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Spousal violence and receipt of skilled maternity care during and after pregnancy in Nepal

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ABSTRACT

Objectives: a substantial number of Nepali women experience spousal violence, which affects their health in many ways, including during and after pregnancy. This study aimed to examine associations between women's experiences of spousal violence and their receipt of skilled maternity care, using two indicators: (1) receiving skilled maternity care across a continuum from pregnancy to the early postnatal period and (2) receiving any skilled maternity care in pregnancy, childbirth, or postpartum.

Methods: data were analysed for married women aged 15–49 from the 2011 Nepal Demographic and Health Survey. Data were included on women who completed an interview on spousal violence as part of the survey and had given birth within the five years preceding the survey (weighted n=1375). Logistic regression models were developed for analyses.

Results: the proportion of women who received skilled maternity care across the pregnancy continuum and those who received any skilled maternity care was 24.1% and 53.7%, respectively. Logistic regression analyses showed that spousal violence was statistically significantly associated with receiving low levels of skilled maternity care, after adjusting for accessibility of health care. However, after controlling for women's sociodemographic backgrounds (age, number of children born, educational level, husband's education level, husband's occupation, region of residence, urban/rural residence, wealth index), these significant associations disappeared. Better-educated women, women whose husbands were professionals or skilled workers and women from well-off households were more likely to receive skilled maternity care either across the pregnancy continuum or at recommended points during or after pregnancy.

Conclusion: spousal violence and low uptake of skilled maternity care are deeply embedded in a society in which gender inequality prevails. Factors affecting the receipt of skilled maternity care are multidimensional; simply expanding geographical access to maternity services may not be sufficient to ensure that all women receive skilled maternity care.

Introduction

Despite a period of prolonged political instability, Nepal has made significant progress in reducing maternal mortality in line with commitments to the Millennium Development Goals (MDGs) (Bhandari et al., 2015, Regmi et al., 2016). The maternal mortality rate decreased by 71 percent between 1990 and 2015, from 901 maternal deaths per 100,000 live births to 258 maternal deaths per 100,000 live births (WHO/UNICEF/UNFPA/World Bank Group/UN, 2015), reflecting an improvement in utilisation of maternity care services (Shrestha et al., 2014), family planning and safe abortion (Karkee, 2012). Despite such progress, the maternal death rate is still unacceptably high, and gender inequality and violence against women remains an issue that may hinder further progress towards improving maternal health in Nepal. This paper presents a study which explores associations between spousal violence and uptake of skilled maternity across the pregnancy continuum.

In Nepal, facilities such as women and children's centres have been

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established across the country to provide increased legal protection and social support to survivors of spousal violence (ADB, 2014). Nevertheless, a substantial number of Nepali women (32%) aged 15–49 years report having experienced spousal violence (MOHP, 2012). In a global context, this is one of the highest reported prevalence rates of violence against women(Solotaroff and Pande, 2014). Violence against women is defined as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women' (United Nations, 1993).

Although different terms are used, such as 'spousal violence', 'domestic violence' and 'intimate partner violence', it seems appropriate to use the term, 'spousal violence' in this study, given that women in Nepal are more at risk of violence from their husbands than from any other person and this types of violence is important within the context of maternity health care. Spousal violence is associated with adverse health outcomes in women, with the most extreme consequence being suicide (Solotaroff and Pande, 2014). Suicide is currently the leading cause of death for Nepali women of reproductive-age (Pradhan et al., 2011), with the rate increasing from 10 percent of all deaths in this age group in 1998 to 16 percent in 2009 (Pradhan et al., 2011). The Office of the Prime Minister (2012) reported that the rate of attempted suicide was ten times higher in women who had experienced spousal violence, compared to those who had not.

Spousal violence is also associated with a number of negative reproductive health consequences (Campbell et al., 2003, Koziol-McLain et al., 2006) such as adverse pregnancy outcomes, sexually transmitted infections [STIs] including human immunodeficiency virus [HIV]) and maternal mental disorders (e.g., depression, lack of attachment to the child) (Ellsberg et al., 2008, Puri et al., 2010; WHO, 2011). Systematic reviews on the relationship between spousal violence and pregnancy outcomes (Boy and Salihu, 2004, Shah and Shah, 2010) reported that adverse health consequences of spousal violence included low birth weight, preterm births, maternal and infant mortality. These outcomes may occur due to the direct traumatic injury to a woman's body, as well as indirect effects related to neuroendocrine dysregulation associated with maternal stress, depression, and post-traumatic stress disorder, and attendant behavioural sequelae such as increased maternal smoking (Bacchus et al., 2004, El Kady et al., 2005, Parker et al., 2003, Thananowan and Heidrich, 2008).

Pregnancy is considered to be an ideal time to screen for spousal violence because at this stage health professionals are in regular contact with women who normally would not enter the healthcare system (Jones and Bonner, 2002; Australian Institute of Health and Welfare, 2015). However, some studies have identified that spousal violence is associated with low, infrequent, and/or delayed antenatal care (Dietz et al., 1997, Parker et al., 2003). For example, based on data analysis of 27,836 women who delivered live infants in the United States, Dietz et al., (1997) reported women who experienced physical violence were 1.8 times more likely (95% CI: 1.5 – 2.1) to have delayed entry into antenatal care than women who had not experienced such violence.

To date, research has tended to focus on individual maternity healthcare service issues, such as low and/or infrequent use of antenatal or birth care (Tuladhar et al., 2013; Solanke, 2014; Simona et al., 2015). However, only being in contact with individual maternity healthcare services either during pregnancy or at birth has limitations in terms of improving pregnancy outcomes. The importance of ensuring skilled care across the continuum of pregnancy, that is, care from a skilled attendant during pregnancy, labour, birth and following birth has been recognised (Wang and Hong, 2015; Regmi et al., 2016). More specifically, the World Health Organization (WHO) recommends that pregnant women receive a continuum of skilled care across pregnancy which includes at least four antenatal care contacts (of which at least one was from a skilled provider), skilled labour and birth care, and a skilled postnatal maternal check within two days of giving birth (WHO, 2015; Saad–Haddad et al., 2016). Skilled providers are defined here as doctors, nurses, and midwives based on WHO guidelines (WHO, 2004) and the Ministry of Health and Population in Nepal (MOHP, 2012).

Skilled care across the pregnancy continuum is particularly critical for women who experience spousal violence, not only because it may increase health professionals' ability to identify abused women who need support, but also because abused women are vulnerable to maternal complications and poor pregnancy outcomes (Campbell, 2002; Parker et al., 2003; Boy and Salihu, 2004). The aim of this study was, therefore, to examine the association between women's experiences of spousal violence in Nepal and the use of skilled maternity care across the pregnancy, while adjusting for factors such as women's socio-demographic characteristics and geographical, financial and socio-cultural accessibility of healthcare.

Methods

This study analysed data from the 2011 Nepal Demographic and Health Survey (NDHS) (MOHP, 2012). The survey employed a nationally representative sample of 12,674 ever-married women aged 15–49 from 10,826 households, who were selected using an urban-rural stratified, two-stage sampling procedure (MOHP, 2012). In the NDHS, a subsample of households (n=4,210) was further selected for the domestic violence component, which yielded interviews about spousal violence with 4,197 women. Only one woman per household was interviewed to maintain confidentiality. Of women interviewed about spousal violence, the present analyses were restricted to those who were currently married and had given birth in the five years preceding the survey (weighted n=1375), so that possible associations between spousal violence and receipt of skilled maternity care could be examined.

Ethical review

The dataset was obtained from the Demographic Health Survey (DHS) programme site with permission to use for this study. As the original DHS survey had been approved by the ICF International Institutional Review Board (IRB) (DHS Programe, 2016) and the current study was a secondary analysis of the existing anonymised data set, there was no requirement to seek further ethical review of the study. However, we undertook the study using ethical research principles to maintain the confidentiality and anonymity of participants, and data were securely stored during the study.

Receipt of skilled maternity care

For our primary outcome, 'receiving skilled maternity care across the pregnancy continuum', we created a binary outcome: 'yes' if women received all three types of care—ie. at least four antenatal care contacts (of which at least one was from a skilled provider), labour and birth care provided by skilled personnel (a doctor, nurse, and/or midwife), and a postnatal maternal check within two days of giving birth and 'no' if women did not receive one or more of these types of care.

For the secondary outcome, 'receiving any skilled maternity care: yes/no', the answer was 'yes' if women had at least one recommended skilled maternity care contact mentioned above (ie. at least four antennal care contacts, skilled labour and birth care, or skilled postnatal care). The answer was 'no' if women did not receive any recommended skilled maternity care mentioned above. We included this as a secondary outcome because the answer 'no' indicated women who did not have any opportunity to receive maternity care from skilled personnel, and who were therefore presumably the most vulnerable to poor pregnancy outcome.

Spousal violence

The NDHS measured spousal violence by asking women a set of

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