Violence Exposed Nepalese Pregnant Women have an Accepting Attitude to Domestic Violence and Suffer from Emotional Distress

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ABSTRACT

Background

Violence against women and girls is frequent, a third of all women is estimated to experience violence in their lifetime and mostly by an intimate partner. Women in Southeast Asia are most affected, and previous studies in Nepal found that one in five women had experiences of domestic violence, including being afraid of someone in the family.

Objective

To investigate women's attitudes to domestic violence and their emotional distress, in a specific group of pregnant women.

Method

Validated questions from the WHO multi-country study on women's health and experiences of domestic violence, and questions from the Hopkins Symptom Checklist (HSCL-5), measuring depression and anxiety, were used. Women could answer anonymously by hearing questions in a headset and touching a tablet screen, for 'yes' or 'no'.

Result

In total 1011 pregnant women participated in the research and 240 women admitted being exposed to domestic violence (23.7%). These women had a more accepting attitude to violence compared to non-violence exposed women. They agreed more that the husband had good reasons to hit his wife, if she does not complete the household work to his satisfaction, she disobeys or refuses to have sex with him. Violence exposed women also reported more emotional distress and subsequently reduced wellbeing. They admitted worrying too much, feelings of hopelessness, feeling blue, fearful, or nervous.

Conclusion

The present study found that the pregnant Nepali women having an accepting attitude to violence suffer from emotional distress.

KEY WORDS

Attitudes, Domestic violence, Emotional distress, Pregnant women

INTRODUCTION

Violence against women is frequent and defined by the UN's General Assembly in 1993, 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, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. This could be in the form of domestic violence, intimate violence, sexual violence and harassment or non-physical forms of abuse.[1] WHO urges gender inequality to be addressed in research, guidelines, norms, capacity strengthening and building political will through advocacy and partnership.[2]

Violence exposed women may develop serious health consequences, and they are likely to feel fear of partner violence, or to be killed.[3] One in three women globally is estimated to have experienced violence in their lifetime, by an intimate partner at home, and in Southeast Asia 37% of women admit being exposed to violence.[2,4] Men on the contrary are most likely to experience violence in a public place, by a male stranger.[5] Women's attitudinal acceptance of violence is found to be related to socioeconomic factors, parental violence in the childhood, and education levels of husband and wife.[6]

Pregnant women are in a vulnerable period of life and women exposed to physical assault during pregnancy they have higher levels of depressive symptoms compared to non-victims.[7,8] A quantitative study from Nepal conducted among 2004 pregnant women, showed that 21% had experiences of domestic violence, including fear of someone in the family, 3.1% were physically abused during the previous year.[9] Similarly, another Nepalese study, showed that 25% of women were exposed to intimate partner violence and was found that low caste, wife employment, income stress, quarrelling, alcohol consumption, previous exposure to violence, were associated with domestic violence.[10] The Nepal Demographic Health Surveys which had included questions on whether women justify wife-beating and whether they sought help, found that women who felt wife-beating justifiable, were more likely to have experienced domestic violence, but less likely to seek help.[11]

Other studies have been conducted in Nepal regarding the prevalence of violence against women.[9-11] However, the aim of this study was to investigate pregnant Nepalese women's attitudes to domestic violence and emotional distress during ongoing pregnancies. It is hoped that the study will add knowledge to the studies carried out in the field of women's health focusing on the investigation of the prevalence, and women's perceptions of domestic violence, and the pregnancy outcome.[9,12,13]

METHODS

The study was conducted at a hospital, in an semi-urban area, 30 km East of Kathmandu, Nepal, with 17500 inhabitants and the average age of the women who came to the hospital for birthing was 26 years.[14] The study period was from 2014 to 2015. The hospital provides services to approximately 1.9 million people from more than 50 districts. There are close to 3000 childbirths at the hospital, and 15000 antenatal visits a year. Midwives manage normal pregnancies and high-risk cases are referred to obstetricians.

As part of a larger cross-sectional longitudinal investigation on domestic violence in Nepal, pregnant women in gestational age of 12-28 weeks pregnancy were invited for voluntary participation at the antenatal clinic at the hospital.[9,13] Inclusion criteria were women without seeing, hearing or mental disabilities. Exclusion criteria were severely ill or inability to understand Nepali. Illiteracy was not an exclusive criterion. The women were only included once in the study in the same pregnancy.

The recruitment process was facilitated by social mobilisers in the area under the supervision of a research assistant and the first author. For one-year, a self-completed questionnaire was distributed to pregnant women. Information was collected by using a color-coded audio computer-assisted self-interview (C-ACASI) questionnaire on a tablet computer.[9] The participating women received a computer tablet and headset. They were informed to listen to the questions and answer on the tablet. The audio-recording and text were in Nepali. Five questions from the WHO multi-country study of women's health and domestic violence against women with a modified version of the Abuse Assessment Screen (AAS) were used to identify attitudes to domestic violence by the participants.[15] The overarching question was 'Does a man have a good reason to hit his wife if…' and to answer, the responded could select from five scenarios which were: not completing the household to satisfaction, disobedience, refusing sex, asking him if he has other girlfriends or if he suspects her being unfaithful. The women answered by touching color-coded buttons on the screen, indicating "yes", "no" or "I don't know" to the proposed question.[15,16]

Five questions on emotional well-being from the Hopkins Symptom Check List 5 (HSCL-5) measuring psychological and emotional distress were included in the C-ACACI questionnaire.[15,17] The women were asked if …. 'Within the last 14 days have you been'… feeling fearful, experienced nervousness, feeling hopeless or blue or worrying too much. These questions could be answered with one of the options given: "not at all", "a little", "quite a bit" or "extremely". Socio-demographic information such as age, education, income in the family, geographic setting, and obstetric history were added. The questionnaire was translated from English to Nepali and back translated to ensure the accuracy. The answers were transferred from the C-ACASI platform to a data base, the technique has been used in the same group in other Nepalese studies.[9,13]

Eligible women were informed about the ongoing study titled "Women's reproductive health." They were asked if they would like to receive further details about the study and potentially participate. On positive response from them, they were provided with more information. Then if they consented to participate, the women were shown how to use the tablet computer. They completed the questionnaires alone in a private room which required on average 15-30 minutes. Afterwards the women attended their planned antenatal checkup. Only few women declined to participate.

The collected data were analyzed using SPSS version 22. Women's characteristics are described in table 1. Complete information was obtained from 954 women. Differences in attitude to violence and emotional distress, between exposed and non-violence exposed women were calculated with Chi^2 test, after options were dichotomized. For emotional distress, responses 'quite a bit' and 'extremely' were taken to interpret 'being more affected emotionally' and 'not at all' and 'a little', for 'less emotionally affected' in the last 14 days.

Approval for the study was granted by the national, regional, and local Institutional Review Committees. The ethical committees approved the obtaining of verbal consent from the women participants. The women were informed about the possibility to opt out at any time without giving a reason. All women received a brochure called "Safe motherhood," produced by the government of Nepal. They received an anonymous-looking business card with a telephone number to a common female forename. This was a contact number of a female psychosocial counsellor employed at a One-Stop Crisis Management Centre for survivors of gender-based violence, located close to the hospital.[18] This precaution aimed to assist the women in explaining why their visit took longer than expected, if someone accompanying them questioned. Access to a private counselling after the interview was also offered, but none used this.

RESULTS

During one-year 1033 women consented to participate. Twenty-two women were excluded as they did not answer the questions on violence, or they were outside the gestational period of 12-28 weeks. Data from 1011 women was analyzed.

Close to one-quarter of the women, 23.7%, reported experiencing some domestic violence, including fear. Eleven percent of the women had no education and could not read. A quarter of the women had an own income, 7% of them were not allowed to use the income, without the husband's permission. Half of the included women were expecting their first child, and eight out of ten were between 12-24 weeks of gestation (Table 1).

Table 1. Distribution of domestic violence, socio-demographic determinates, and obstetric characteristics among pregnant women in Nepal (n = 1011)

Characteristics	n = 1011 f (%)
Domestic violence	
No domestic violence	771 (76.3)
Violence, including fear of violence	240 (23.7)
Education of women (n = 1008)	
No education (not able to read)	111 (11.0)
Primary education (grade 1-5)	185 (18.4)
Secondary education (grade 6-10)	232 (23.0)
Higher secondary and above (grade 11+)	480 (47.6)
Women's own income and autonomy to use	
No income	766 (75.8)
Income but no autonomy	71 (7.0)
Income and autonomy	174 (17.2)
Parity (n = 957)	
First pregnancy	503 (52.6)
Previous pregnancy without complication	387 (40.4)
Previous pregnancy with complication	67 (7.0)
Gestational age (n = 1003)	
12-24 weeks	814 (81.2)
25-28 weeks	189 (18.8)

In parentheses number n=the numbers of answers given.

Frequency figures in numbers and percentage of prevalence regarding attitudes to domestic violence among violence exposed and non-exposed women are presented in table 2. There were statistically significant differences ($p < 0.05$) between the two groups. Women who had experiences of domestic violence had a more accepting attitude to violence, than women who had not been exposed. The violently treated women agreed more to that a husband has reasons to discipline his wife violently, if she refuses to have sex with him 1.9% differences ($p < .0001$), does not complete the household work to his satisfaction 4.2% differences ($p = 0.001$), or 3.7% differences if she disobeys him ($p = 0.044$). However, there were no statistical differences between the two groups if she asks him whether he has other girlfriends 1.6% differences ($p = 0.081$), nor if he suspected her to be unfaithful 7% differences ($p = 0.07$).

Compiling emotional distress options; 'quite a bit' and 'extremely', among all pregnant women showed that 10-20% admitted being fearful, nervous , hopeless, blue or admitted they were worrying too much in the last 14 days (table 3).

It was found that violence exposed women were more emotionally affected in the last two weeks. Eight out of ten agreed to that they had been distressed to some extent with responses of 'a little', 'quite a bit' or 'extremely'. They had been fearful (81.2%), experienced nervousness or

Table 2. **Attitudes to domestic violence among pregnant women, exposed to violence (N = 240) and non-exposed to violence in Nepal (n=771)**

Does a man have a good reason to hit his wife if ...	Exposed women n=240 f (%)	Non-exposed women n=771 f (%)	Differences (%) between exposed and non-exposed women	p-value
...she does not complete her household work to his satisfaction? n=859	10 (5.4)	8 (1.2)	4.2	0.001
...she disobeys him? n=801	15 (7.9)	26 (4.2)	3.7	0.044
...she refuses to have sexual relations with him? n=908	10 (4.7)	2 (2.8)	1.9	< 0.0001
...she asks him whether he has other girlfriends? n=892	6 (2.8)	8 (1.2)	1.6	0.081
...he suspects or find out that she is unfaithful? n=796	20 (2.5)	58 (9.5)	7	0.07

Table 3. **Emotional distress among pregnant women in Nepal (n=1011)**

Within the last 14 days have you been...	Not at all	A little	Quite a bit	Extremely
Feeling fearful? n=956	314 (32.8)	452 (47.3)	44 (4.6)	146 (15.3)
Experienced nervousness or shakiness? n=919	416 (45.3)	404 (43.9)	21 (2.3)	78 (8.5)
Feeling hopeless about the future? n=933	316 (33.9)	431 (46.2)	39 (4.2)	147 (15.8)
Feeling blue? n=923	372 (40.3)	375 (40.6)	33 (3.3)	143 (15.5)
Worrying too much about things? n=943	335 (35.5)	415 (44.0)	49 (5.2)	144 (15.3)

shakiness (71.6%), felt hopelessness for the future (81.3%), were feeling blue (81.6%) or worrying too much (80.1%) (table 4).

Comparing the two groups, exposed or non-exposed to violence, and answering being 'quite a bit' or 'extremely' emotionally affected in the last two weeks showed statistically differences regarding experiencing nervousness, or shakiness' with 11.5% difference ($p < 0.0001$), 'feeling hopeless about the future' differed 22.9% ($p < 0.0001$), 'feeling blue' 22.2% differences ($p < 0.0001$) and 'worrying too much' 24.5% differences ($p < 0.0001$). 'Feeling fearful' showed 15.1% difference ($p = 0.4899$), did not fall out statistically significantly.

Table 4. **Emotional distress among pregnant women exposed to domestic violence in Nepal (n=240)**

Within the last 14 days have you been...	Not at all f (%)	A little f (%)	Quite a bit f (%)	Extremely f (%)
Feeling fearful? n=230	44 (19.1)	109 (47.4)	19 (8.3)	58 (25.2)
Experienced nervousness or shakiness? n=215	61 (28.4)	106 (49.3)	9 (4.2)	39 (18.1)
Feeling hopeless about the future? n=224	42 (18.8)	88 (39.3)	19 (8,5)	75 (33.5)
Feeling blue? n=225	42 (18.7)	90 (40.0)	13 (5.8)	80 (35.6)
Worrying too much about things? n=231	46 (19.9)	81 (35.1)	24 (10.4)	80 (34.6)

Table 5. **Differences in % among emotionally affected pregnant women in Nepal by domestic violence, violence exposed (n=240) and non-exposed (n=771) women**

Within the last 14 days have you been	Exposed women f (%)	Non-exposed f (%)	Differences (%)	P-value
Feeling fearful	77 (35.0)	190 (19.9)	15.1	0.4899
Experienced nervousness or shakiness?	48 (22.3)	99 (10.8)	11.5	<0.0001
Feeling hopeless about the future?	94 (42.0)	186 (19.9)	22.9	<0.0001
Feeling blue?	93 (41.3)	176 (19.1)	22.2	<0.0001
Worrying too much about things?	104 (45.0)	193 (20.5)	24.5	<0.0001

'Quite a bit+ Extremely' emotionally affected, dichotomized

DISCUSSION

Close to a quarter (23.7%) of more than thousand (1011) Nepali women in this study admitted being exposed to domestic violence. This establishes the severity of this global public health issue and other studies substantiate it with similar figures that violence against women is frequent, and should be addressed.[2,4,15] Pregnancy might be a vulnerable period of life. Studies show that physical assault or sexual coercion by their intimate partners during pregnancy, is closely tied to higher levels of depression, regardless of its frequency compared to non-victims and have provided evidence of chronic, severe, long-term adverse mental health effects for victims.[7,19,20] Further, a study has shown that women with previous psychiatric illness commonly suffer from perinatal distress and have poor prognosis of their disease compared to women with good prognosis of their mental illness.[21] Thus, it is important to investigate and reduce risk factors for emotional distress.

Not surprisingly our study reveals, as other studies, increased emotional distress among women who have

experiences of violence. They felt nervous, hopeless, sad (blue) and worried. Similarly, a study from Myanmar shows that mental distress was significantly associated with domestic violence in women who were afraid of their husbands.[22] The prevalence of postpartum depression in women at a Nepalese postnatal clinic, was not more common than depression rate amongst average Nepalese women, despite the poor living conditions, however association to violence was not examined.[23] Though poverty is debated as one risk factor for domestic violence.[24]

Tolerance to domestic violence may have various reasons and can follow the process of 'normalization', gradually accepting a harmful situation as a socially approved norm.[25] Our study shows a higher acceptance or tolerance to violence among women who are abused, 76% of the women had no own income, which might indicate that they do not see any other option than to stay in the relationship. Women can be forced to stay in a destructive relationship for number of reasons such as dependence on the husband's economy, a divorce may stigmatize a woman, inhibit her from marry again, no allowance to inherit or possess land or fear of having to leave the children with the husband's family in case of a divorce.[26]

The patriarchal structure and male dominance in a society are mentioned as the roots for this common form of violence, and boys learn from men how to be a man in the present culture.[27-29] They meant that violence against women was needed to show manhood.[29] Although in a study it was found that Nepali men believed physical violence should be avoided during pregnancy, as it was considered a sin, and that men who beat pregnant women were not respected by other men. Besides, elderly women's' abuse of daughters-in-law, lack of education and women's powerlessness to escape form a vicious relationship are possible reasons for domestic violence, globally and in Nepal.[12] A Tanzanian study showed that older women accepted domestic violence more than younger women.[30]

The current study was conducted before the pandemic outbreak. High prevalence of domestic violence during the COVID-19 pandemic lockdown is described from Ethiopia and South Africa. Loss of job opportunities, women being more isolated at home, and travel restrictions, are likely to place women at risk of increased abuse. The authors conclude that attention must be given to gender disparities or women may experience worse outcomes.[31,32] A study evaluated the acute impact of COVID-19 on mental health and violence against women in Tunisia, Africa, and the Arab world and found that women who had experienced abuse before the pandemic were at a significant increased risk of violence during lockdown.[33] This might also be the case in Nepal.

Society needs to react with both primary and secondary prevention, engaging social and health workers, as well as communities. Secondary prevention, such as One-Stop Management Crisis Centre which shelters women and children is an immediate way of protection.[18] However, primary prevention by increasing general knowledge to reduce violence is a more sustainable way in societies, not only in patriarchal contexts, as violence against women is a global public health issue. A recent systematic review evaluated 26 interventions aiming to reduce violence against women. They summarize that some services reduced re-exposure to some types of violence, but future interventions need to strengthen capacity to address violence within health systems, communities, and individuals. Furthermore, that support should be better tailored to women's needs and expectations.[34] Women's groups are prevalent and common in Nepal and they discuss various issues, but the men, most often the perpetrators of the intimate violence, need to be enlightened to understand the consequences of violence, and be engaged in men's group, led by men and customized for them.[12]

To identify both victims and perpetrators is crucial to create effective interventions to eliminate domestic violence and mental illness. This is an issue for all health services, and it is important in primary and secondary prevention of domestic violence to reach the Sustainable Developing Goals SDG 5 'Gender equality' and SDG 3 'Good health and Wellbeing' as emphasized by Dr Tedros Adhanom Ghebreyesus, the Director-General of WHO.

"Eliminating all forms of violence against women and girls is critical for achieving the SDG health targets... it is vital that health systems are equipped to prevent and respond to violence. Health systems that are designed to support universal health coverage should ensure that women can access the health services they need, without facing financial hardship".[2,35,36]

Limitation of the present study is that no men or health personnel were included in the study. Their inclusion may have given a more complete picture of the situation. However, it was not the aim of this study. The aim was to find out the women's attitudes and emotions among pregnant women. A strength is that a large material was collected with more than 1000 women included. To use the C-ACASI tablet system is a novelty for a quantitative survey, especially in low resources settings, with the ability to include illiterate women giving anonymous answers.[37]

CONCLUSION

Various studies have shown that violence against women is prevalent, and it affects the emotional well-being of pregnant women. The present study has added that pregnant women accept violence and endure emotional stress that will have potential severe consequences. To successfully address this public health problem, it has become urgent to recognize and address domestic violence at various levels by individual women and men in the communities and by health workers through increasing their awareness about it.

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