



Intimate partner violence during pregnancy and use of antenatal care among rural women in southern Terai of Nepal



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ARTICLE INFO

Article history:

Received 5 October 2016

Received in revised form 23 July 2017

Accepted 25 July 2017

Keywords:

Pregnancy

Maternal and child health

Antenatal care

Intimate partner violence

Nepal

ABSTRACT

Background: Underutilisation of antenatal care services due to intimate partner violence during pregnancy has been well documented elsewhere, but it is understudied in Nepal. Our study aimed at exploring the impact of intimate partner violence on antenatal care service utilisation in southern Terai of Nepal.

Method: A community-based cross-sectional study was performed in 6 village development committees in Dhanusha district, Nepal. A total of 426 pregnant women in their second trimester were selected using a multistage cluster sampling method. Multivariable regression analyses were used to examine the association between exposure to intimate partner violence and selected antenatal care services, adjusting for covariates.

Results: Among 426 pregnant women, almost three out of ten women (28.9%) were exposed to intimate partner violence at some point during their pregnancy. Pregnant women who were exposed to intimate partner violence were less likely to: register for antenatal care (OR 0.31; 95% CI (0.08–0.50)), take iron and folic acid (OR 0.55; 95% CI (0.12–0.90)), report dietary diversity (middle vs low: OR 0.34; 95% CI (0.11–0.58) and high vs low: OR 0.18; 95% CI (0.08–0.37)), have rest and sleep during day time (OR 0.47; 95% CI (0.61–0.58)), and attend mother's group meetings (OR 0.29; 95% CI (0.10–0.83)).

Conclusions: Intimate partner violence during pregnancy is associated with low utilisation of antenatal care services. Therefore, effective strategies to prevent or reduce intimate partner violence during pregnancy is needed, which may lead to improved antenatal care service utilization in Nepal with healthier mothers and children's outcome.

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Statement of significance

Problem or issue

There is poor utilisation of Antenatal Care (ANC) services in Nepal.

What is already known

Intimate partner violence (IPV) during pregnancy is common in developing countries and it is one of the major factors associated with poor utilisation of ANC services.

What this paper adds

The study identified that about three of ten women in rural southern Terai of Nepal experiencing IPV during pregnancy, which warrants immediate actions.

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<http://dx.doi.org/10.1016/j.wombi.2017.07.009>

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1. Introduction

Maternal mortality remains high in the developing world, approximately 830 mothers die every day from preventable causes related to pregnancy and childbirth; the rate is higher among women living in rural areas, and among poorer communities.¹ Despite substantial efforts in reducing maternal and child mortality, Nepal has a high maternal mortality ratio of 229 per 100,000 live births, contributing to 11% of all deaths among women of reproductive age (15–49 years), the majority of which are preventable.^{2,3} The government of Nepal introduced a maternity incentive scheme in 2005 which provides women with four Antenatal Care (ANC) visits, free institutional delivery (of baby), maternity care and provision of transportation costs in an effort to reduce maternal mortality.^{4,5} Still, the proportion of pregnant women utilizing ANC service is low in Nepal. About a half of all births are attended by a Skilled Birth Attendant (SBA) in Nepal. There are wide discrepancies in utilising ANC services from a skilled provider (nursing staff) between urban (88%) and rural (55%) areas in Nepal. In Terai region, only 63% of pregnant women are receiving ANC services from a skilled provider.⁶

Utilisation of ANC service is the key strategy to improving maternal and child health outcomes.^{7,8} The benefits of ANC service are numerous. It can help to detect, treat, and prevent pregnancy-related problems; provide tetanus diphtheria immunization, iron tablets, de-worming tablets, nutritional care, advice on appropriate nutrients intake, and proper rest.^{9–12} However, millions of women from low-income countries are not receiving the recommended standard and quality of ANC services.⁸

A number of previous studies on utilisation of ANC services highlighted that maternal age, education, parity, wealth, decision making, and their husband's education and occupation were associated with poor ANC use in Nepal.^{13–15} IPV during pregnancy has been identified as an important factor associated with poor utilisation of ANC services.¹⁶ IPV during pregnancy in Nepal is more prevalent than many other low-income countries,¹⁷ however, no previous study has explicitly examined the impact of IPV on the ANC service utilisation.

IPV refers to any behaviour within the intimate relationship that causes physical, psychological or sexual harm.¹⁸ Several studies from other low- and middle- income countries (LMICs) have demonstrated that IPV was associated with negative maternal and child health outcomes.^{19–23} For example, studies revealed that IPV during pregnancy was significantly associated with termination of pregnancy,²⁴ premature rupture of membranes and increased risk of low birth weight,¹⁹ perinatal and neonatal mortality,²⁵ and pre-term labour which increases in the number of caesarean section cases and hospitalization during pregnancy.²⁶ Similarly, other studies showed that IPV during pregnancy is associated with increased risk of common mental disorders, postnatal depression, and poor health-related quality of life.^{27–29}

Secondary data analysis of national surveys from 19 different countries (17 LMICs and 2 high income countries) showed that IPV during pregnancy is a common experience, ranging from 2% (Australia, Cambodia, Denmark and Philippines) to 13.5% (Uganda).¹⁷ Rates also vary within country: for example, the proportion of women experiencing violence during pregnancy is higher in rural areas (7%) than in urban areas (4%) in Nepal. Rate of IPV during pregnancy is particularly high in the Terai region (9%) compared with other regions in Nepal (4–5%).⁶

In general, women who have experienced IPV during pregnancy reported a lower utilisation of health services, have a lower prospect of decision making power, decreased freedom of movement and increased economic dependency^{30,31} compared to women who did not experience IPV. This also holds true for utilisation of ANC services. For example, a nationally

representative survey in India reported that women who experienced physical violence during pregnancy were less likely to receive prenatal care, home-visits from a health worker for a prenatal check-up, receive at least three prenatal care visits, and less likely to initiate prenatal care early in the pregnancy.³² Similar evidence has been reported from studies in Ghana, Bangladesh, Kenya and Nigeria.^{33–36}

Although the prevalence of IPV during pregnancy is higher in the Terai region compared to other regions of Nepal. It is evident that the associations between IPV and poor utilisation of ANC throughout the country is under-researched. Furthermore, the southern region of Terai in Nepal is characterised by extreme poverty, geographic isolation, low levels of education, poor utilisation of antenatal services.

As mentioned previously, the prevalence of IPV during pregnancy is higher in the Terai region of Nepal, and it is also evident that IPV is associated with poor utilisation of ANC services. However, the evidence for the association of IPV on ANC service utilisation in the southern Terai of Nepal has not well documented. Therefore, we aimed to explore the impact of IPV on ANC service utilisation in the southern Terai of Nepal.

2. Materials and methods

2.1. Study design and setting

This study used a community-based cross-sectional design. The study was conducted across six Village Development Committees (VDCs) consisting of 52 wards in the Dhanusha district of Nepal. This study used the baseline data of 'MATRI-SUMAN' a capacity building and text messaging intervention to enhance maternal and child health service utilisation among pregnant women from rural Nepal: study protocol for a cluster randomised controlled trial (paper under communication). Dhanusha is one of the 75 districts of Nepal situated in the southern Terai (plain area). VDCs are the basic political unit of the district, which is further divided into nine smaller units called wards.³⁷ Each ward functions as a cluster in our study. The study area is predominantly inhabited by rural communities with agriculture as the main occupation (particularly vegetable farming) and the study population is relatively stable. The main residents of the district are from the Maithili ethnic group and the adult literacy rate is 69%. Administratively, the district comprises one municipality and 101 VDCs with an estimated population of 754,777 in 2011.^{37,38} Two health facilities (Dhalkewar health post & Mahendranagar primary health care centre) in the district were purposively selected. There are 12 VDCs in both health facilities, and each health facility was divided into three strata. Then, one VDC was selected randomly from each stratum yielding 6 VDCs comprised of 54 wards that served as clusters. Of the 54 clusters, 2 clusters were excluded from the study as they were semi-urban areas. Data were collected from July 2015 and September 2015.

2.2. Sampling

The sample size was calculated using Open Epi software.³⁹ Our calculation was based on knowing that about 84% of pregnant women in Nepal made at least one ANC visit. We also know that pregnant women who were not a victim of IPV are two times as likely to utilise ANC services as those who were a victim of IPV.⁶ Under these assumptions and presuming 80% power at 95% confidence level, 398 pregnant women were required for a study. We assumed 12% non-response rate and invited a total of 453 participants in this study (Fig. 1).

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