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Exploring the associations between intimate partner violence victimization during pregnancy and delayed entry into prenatal care: Evidence from a population-based study in Bangladesh

Md. Jahirul Islam, M.Sc, MPP (Doctor of Philosophy Candidate)[a,b,*], Lisa Broidy, PhD (Associate Professor)[a,c], Kathleen Baird, PhD (Senior Lecturer)[d], Paul Mazerolle, PhD (Professor)[a]

[a] School of Criminology and Criminal Justice, Griffith University, Brisbane, Queensland 4122, Australia
[b] Ministry of Planning, Bangladesh Planning Commission, Sher-e-Bangla Nagar, Dhaka 1207, Bangladesh
[c] Department of Sociology, 1 University of New Mexico, Albuquerque, NM 87131, United States
[d] School of Nursing and Midwifery, Menzies Health Institute Queensland, Griffith University, Brisbane, QLD, Australia

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ABSTRACT

Objective: Intimate partner violence (IPV) during pregnancy can have serious health consequences for mothers and newborns. The aim of the study is to explore: 1) the influence of experiencing IPV during pregnancy on delayed entry into prenatal care; and 2) whether women's decision-making autonomy and the support for traditional gender roles act to mediate or moderate the relationship between IPV and delayed entry into prenatal care.
Design: cross-sectional survey. Multivariate logistic regression models were estimated that control for various socio-demographic and pregnancy related factors to assess whether women who experienced IPV during pregnancy were more likely to delay entry into prenatal care compared with women who had not experienced IPV. The influence of traditional gender roles acceptance and decision-making autonomy were examined both as independent variables and in interaction with IPV, to assess their role as potential mediators or moderators.
Setting: Chandpur district, Bangladesh.
Participants: the sample comprised of 426 Bangladeshi women, aged 15–49 years. Postpartum mothers who visited vaccinations centres to receive their children's vaccinations constitute the sampling frame.
Results: almost 70% of the women surveyed reported patterns consistent with delayed entry into prenatal care. Accounting for the influence of other covariates, women who experienced physical IPV during pregnancy were 2.61 times more likely (95% CI [1.33, 5.09]) to have delayed entry into prenatal care than their counterparts who did not report physical IPV. Neither sexual nor psychological IPV victimization during pregnancy was linked with late entry into prenatal care. Both gender role attitudes and levels of autonomy mediate the effect of IPV on prenatal care.
Key conclusions: the results suggest that the high rates of IPV in Bangladesh have effects that can compromise women's health seeking behaviour during pregnancy, putting them and their developing fetus at risk. Specifically, Bangladeshi women who experience physical IPV during pregnancy are more likely to delay or forgo prenatal care, an effect that is further magnified by cultural ideals that emphasize women's traditional roles and limit their autonomy.
Implications for practice: this study reinforces the need to detect and assist women suffering IPV, not only to offer them help and support but also to increase entry into prenatal care. Healthcare professionals involved in obstetrics and midwifery need to be aware of the risk factors of IPV during pregnancy and be able to identify women who are at risk for delayed entry into prenatal care.

Introduction

Pregnancy has been described as a life-changing event for women, introducing a range of new trials and tribulations. On the one hand, pregnancy is often a time of happiness and expectancy characterized by maternal optimism, emotional uplifts and growing social support

* Correspondence to: School of Criminology and Criminal Justice, Griffith University, 176 Messines Ridge Road, Mt Gravatt, Queensland 4122, Australia.
E-mail address: mdjahirul.islam@griffithuni.edu.au (Md. J. Islam).

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(DiPietro et al., 2002). Culturally, pregnancy is generally viewed as a joyful event in women's lives from the thinking that the expected child will bring a new generation to the family (Ogbonnaya et al., 2013; Modh et al., 2011). However, pregnancy can also be a stressful and anxiety-provoking life event (Bondas and Eriksson, 2001) since it is a major life transition (Bost et al., 2002) and, for some women, poses a maturational crisis they are ill-prepared for (Bondas and Eriksson, 2001). Regrettably, pregnancy can also introduce an increased risk of intimate partner violence (IPV) for millions of women of reproductive age worldwide (Chang et al., 2005; Kendall-Tackett 2007; Devries et al., 2010; Garcia-Moreno and Watts, 2011; James et al., 2013). IPV is the most frequent form of violence against women and includes acts of physical, sexual and psychological coercion as well as controlling behaviours by a current or former intimate partner or husband (World Health Organization (WHO) and Pan American Health Organization (PAHO), 2012; Krug et al., 2002; Rahman et al., 2012). Population-based studies indicate that anywhere from 15% to 71% of women experience IPV worldwide (Ellsberg and Heise, 2005; Garcia-Moreno et al., 2006). A recent meta-analysis synthesizing the results of 92 studies from developed and developing countries demonstrates that the prevalence of IPV against pregnant women varies between 4.8% in China and 63.4% in Brazil (James et al., 2013). IPV during pregnancy is a crucial public health risk and has serious health consequences to the mother, and the developing fetus and baby during gestation, birth, and postpartum (Bohn 1990; Krulewitch et al., 2001; Huth-Bocks et al., 2002; Anderson et al., 2002; Espinosa and Osborne 2002; Kendall-Tackett, 2007; Lau and Chan 2007; Gomez-Beloz et al., 2009; Leneghan et al., 2012; de Jager et al., 2013; Trabold et al., 2013; Cha and Masho 2014; Liou et al., 2014).

Maternal and child health has traditionally been considered an important indicator of the health progress, and the overall social and economic well-being of a country (Abedin et al., 2008). Although considerable progress has been made to reduce maternal mortality globally, Bangladesh remains a leader in maternal mortality, with a ratio of 194 per 100,000 live births in 2010 (National Institute of Population Research and Training (NIPORT) et al., 2012). Prenatal or antenatal care is the most important mechanism for identifying the adverse outcome of pregnancy (WHO and UNICEF, 2003; Alderliesten et al., 2007). Currently, 32% of women receive no prenatal care in Bangladesh (Kamal, 2013), a scenario that is common in other developing countries (Navaneetham and Dharmalingam, 2002; WHO and UNICEF, 2003). The World Health Organization recommends at least four prenatal visits during pregnancy for women without complications and at least one visit within the first 4 months of gestation (Baird and Mitchell, 2013). It is well recognized that low use of prenatal care (Jasinski, 2004), limited postnatal care (Chaudhury, 2008; Chakraborty et al., 2003; Kidney et al., 2009), and low birth assistance and attendance by a medically trained professional (Choudhury et al., 2000; Ronsmans et al., 2009) contributes to high maternal and child mortality. Both the timing and adequacy of prenatal care visits is a contributing factor in reducing maternal and child mortality and morbidity by preventing adverse pregnancy outcomes (Abedin et al., 2008; Baird and Mitchell 2013; Ononokpono and Azfredrick 2014).

Although service accessibility (Rahman et al., 2008), demographic (Chakraborty et al., 2002; Chakraborty et al., 2003; Rai et al., 2014), and socio-economic (Paul and Rumsey, 2002; Rahman et al., 2008; Amin et al., 2010; Rai et al., 2014) factors are notable in affecting when, where and how often women receive prenatal care; research has begun to investigate the influence of other psychosocial risk factors. In Western countries where prenatal care is readily available, there is still wide individual variation in the timing and adequacy of prenatal care (Pagnini and Reichman, 2000). This, in part, reflects the same risks that limit access to quality healthcare more generally, particularly those linked to poverty and geographic isolation. But scholars have also proposed that IPV might introduce unique risks that negatively affect women's utilization of health care services such as prenatal care (Bailey and Daugherty, 2007; Moraes et al., 2010; Taillieu and Brownridge 2010). Studies from Western countries offer some support for this proposition, showing that IPV during pregnancy is associated with delayed entry into prenatal care (Bailey and Daugherty, 2007; Dietz et al., 1997; Perales et al., 2009; Pallitto et al., 2005). By contrast, one study of women in the USA also found that those who experienced IPV had elevated odds of early entry into prenatal care (Pagnini and Reichman, 2000). These varied results are likely due to a reliance on non-representative samples and a lack of attention to potential confounding factors and to possible interactions among the range of relevant risk factors assessed.

In South Asia, studies have reported linkages between experiences of IPV among women and various reproductive health consequences (Jasinski, 2004; Silverman et al., 2007; Jacoby et al., 1999; Koenig et al., 2006; Bates et al., 2004; Bhuiya et al., 2003; Islam et al., 2017). However, few studies from this region have specifically examined the impact of IPV during pregnancy on receipt of prenatal care. One study from India examined the influence of physical IPV on delayed entry to prenatal care utilizing a sample of rural women from four states (Koski et al., 2011). This study revealed that women who experienced physical IPV during pregnancy were much less likely to initiate prenatal care during the first four months of gestation. We do not know of any studies that have examined this question in Bangladesh, but given high rates of IPV coupled with the government's focus on improving pregnancy outcomes, the question is particularly important and timely. Additionally, it is important to investigate whether the effect is further exaggerated by cultural ideals that emphasize women's traditional roles and limit their decision-making autonomy.

IPV is viewed broadly as a function of prevailing social and cultural norms and attitudes that not only condone but also legitimate violent acts (Dobash and Dobash, 1979; Straus et al., 1980; Sugarman and Frankel 1996; Haj-Yahia 1998; Fonagy 1999; Herzog 2007; Ashrafun and Säävälä 2014). Evidence suggests that IPV commonly occurs in societies and in families where high levels of gender inequality exist, women are less empowered, and male partners have more power and control (Ashrafun and Säävälä, 2014; Yllo 2005; Schuler et al., 2008; Ackerson and Subramanian 2008). These elements reinforce male dominance and female subjugation and subordination (Yllo, 2005; Schuler et al., 2008; Ackerson and Subramanian, 2008), which are viewed by most feminist scholars as the principal breeding ground for IPV (Dobash and Dobash (1979; Walker 2009; Stark 2007). In a patriarchal social system, the social acceptability of male domination supports the belief that men should be the head of the family. This role comes with a range of responsibilities and privileges. Males are responsible for earning money to support the family, but they also have decision-making authority and it is often viewed as acceptable for them use physical force to discipline disobedient partners and correct unsatisfactory performance of household duties (Sugarman and Frankel, 1996; Healey et al., 1998; NIPORT et al., 2009). In many Asian countries including Bangladesh, women's subordination is reflected in the sexual division of labour, women's limited decision-making power, restrictions on freedom of movement, and differential access to resources within the family (Hadi, 2000; Rashid et al., 2014). Existing studies reveal a positive association between conservative attitudes towards traditional gender roles and tolerant views of IPV (Dobash and Dobash, 1979; Straus et al., 1980; Sugarman and Frankel 1996; Haj-Yahia 1998; Willis et al., 1996). Furthermore, traditional norms support a man's right to inflict IPV when a wife fails to conform to certain traditional gender role expectations (Garcia-Moreno et al., 2006; Hadi 2005). Abused women are likely to have less decision-making autonomy, decreased liberty of movement and higher financial dependency on their male partners (Ellsberg et al., 2000; Smith and Martin, 1995), which may reduce their ability to make decisions for themselves and their families, including the choice of receiving appropriate maternal health care services (Koski et al., 2011).