pakistan.The current study is aimed at identifying socio-demographic determinants of IPV in pregnant women.

Materials and Methods

Data and Sample: The prevalence of Intimate Partner Violence during pregnancy was measured using secondary data from the Pakistan Demographic and Health Survey (PDHS) 2012-2013.The Demographic and Health Survey is a key tool for the collection, measuring and monitoring of information on women's fertility, health and nutritional status on a global scale. The PDHS (2012-2013) data was collected across 14,000 household representing a total of 14,569 ever-married women of reproductive age (15-49) of the national sample using a stratified two-stage cluster sampling method. Of the eligible women, 13,558 were effectively interviewed, generating a 93 percent response rate. Our study included 3,687ever married women within the ages of 15-49 who completed the domestic violence module.

Measurement variables: The socio- demographics characteristics of participants were analyzed using following variables; (1) respondent age (with 3 categories of '15–24', '25–34' or '35–49' years), (2) educational status of the respondent ('illiterate' or 'literate'), (3) type of respondent occupation ('unemployed', 'unskilled', 'skilled' or 'managerial'), (4) total number of children ever born ('1–3' or '<4'), (5) regional affiliation ('urban' or 'rural'), (6) provincial affiliation ('Punjab', 'Sindh', 'KPK' or 'Baluchistan'), (7) wealth status ('poor', 'middle' or 'rich'), (8) Husbands education ('illiterate' or 'literate'), (9) husbands occupation ('unemployed', 'unskilled', 'skilled' or 'managerial') and (10) use of alcohol by the husband ('yes' or 'no'), (11) access to information such as radio ('yes' or 'no'), (12) Living with Partner ('yes' or 'no'), (13) Cousin Marriage ('yes' or 'no'), (14) Planned Pregnancy ('yes' or 'no') and (15) Autonomy ('yes' or 'no'), Autonomy of womenincluded measurement of two attributes i.e. autonomy related to women mobility and autonomy of decision making within four domestic spheres. The response to question (a) Person who usually decides on visits to family or relatives was used to measure women's mobility. Decision making in domestic spheres was measured by four questions (a) Person who usually decides on respondent's health care, (b) Person who usually decides what to do with money husband earns (c) person who usually decide about the health of children (d) Person who usually decides how to spend respondent's earnings. The responses for these four questions were a) respondent alone, (b) respondent and husband/ partner, (c) respondent and another person, (d) husband alone, and (e)someone else. Furthermore, a variable was created after creating dummy variable and then assigning '0' for responses (d) or (e) and '1' for responses (a), (b), (c).

Statistical analysis: Findings of IPV during pregnancy were reported using descriptive statistics through frequencies and percentages. The associations between socio-demographic and experience of IPV during pregnancy were identified using simple and multiple bivariate binary logistic regression. The significance level was set at 0.05% after calculating p values and odds ratio with 95% confidence intervals.

Results:

Table 1 illustrates the socio-demographic details of women who experienced or did not experience violence during pregnancy. A majority of women in age group of 35-49 years were more exposed to violence during pregnancy. There were important differences in literacy rate and occupation of respondents with respect to their experience of violence during pregnancy. The women who were poor (53.0%), had no formal education (74.7%) and were unemployed (77.4%) experienced more IPV during pregnancy. Table 1 shows that the incidence of violence was higher in KPK (35.2%) followed by Baluchistan (25%) and Punjab (22%). Furthermore, women who belonged to rural areas were more prone to violence (66.7%) as compared to those living in urban (33.3%) areas. The table also reveals that women with higher experience of IPV during pregnancy had husbands who were illiterate (48%), had unskilled jobs (52%) and consumed alcohol (63%). In addition, a majority of participants who reported experiencing violence during pregnancy were currently living with their intimate partners (89.9%), had more than four children (63.4%), and had planned pregnancies (67.7%).

Table 1 Socio-demographics of women with experience and no experience of IPV during pregnancy in Pakistan, PDHS 2012–13 (n = 3449)

Demographic Variables	No Experience of Violence(n=3113) N (%)	Experience of Violence(n=336) N (%)
Age of respondents		
15-24	448 (14.4)	38 (11.3)
25-34	1164 (37.4)	136 (40.5)
35-49	1501 (48.2)	162 (48.2)
Education of respondent		
No formal education	1686 (54.2)	251 (74.7)
Primary	466 (15.0)	37 (11.0)
Secondary	565 (18.1)	38 (11.3)
Higher	395 (12.7)	10 (3.0)
Occupation of respondent		
Unemployed	2368 (79.6)	243 (77.4)
Unskilled	102 (3.4)	4 (1.3)
Skilled	459 (15.4)	60 (19.1)
Province		
Punjab	947 (36.8)	71 (22.9)
Sindh	729 (28.3)	51 (16.5)
KPK	530 (20.6)	109 (35.2)
Baluchistan	367 (14.3)	79 (25.5)

Residence		
Urban	1515 (48.7)	112 (33.3)
Rural	1598 (51.3)	224 (66.7)
Wealth index of respondents		
Poor	1126 (36.2)	178 (53.0)
Middle	570 (18.3)	71 (21.1)
High	1417 (45.5)	87 (25.9)
Husbands education		
Illiterate	1069 (34.4)	163 (48.5)
Literate	2038 (65.5)	172 (51.2)
Husbands occupation		
Unemployed	88 (2.8)	20 (6.0)
Unskilled job	820 (26.3)	114 (33.9)
Skilled job	1802 (57.9)	177 (52.2)
Managerial job	402 (12.9)	25 (7.4)
Access to information		
Yes	1194 (64.1)	165 (49.1)
No	1117 (35.9)	171 (50.9)
Living with partner		
Yes	2658 (89.5)	294 (89.9)
No	312 (10.5)	33 (10.1)
Number of children		
1-3	1443 (46.4)	116 (34.5)
More than 4	1539 (49.4)	213 (63.4)
Husband Use of alcohol		
Yes	140 (4.5)	63 (18.8)
No	2972 (95.5)	273 (81.3)
Cousin marriage		
Yes	1659 (88.0)	179 (86.5)
No	227 (12.0)	28 (13.5)
Planned pregnancy		
Yes	256 (74.0)	34 (66.7)
No	90 (26.0)	17 (33.3)
Autonomy		
Yes	975 (33.3)	148 (46.8)
No	1956 (66.7)	168 (53.2)

Simple bivariate logistic regression: Simple bivariate regression analysis (Table 2) illustrates that women were more likely to be exposed to IPV during pregnancy if they had no formal education (OR 5.89; 95% CI 3.10-11.19), belonged to Baluchistan province (OR 2.81; 95% CI 2.03-4.04), and had residence in rural areas (OR 1.89; 95% CI 1.49-240). Additionally, the odds for experience of IPV during pregnancy were significantly higher for women from poor households (OR 2.57; 95% CI 1.96-3.36) with no access to information (OR 1.630; 95% CI 1.119-2.374) and unemployed husbands (OR 3.655; 95% CI 1.943-6.873) or with husbands who consumed alcohol (OR 4.899; 95% CI 3.550-6.761). Finally, having autonomy (OR 1.767; 95%

CI 1.399-2.233) and more than four children (OR 0.581; 95% CI .178 -.837) protected women against violence during pregnancy from their intimate partners.

Table 2 Simple bivariate and multiple logistic regression for factors of IPV during Pregnancy among women in Pakistan, PDHS 2012–13 (n = 3449)

Variables	IPV during pregnancy OR* (95% CI)	P value
Age of respondent		
15-24	.786 (.544-1.377)	0.200
25-34	1.083 (.851-1.377)	.5018
35-49	Reference	
Education of respondent		
No formal education	5.895 (3.104-11.196)	.000***
Primary	3.144 (1.544-6.403)	.002***
Secondary	2.663(1.312-5.408)	.007***
Higher	Reference	
Province		
Baluchistan	2.81 (2.03-4.04)	.000***
KPK	2.74 (1.99-3.76)	.000***
Sindh	.933 (.643-1.35)	0.716
Punjab	Reference	
Occupation of Respondent		
Unemployed	996 (.741-1.339)	0.98
Unskilled	.863 (290-2.569)	0.792
Skilled	Reference	
Residence		
Rural	1.89 (1.49-2.40)	.000***
Urban	Reference	
Wealth index of respondents		
Poor	2.57 (1.96-3.36)	.000***
Middle	2.02 (1.46-2.81)	.000***
High	Reference	
Spouse education		
Literate	.45 (.047-4.42)	0.49
Illiterate	Reference	
Spouse occupation		
Un-employed	3.655 (1.943-6.873)	.000***
Unskilled job	2.236 (1.427-3.502)	000***
Skilled job	1.579 (1.025-2.434)	0.038*
Managerial job	Reference	
Access to information		
No	1.630 (1.119-2.374)	.011*
Yes	Reference	

	Living with partner	
Yes	1.04 (.716-1.52)	0.817
No	Reference	
	Number of children	
4 and above	.581 (.178 -.837	.016*
1-3	Reference	
	Planned pregnancy	
No	1.42 (.758 - 2.67)	0.273
Yes	Reference	
	Husband use of alcohol	
Yes	4.899 (3.550-6.761)	.000***
No	Reference	
	Cousin marriage	
Yes	.875 (.574-1.334)	0.534
No	Reference	
	Autonomy	
Yes	1.767 (1.399-2.233)	.000***
No	Reference	

Multivariable Logistic Regression Analysis: According to Table 3, after adjusting for women's age, education, wealth quintile, and residence, women who had no formal education (AOR 4.065; 95% CI 2.064-8.006), belonged to KPK (AOR 2.458; 95% CI 1.780-3.39) and Baluchistan (AOR 2.234; 95% CI 1.554-3.212), and were residing in rural areas (AOR 3.065; 95% CI 2.064-8.006) were more likely to experience IPV during pregnancy. In addition, the odds of experiencing IPV during pregnancy were higher for women with husbands who were unemployed (AOR 2.324; 95% CI 1.212 -4.456) and consumed alcohol (AOR 4.311; 95% CI 3.102-5.991). However, the odds for IPV during pregnancy increased for women who had no access to information (AOR 1.124; 95% CI .850-1.488), the relationship lost its significance. Notably, the likelihood for IPV during pregnancy increased for women who had more than four children (AOR 2.548; 95% CI 1.121-5.790).

Table 3 Multiple logistic regression for factors of IPV during Pregnancy among women in Pakistan, PDHS 2012–13 (n = 3449)

Variables	**AOR* (95% CI)**	**P Value**
	Age of respondent	
15-24	1.458 (.997-2.132)	0.052*
25-34	1.277 (.877-1.858)	0.202
35-49	Reference	
	Education of respondent	
No formal education	4.065 (2.064-8.006)	.000***
Primary	2.628 (1.276-5.413)	.009***
Secondary	2.495 (1.226-5.078)	.012*
Higher	Reference	

	Province	
Baluchistan	2.234 (1.554-3.212)	.000***
KPK	2.458 (1.780-3.396)	.000***
Sindh	922 (.629-1.353)	0.68
Punjab	Reference	
	Occupation of Respondent	
Unemployed	.991 (.738-1.332)	0.954
Unskilled	.619 (215-1.785)	0.374
Skilled	Reference	
	Residence	
Rural	3.065 (2.064-8.006)	.000***
Urban	Reference	
	Wealth index of respondents	
Poor	1.545 (1.091-2.187)	.014*
Middle	1.444 (1.007-2.070)	.046*
High	Reference	
	Spouse education	
Literate	.818 (.637-1.051)	0.116
Illiterate	Reference	
	Spouse occupation	
Un-employed	2.324 (1.212 -4.456)	.034*
Unskilled job	1.274 (.796-2.040)	.011*
Skilled job	1.112 (.712-1.735)	0.312
Managerial job	Reference	
	Access to information	
No	1.124 (.850-1.488)	0.412
Yes	Reference	
	Living with partner	
Yes	1.114 (.757-1.638)	0.583
No	Reference	
	Number of children	
4 and above	2.548 (1.121-5.790)	.026*
1-3		
	Planned pregnancy	
No	1.207 (.611-2.382)	0.588
Yes	Reference	
	Husband use of alcohol	
Yes	4.311 (3.102-5.991)	.000***
No	Reference	
	Cousin marriage	
Yes	1.178 (.768-1.808)	0.453
No	Reference	
Autonomy		
Yes	.791 (593-1.053)	.110*

Discussion

Studies on IPV indicate that IPV during pregnancy in developing countries ranges from 4% to 29% (7). Our study estimates that around 10% of all ever-married females aged between 15–49 years in Pakistan who had experienced IPV in a lifetime had experienced IPV during pregnancy as well. Majority of these victims of IPV during pregnancy were illiterate, belonged to rural regions, were unemployed and had poor wealth status. In many cases these women (18.8%) had husbands that had a history of alcohol abuse.

Consistent with other studies, our findings also confirm that age protects against IPV in adulthood (22). This finding has important implications given the fact that Pakistan has one of the highest rates of child marriage (females married before the age of 18 years) along with an unacceptably high maternal mortality ratio per 100,000 live births. The majority of women dying of pregnancy related complications in Pakistan are under 20 years of age (23). Moreover, our study reveals that one third of women (33 %) who experienced IPV during pregnancy had unplanned pregnancies. This is supported by research that indicates that the likelihood for usage of contraceptives is low for female victims of IPV with far reaching implications for women's overall reproductive and general health (16).

Research substantiates the significant relation between increasing parity and IPV during pregnancy (24). Studies indicate an increase in risk for abuse during pregnancy by 34% with every additional child. This may be due to increased financial strain or woman’s refusal to continue with the pregnancy (25). Our findings similarly suggest that the likelihood for IPV during pregnancy increases two times with increase in number of children (AOR 2.548; 95% CI 1.121-5.790). This trend needs further exploration, since the gender of children born is significant in determining the power of women and social support, they receive within their relationships (26).

This study has a number of limitations. Firstly, the cross-sectional analysis in this study makes assessment of causality not possible. Nonetheless, future studies are required to assess the cause and effect relation of IPV during pregnancy with socio-demographic characteristics of women. The study also does not look at the frequency of each kind of abuse experienced by women and how it affected by the demographic features of women and their partners. Moreover, PDHS (2012-13) does not include data from the Federally Administered Tribal Areas, Federally Administered National Areas and Azad Jammu and Kashmir due to political and regional instability. Consequently, the overall statistics for female victims of IPV during pregnancy in Pakistan may be higher than estimated by PDHS (2012-13), as a result of the socio-structural problems for women in these northern regions of the country.

To the best of our knowledge, it is the first study of its kind that assesses the association of IPV during pregnancy with socio-demographic characteristics of women with a large nationally representative data in Pakistan. In addition to that it expands the issue of IPV from its commonly accepted understanding as legal and human right issue to a public health concern when it looks at the aspect of violence during pregnancy. This study also indicates that IPV during pregnancy is a risk factor of women’s health and their children. Results of this study encourage further research and policy improvements for victims of IPV.

Conclusion:

The rate of IPV experienced by women both, globally and in Pakistan is alarming. In developing countries women are experiencing violence in their homes due to patriarchal structures (23). Women with no formal education, residing in Baluchistan and KPK, of poor and rural

backgrounds with no access to information are most vulnerable to experience of IPV during pregnancy. Furthermore, husband's unemployment and consumption of alcohol increases the likelihood of IPV for women while they are pregnant. Despite limitations, this study points out to the important fact that pregnancy does not protect many women from abuse from their partners in Pakistan. In addition, it also indicates the structural barriers that expose women to violence from their partners during pregnancy and put them as well as their unborn children in unsafe situations. Therefore, there is dire need for awareness campaign regarding the women rights and reproductive health in the country.

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