

Intimate Partner Violence Disclosure and Associated Factors Among Pregnant Women Attending a City Hospital in South-Western Uganda: A Cross-sectional Study

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Abstract

Background: Pregnancy-associated Intimate Partner violence (IPV) is a significant public health problem in Uganda impacting on maternal and newborn health outcomes adversely. However, IPV disclosure and related factors among gravid women have remained poorly documented in southwestern Uganda.

Methods: In a cross-sectional design, 283 women attending Mbarara City Hospital Antenatal Clinic (ANC) were recruited into the study. The current analysis included 199 women reporting emotional, physical and sexual violence experiences through the present pregnancy.

Results: Of the 199 (70.3%) women who experienced IPV, 99(49.7%) disclosed it to someone. Majority (66.7%) disclosed IPV to their family of birth, 55.5% to friends, 35.3% to husband's family member, 12.1% to neighbors, 9.1% to the healthcare providers, 8.1% to religious leaders, and 3.1% to police. Gravidity, OR= 1.9[95%CI: 1.07-3.31, $p=0.027$], parity OR=1.9[95%CI: 1.08-3.34, $p=0.026$] and witnessed IPV OR: 5.4[95%CI: 1.93-14.96; $p=0.001$] were significantly associated with IPV disclosure.

Conclusion: Half the participants disclosed their IPV experience. Majority of the women disclosed to their female family of birth and very few to healthcare workers. These findings point to the need for healthcare providers to routinely screen for IPV during antenatal care if a high IPV disclosure rate is to be achieved.

Background

Intimate Partner Violence (IPV) during pregnancy is a significant public health problem worldwide (Bailey, 2010). Precisely IPV during the prenatal period is still debatable, though it irrefutably involves many women (Van Parys et al., 2015). Globally, IPV accounts for 30% of all the violence against women aged 15 years and above (Devries et al., 2013). The prevalence of pregnancy-related IPV in sub-Saharan Africa is between 2%-57% (Devries et al., 2010; Shamu, Abrahams, Temmerman, Musekiwa, & Zarowsky, 2011), but 39% in East Africa (García-Moreno et al., 2013). In 2017, the Uganda Demographic and Health Survey (UDHS) reported that six in ten women suffered at least one of the three forms of IPV in their lifetime (UBOS, 2017). Recently in eastern Uganda, IPV of any form during pregnancy was reported as 27.8% (Eputai, Udho, Auma, & Nabirye, 2019). However, men are also victims of partner violence though evidence indicates that women are more susceptible (García-Moreno et al., 2013).

IPV causes great danger to the success of Safe Motherhood Initiative (Onoh et al., 2013). The mother and the fetus suffer adverse effects of IPV (Heaman, 2005; Helweg-Larsen, 2013; Koenig et al., 2010; Sanjel, 2013). Women, in general, tend to desire not to open up personal issues (also known as bedroom issues) to the public, because of the fear of shame and they lack trust in individuals within their social networks (Magnussen et al., 2011). If IPV disclosure process is appropriately conducted, it is an effective strategy to cope with the violence and results in other positive impacts on the victims (Katiti, Sigalla, Rogathi, Manongi, & Mushi, 2016).

However IPV disclosure remains low among women in general for instance 77.9% of the Serbian women did not disclose (Djikanović et al., 2012), in Nigeria, only 46% disclosed IPV experience to either recognized or informal services (Okenwa, Lawoko, & Jansson, 2009), 2009). Among pregnant women 28.6% (Ayodapo, Sekoni, & Asuzu, 2017) and 23.3% (Katiti et al., 2016) did not disclose to anyone. In some cultural groups, taboos around discussing family problems with an outsider are still prohibitive (Mezey & Bewley, 1997). Many pregnant women in abusive relationships experience shame, fear, and stigma which leads to isolation and secrecy for the victim (Murray, Crowe, & Brinkley, 2015). The reported positive effect of IPV revelation include an end to the violence which may guarantee the wellbeing of the mother, her pregnancy, as well as impacting onto IPV strategy formulation (Montalvo-Liendo, 2009). Worldwide, IPV disclosure is projected to vary between 4% and 8% (Shah & Shah, 2010). However, in Nigeria and Tanzania, majority of women disclosed to relatives, friends, religious leaders, or a third party (Ayodapo et al., 2017; Katiti et al., 2016). Victims of partner violence hesitate to disclose abuse to formal establishments including healthcare institutions (Githui, Chege, Wagoro, & Mwaura, 2018). In an earlier study, pregnant women believed that screening provides the victims with the care and facts they require, they acknowledged the failure of disclosing IPV in the healthcare setting (Scholle et al., 2003). The factors identified to accelerate disclosure consist of the belief that family members and treasured friends would not be harmed when the IPV incident is reported, access to support such as housing and support groups, and a sense that privacy, desires, and aspirations would be valued in the incident of disclosing IPV (Curry et al., 2011). On the other hand involvement in communal, spiritual or partisan assemblages aided women to inform someone about the violence experienced (Katiti et al., 2016). However major reasons for failure to disclose among women in general include fear of the perpetrator, feeling uncomfortable with the health care provider and the feeling that IPV was not serious (Spangaro, Zwi, Poulos, & Man, 2010), perceived absence of privacy, unsuitable means of probing and stigmatizing attitude from care providers (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Githui et al., 2018). The lack of trust in service providers and insufficient time in talking over IPV with ANC clients contribute to the failure of disclosure among prenatal women, (Katiti et al., 2016). Failure to disclose may predispose to maternal mental health problems (Helweg-Larsen, 2013) reduced maternal weight, increased likelihood of undergoing caesarian delivery, and maternal mortality (Koenig et al., 2010; Sanjel, 2013), and inadequate uptake of ANC (Heaman, 2005) hence an obstacle to achievement of the safe motherhood initiative (Onoh et al., 2013). On the other hand, fetal effects include premature birth and intrauterine fetal demise (Koenig et al., 2010; Sanjel, 2013). ANC visit provides an opportunity for disclosure and intervention that could reduce the adverse effects of IPV during the perinatal period (Githui et al., 2018).

The majority of women in developing countries interact with healthcare workers during ANC. In Uganda, the ANC policy recommends at least four visits during pregnancy and at least once during the postnatal period with a likelihood of continued monitoring, hence providing a perfect opportunity for reporting and discussing IPV (Devries et al., 2010). However, there is little evidence on IPV disclosure among pregnant women attending ANC in Uganda. In this setting, earlier IPV studies focused on the general population while few investigated IPV prevalence in pregnancy (Auma et al., 2020; Clarke et al., 2019; Eputai et al.,

2019). Therefore, this study determined the IPV disclosure and associated factors among pregnant women attending a large City hospital.

Methods

Study design, setting and population

This study adopted a descriptive cross-sectional design and was conducted among antenatal women at the ANC clinic of a high-volume Mbarara City Hospital in southwestern Uganda during January 2019. The hospital operates daily general outpatient, ANC, family planning and young child clinics; and an inpatient maternity ward. The hospital database of 2018 indicated that on average, there were 800 pregnant women monthly attendance (new ANC cases and re-attendance) and they resided in and outside Mbarara City.

Sample size and data collection

A sample of 283 pregnant women was determined for recruitment following standard methods (Kish & Sons, 1965), assuming 23.3% disclosure as reported in Moshi Municipality of Tanzania (Katiti et al., 2016) with probability (p -value) set at 0.05.

Quantitative data collection commenced following the three-day training of two research assistants and a qualified counsellor. Data were collected using World Health Organization (WHO) study questionnaire for assessing IPV among women (García-Moreno et al., 2005), as had been used elsewhere (Ayodapo et al., 2017; Kapiga et al., 2017). A second structured questionnaire on whom the disclosure was made, was constructed based on literature. Both questionnaires in English were translated into Runyankore (the local language) and back-translated into English by a language expert.

After the routine health education sessions that start at 08:30 hours before healthcare workers start receiving clients in the ANC clinic, all women were briefed about the study. Individual interviews were conducted privately with pregnant women aged 15 to 49 years in one of the consultation rooms at the hospital after written consent. The filled questionnaires were manually checked for completeness before leaving the participants.

Study variables and measures

Outcome measures

Presence of intimate partner violence

With the WHO data collection tool, the presence of IPV stood well-defined as participants who experienced one of the three forms of IPV (psychological, physical and sexual violence). The woman stating the following: restricted from seeing friends and family members of origin, actions were done on purpose to intimidate her, having been demeaned in front of others; threatened to be injured, destined to psychological violence. Having been beaten up; punched: strangulated; intimidated with a weapon destined to physical violence. Had involuntary coitus with her partner: had coitus due to fear of what the spouse would do: having coitus in a way that was humiliating destined to sexual violence. This was reported to be effective and can distinguish the numerous types of IPV among individuals (Schraiber, Latorre, França Jr, Segri, & d'Oliveira, 2010).

IPV disclosure

The primary outcome was IPV disclosure that was measured as a binary variable (Yes/No).

Data Management and analysis

The filled questionnaires were cleaned before data entry in EpiData 3.1 software (The EpiData Association, Odense, Denmark) and analysed in STATA (v.14, Stata Corp. LP, College Station, Texas, USA) for analysis. Univariate followed by bivariate analyses were carried out.

Results

Socio-demographic and Clinical Characteristics of Pregnant Women

Overall 283 ANC women who attended Mbarara City Hospital during January 2019 were recruited into the study (Table 1). Approximately 50.2% were aged 20-24 years with the youngest and eldest being 15 and 49 years old, respectively. The same proportion of participants (50.2%) was in the second trimester. Again 51.6% were carrying their first pregnancy. Some 54.8% had never had any child before and this included the first pregnancy and those who had miscarriage. The majority (93.6%) were living with their sexual partners. Only 71% intended to conceive the current pregnancy. Again 50.2% were Anglicans, 38.9% Catholic, 9.5% Muslim while the rest belonged to minority religious groups that included Seventh Day Adventists (SDA). The study setting being their home district, the Banyankore ethnic group constituted the majority (72.8%). Regarding employment, 41% was self-employed. Some (44.5%) participants attained secondary education. Meanwhile, 92.9% were not alcohol users.

Table 1

Socio-Demographic and Clinical Characteristics of Study Participants

Variable	<i>n (%)</i>
Age in years	24.58±4.33*
15 - 19	23(8.1)
20 - 24	142(50.2)
25-29	83(29.3)
30-34	29(10.3)
≥35	6(2.2)
Trimester at time of interview	
1 st	15(5.3)
2 nd	142(50.2)
3 rd	126(44.5)
Gravidity	1.82±1.04*
1	146 (51.6)
2	71(25.1)
3	46(16.3)
≥4	20(7)
Parity	
None	155(54.8)
1	69(24.4)
2	38(13.4)
3	13(4.6)
4	7(2.4)
≥5	1(0.4)
Intended pregnancy	
Yes	201(71)
No	82(28.9)
Religion	
Anglican	140(50.2)

Catholic	109(38.9)
Muslim	27(9.5)
Seventh-Day Adventist	4(1.4)
Others	3(1.1)
Tribe	
Munyankore	206(72.8)
Mukiga	39(13.8)
Muganda	24(8.5)
Others	14(5)
Marital status	
Living with a partner	265(93.6)
Separated	14(5)
Single	4(1.4)
Occupation	
Salaried job	67(23.7)
Self-employed	116(41)
Not employed	100(35.3)
Education level	
No formal education	93(1.1)
Primary	62(21.9)
Secondary	126(44.5)
Tertiary	92(32.5)
Alcohol consumption	
Yes	20(7.1)
No	263(92.9)
*±Mean and standard deviation	

The IPV prevalence

Out of the 283 pregnant women enrolled, 199(70.3%) had experienced some form of IPV in their current prenatal period (Table 2). Psychological IPV was the most prevalent (38.2%). None of them had experienced exclusively physical violence. The majority had both psychological and sexual violence (22.3%) and 3.5% experienced all the forms of IPV.

Table 2

Prevalence and forms of IPV among pregnant women

Variable(N=283)	<i>n (%)</i>
Experienced IPV	199(70.3)
Forms of IPV	
One	
Psychological	108 (38.2)
Sexual violence	9(3.2)
Physical violence	0(0)
Two	
Psychological plus Sexual	63(22.3)
Psychological plus Physical	8(2.8)
Physical plus Sexual	1(0.4)
Three	
Psychological plus Physical plus Sexual	10(3.5)

The Prevalence of IPV Disclosure

Out of 199 women who experienced violence in the current pregnancy, 99(49.7%) told a third person about it (Table 3). Most of the participants informed a supporter from their family of origin (66.7%) and only (9.1%) disclosed to healthcare providers.

Table 3

The Prevalence of IPV Disclosure

Variable	Disclosure	
	Yes <i>n</i> (%)	No <i>n</i> (%)
Overall	99 (49.7)	100(50.3)
Person of Disclosure*		
Health worker	9(9.1)	90(90.9)
Husband's birth family	35(35.3)	64(64.6)
Woman's family of origin	66(66.7)	33(33.3)
Neighbor	12(12.1)	87(87.9)
Religious leader	3 (3)	96(97)
Woman's Friends	51(55.5)	48(48.5)
Police	8 (8.1)	91(91.9)
Others	3 (3)	96(97)
*Multiple response questions		

Reasons for disclosure of IPV experience among pregnant women

Variable	Frequency*	Percentage (%)
To access support	108	96.5
needs and wishes would be respected	82	73.2
Personal safety	78	69.6
Could not endure any more	76	67.9
Keeping other family members/loved ones safe	39	34.8
Threatened or tried to kill me	25	22.3
Saw that children were suffering	17	15.2
*Multiple responses		

The majority of the participants wanted to disclose to access support (96.5%) and the minority 15.2% disclosed because they saw their children suffering.

Factors associated with IPV disclosure among pregnant women

From table 4 below, experiencing IPV in the presence of someone accounted for five times the likelihood of disclosing than those experiencing it in absence of a third person (OR = 5.7, 95%CI: 2.09-15.83, $p=0.001$). Women who had had two or more pregnancies were 1.9 times more likely to disclose than those with the first pregnancy (OR= 1.9, 95%CI: 1.07-3.31, $p=0.027$). Again women with one or more children were 1.9 times more likely to disclose than those who had never had a child (OR=1.9, 95%CI: 1.08-3.34, $p=0.026$).

Table 4

Bivariate analysis of factors influencing IPV disclosure among pregnant women

Variable		Disclosure		UOR(95%CI)	p-value
		Yes, n (%)	No, n (%)		
N=199					
Age (years)	15-29	84(48%)	91(52%)	1.0	0.180
	30 +	15(62.5%)	9(37.5%)	1.8(0.75-4.34)	
Trimester at time of interview	1st	4(40%)	6(60%)	1.0	0.799
	2nd	48(49.5)	49(50.5)	1.5(0.39-5.54)	
	3rd	47(51.1)	45(48.9)	1.6(0.41-5.92)	
Gravidity	First pregnancy	46 (42.9)	61(57.0)	1.0	0.027*
	≥2 pregnancies	54(58.7)	38(41.3)	1.9(1.07-3.31)	
Parity	None	48 (43.2)	63(56.8)	1.0	0.026*
	≥1	52(59.1)	36(40.9)	1.9(1.08-3.34)	
Intended pregnancy	Yes	63(46.7%)	72(53.3%)	1.0	0.207
	No	36(56.3%)	28(43.8%)	0.7(0.37-1.24)	
Religion	Catholics	43(57.3)	32	1.0	0.206
	Anglican	47(48)	51(52)	0.7(0.37-1.26)	
	Others	10(38.5)	16(61.5)	0.5(0.19-1.16)	
Tribe	Munyankore	75(52.5%)	68(47.6%)	1.0	0.322
	Others	25(44.6)	31(55.4)	0.7(0.39-1.36)	
Marital status	Living with partner	92(49.5)	94(50.5)	1.0	0.4
	Not living with partner	8(61.5)	5(38.5)	1.1(0.60-1.91)	

Occupation	Gainfully employed	63(49.6)	64(50.4)	1.0	0.809
	Not employed	37(51.4)	35(48.6)	1.1(0.60-1.91)	
Education level	None or primary education	25(52.0)	24(49)	1.0	0.901
	Secondary and above	45(51.1)	43(48.9%)	0.9(0.50-1.83)	
Communication to the family of birth/partner	At least once a week	86(51.5)	81(48.5)	1.0	0.422
	Once a month and above	14(43.8)	18(56.3)	0.7(0.34-1.57)	
Forms of violence	One form	67(57.3)	50(42.7)	1.0	0.061
	Two forms	29(40.3)	43(59.7)	1.9(1.05-3.48)	
	Three forms	4(40)	6(60)	1.9(0.52-7.24)	
Witnessed IPV	No	77(45)	94(55)	1.0	0.001*
	Yes	23(82.1%)	5(17.9)	5.7(2.03-15.46)	
*Statistically significant					

Discussion

Intimate Partner Violence disclosure and the factors associated with the disclosure among pregnant women attending a City Hospital in Southwestern Uganda was determined. Key findings indicate that 70.3% of participants were victims of IPV (including psychological, sexual, and or physical) of whom only 49.7% disclosed their IPV experience. This proportion of disclosure was higher than that observed in Tanzania (23.3%) (Katiti et al., 2016), Nigeria 46% (Okenwa et al., 2009), Dhaka 21% (Parvin, Sultana, & Naved, 2016) but similar to that reported in Ethiopia 51.4% (Agenagnaw, Tebeje, & Tilahun, 2020) and. The higher rate of IPV disclosure reported here may be attributed to the perceived assurance of confidentiality by those they disclosed to and in such cases, the majority disclosed to their family origin considering them as very good at keeping secrets as well as providing constructive marital guidance. Indeed, an earlier study (Sigalla et al., 2017) reported that women disclose affiliation trials to their kinfolk and this, in turn, encouraged them to remain in the abusive relationships (McCleary-Sills et al., 2016).

For the majority of the women (66.7%), IPV disclosure was to the kinfolk. These results are comparable with a Nigerian study wherein, an equivalent proportion of women (68%) expressed the readiness of IPV

disclosure to the kinsfolk (Okenwa et al., 2009). The probable reason for IPV victims to prefer disclosing to the kinsfolk might be due to the solid personal connection between them, unlike other society members who tend to enact stigma and embarrassment upon the victim-survivors. A study in Tanzania explained IPV as being highly normalized, victims are made quiet by their fright of social consequences, the fright reinforced by the acceptance that it is women's IPV disclosure that conveys embarrassment, instead of the perpetrator's violent act (McCleary-Sills et al., 2016). Earlier research showed that the victim's in-laws and friends of the violent intimate partner were least supportive (Rizo & Macy, 2011). Women are respected by in-laws and therefore such respect impacts onto their ability to disclose to the husband's family members (McCleary-Sills et al., 2016). Other studies have associated fear of revenge, not wanting to get the perpetrator into trouble, the feeling that the situation was not worth reporting and to keep the situation more private as factors promoting IPV disclosure to the woman's family (Ayodapo et al., 2017)

Surprisingly in the current study, only 9.1% disclosed IPV experience to healthcare providers. This rate is lower than that reported in Serbia (25.7%) (Djikanović et al., 2012), but it is unacceptably low considering that pregnancy increases women's contact with healthcare staff particularly midwives who provide valuable information to benefit both the mother and her fetus. This low rate of disclosure may be explained by the sociocultural belief that women must keep secret their intimate partner problems. Indeed one study reported that IPV victims perceived conjugal difficulties as their own (Hegarty & Taft, 2001). These pregnant women experiencing IPV need counseling services because of the adverse effects on the fetus and the mother. If disclosure to the healthcare providers increases then IPV associated complications would be reduced. Already a Nigerian study reported that social support was associated with reduced adverse consequences for IPV victims and their quality of life greatly improved (Ayodapo et al., 2017). IPV screening in health facilities points to early IPV detection (De Boinville, 2013) and IPV disclosure is an indispensable step in guaranteeing reassurance healthcare service providers, seeking out safe refuge and attaining lawful protection (Sylaska, 2014).

The current findings revealed that women who experienced violence in the presence of a third party were more likely to disclose, and echoes that reported in the United States of America (Sylaska, 2014). It is possible that the witness provides courage, confidence and guidance for the victim to seek support elsewhere. Previous research reported motivation for IPV disclosure as having children in the violent relationship (Agenagnew et al., 2020; García-Moreno et al., 2005; Parvin et al., 2016). This could be attributed to the women's fear of IPV effect on their children since they might also be threatened or hit by the perpetrator during the scuffle. Pregnant women who had children were more likely to disclose than those who had none. It is natural for women to feel uncomfortable when children are suffering more so women can feel guilty due to the thought of themselves contributing to the suffering as they are directly involved in the violent relationship.

Recommendations

Currently in Uganda, there is no recommended strategy in clinical practice targeting IPV. This denotes that majority of victims will remain suffering the already reported preventable yet fatal consequences of IPV. Therefore as a policy, screening of IPV should be incorporated in the Clinical Guidelines that should routinely be carried out during prenatal care to detect and appropriately manage potential IPV cases as early as possible.

Limitation

Since IPV is culturally a sensitive issue in Uganda, there is a possibility that participants provided socially desired responses. However, this was minimized by ensuring anonymity, confidentiality, training interviewers about empathy, and use of private room during interview.

Conclusion

The IPV burden in this clinical setting is very high and widespread among pregnant women, however, about half of them disclosed their IPV experience. Pregnant women preferred IPV disclosure to their kinfolk and less to healthcare providers. Hence, there is a very high rate of IPV experience with lower disclosure patterns in Mbarara City Hospital in southwestern Uganda, which eventually may have adverse physical, social, and emotional effects on the pregnant women if no intervention is put in place.

Abbreviations

ACOG: American College of Obstetricians and Gynecologists

ANC: Antenatal Care

FGD: Focused Group Discussion

IPV: Intimate Partner Violence

SDG: Sustainable Development Goal

UDHS: Uganda Democratic Health Survey

WHO: World Health Organization

Declarations

- Ethics authorization and consent to participate

The study was reviewed and cleared by Mbarara University of Science and Technology (MUST) Faculty of Medicine Research Committee (Ref: DMS 6) as well as MUST Research Ethics Committee (Ref: MUREC 1/7). MUREC is accredited by Uganda National Council for Science and Technology, and is recognized internationally and received accreditation from the United States Federal Wide Assurance (FWA00007740). Therefore, all methods were carried out in accordance with relevant national and international guidelines and regulations. Each participant signed an informed consent form at the time of enrollment.

- Consent for publication

Not relevant

- Data availability

The dataset used this research is available from the corresponding author on reasonable request.

- Conflicts of Interest

None declared.

- Funding

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- Authors' contribution

KE and BV designed the study. KE took part in data collection, data analysis, and drafted the manuscript. AJB drafted the manuscript. BV advised on data entry, analysis in addition to manuscript review for logical content. All authors read and sanctioned the final manuscript.

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