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ORIGINAL ARTICLE

Gender-based Violence Among Pregnant Women of Syangja District, Nepal

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Abstract

Objectives: This study aims to determine prevalence of gender-based violence among pregnant women attending an antenatal care (ANC) clinic.

Methods: Between September 2014 and December 2014, a cross-sectional study was conducted among 202 pregnant women attending the antenatal ward of the Primary Healthcare Centre (PHC) of Syangja district, Nepal. The data were collected using semistructure questionnaires with face-to-face interviews. SPSS software (IBM Corp, Armonk, NY, USA) was used for analysis the data.

Results: The prevalence rate of gender-based violence was found to be 91.1% (184). Most of the respondents (87%) faced economic violence followed by psychological (53.8%), sexual (41.8%), and physical (4.3%) violence. Women experienced: (1) psychological violence with most complaining of angry looks followed by jealousy or anger while talking with other men, insults using abusive language and neglect; (2) economic violence with most complaining of financial hardship, denial of basic needs and an insistence on knowing where respondents were and restricting them to parents' home or friends/relatives' houses (jealousy); (3) physical violence by slapping, pushing, shaking, or throwing something at her, twisting arm or pulling hair, and punching and kicking; and (4) sexual violence by physically forcing her to have sexual intercourse without consent, and hurting or causing injury to private parts. Most (100%) of the perpetrators were found to be husbands and mothers-in-law (10.7%) who violated them rarely.

Conclusion: The prevalence of gender-based violence (GBV) among pregnant women attending the ANC clinic was greater in the Syangja district of Nepal. Women's empowerment, economic autonomy, sensitization, informal or formal training regarding GBV for men and women, and the need for large-scale population-based surveys are the major recommendations of this study.

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1. Introduction

Gender-based violence (GBV) [1] is “violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately.” As GBV remains one of the most rigorous challenges to women’s health and well-being, it is one of the indispensable issues of equity and social justice [2]. There is no doubt that violence against women is a crime by all standards, and it remains a negative impact on women for years and may continue with it throughout her life [3].

As we know, women are susceptible to violence throughout their lifespan, but this is most common in their fertile years [4]. Violence during pregnancy escalates during a woman’s gestation with serious consequences not only for the woman, but also for the fetus and ultimately for the child’s development. Both mother and fetus suffer adverse effects, e.g., fetal death, low birth weight, preterm delivery, small size for gestational age in fetus, maternal mortality, mental health problems, kidney infections, reduced weight gain during pregnancy, and increased likelihood of undergoing operative delivery in pregnant women [2].

In Nepal, women are considered as second-class citizens in this patriarchal society. Thus, most of the families are headed by men and the women are treated as commodities or child producing machines. Women are affected disproportionately in different ways than men [5]. A study conducted among 350 postnatal mothers in Nepal showed that domestic violence was a frequent phenomenon during pregnancy [6]. The proportion of women experiencing violence during pregnancy was higher in women having three or more children, illiteracy, living in poverty, residing in rural and Terai areas of Nepal [2]. A cross-sectional descriptive study conducted at Paropakar Maternity and Women’s Hospital of Kathmandu, Nepal, shows that 33% of women suffered from GBV, of whom 23% reported physical violence, 13% reported sexual violence, and 47% reported psychological violence [7]. Similarly, a cross-sectional study carried out in four major ethnic groups of Nepal also shows that more than half the women (51.9%) reported having experienced some form of violence in their lifetime [8].

Research has demonstrated that gender-based violence has implications for almost every aspect of health policy and programming, from primary care to reproductive health programs [9]. Accurate and comparable data on violence are needed at the community, national, and international levels to strengthen advocacy efforts, help policy makers understand the problem, and guide the design of interventions [10]. This study aims to determine prevalence of gender-based violence among pregnant women attending an antenatal care (ANC) clinic. Moreover, we also tried to identify types of violence faced among pregnant women.

2. Materials and methods

Between September 2014 and December 2014, a cross-sectional study was conducted in the antenatal ward of the primary healthcare center (PHC) of Syangja district, Nepal. This study protocol received ethical approval from the Department of Public Health of La Grandee International College. Additional permission for the study was obtained from the District Health Office of Syangja district of Nepal and Primary Healthcare Centers. Verbal informed consent was taken from the participant before distributing questionnaires. Anonymity and confidentiality of the individual were maintained.

The study populations were pregnant women attending the antenatal clinic in PHC of the Syangja district of Nepal at the time of the study. The sample size was determined using the formula $n0 = z2pq/d2$, where $n0$ is calculated sample size, d is 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 the final population correction $n = n0/(1+n0/N)$ was applied. Now the required sample size for the study was 192 and it was increased to 202 to take care of nonresponse errors (5%). The required number of pregnant women were selected by a consecutive sampling method where simple random sampling methods were used to select three primary health centers from each of the three constituencies. All pregnant women who attended the antenatal clinic of the PHC facility were eligible for the study. Pregnant women were excluded if they were admitted for delivery and did not attain ANC at PHC.

The data were collected using a semistructure questionnaire with face-to-face interviews. Validity of the data collected was ensured by experts. A pilot study was conducted on 10% of the sample size in Sisuwa PHC, Kaski district. The local languages (Nepali and Gurung) were used for face-to-face interviews. Data analysis software (IBM SPSS Version 20; IBM Corp, Armonk, NY, USA) was used for data processing and analysis. Descriptive statistics (mean, median, mode, standard deviation) were preferred for data entry and analysis.

3. Results

The mean age of pregnant women attending the ANC was 22.96 ± 3.723 years (range 15−37 years). The majority, 77.7% (157), were from rural areas and 99%

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